



3 A.A.C. 3

Supp. 24-4

## TITLE 3. AGRICULTURE

### CHAPTER 3. DEPARTMENT OF AGRICULTURE - ENVIRONMENTAL SERVICES DIVISION

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Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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**The release of this Chapter in Supp. 24-4 replaces Supp. 24-1, 1-52 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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**TITLE 3. AGRICULTURE****CHAPTER 3. DEPARTMENT OF AGRICULTURE - ENVIRONMENTAL SERVICES DIVISION**

Authority: A.R.S. §§ 3-341 et seq. and 3-3101 et seq.

**Supp. 24-1**

*Title 3, Chapter 3, Article 1, Section R3-3-101 renumbered from Title 3, Chapter 10, Article 1, Section R3-10-101; Title 3, Chapter 3, Article 2, Sections R3-3-201 through R3-3-212 renumbered from Title 3, Chapter 10, Article 2, Sections R3-10-201 through R3-10-212; Title 3, Chapter 3, Article 3, Sections R3-3-301 through R3-3-314 renumbered from Title 3, Chapter 10, Article 2, Sections R3-10-301 through R3-10-314; Title 3, Chapter 3, Article 4, Sections R3-3-401 through R3-3-404 renumbered from Title 3, Chapter 10, Article 4, Sections R3-10-401 through R3-10-404; Title 3, Chapter 3, Article 5, Sections R3-3-501 through R3-3-506 renumbered from Title 3, Chapter 10, Article 5, Sections R3-10-501 through R3-10-506; Title 3, Chapter 3, Article 6, Sections R3-3-601 through R3-3-617 renumbered from Title 3, Chapter 10, Article 6, Sections R3-10-601 through R3-10-617; Title 3, Chapter 3, Article 7, Sections R3-3-701 through R3-3-712 renumbered from Title 3, Chapter 3, Article 1, Sections R3-3-01 through R3-3-12; Title 3, Chapter 3, Article 8, Sections R3-3-801 through R3-3-812 renumbered from Title 3, Chapter 3, Article 2, Sections R3-3-21 through R3-3-32; Title 3, Chapter 3, Article 9, Sections R3-3-901 through R3-3-916 renumbered to Title 3, Chapter 3, Article 3, Sections R3-3-41 through R3-3-56 (Supp. 91-4).*

*New Sections R3-10-101, R3-10-201 through R3-10-212, R3-10-301 through R3-10-306, R3-10-308 through R3-10-312, R3-10-401 through R3-10-403, R3-10-501 through R3-10-505, and R3-10-601 through R3-10-617 adopted effective November 20, 1987.*

*Former Sections R3-10-01, R3-10-03, R3-10-20 through R3-10-25, R3-10-40 through R3-10-42, R3-10-42.01, R3-10-43 through R3-10-62, R3-10-64 through R3-10-66, R3-10-70, R3-10-71, R3-10-73 through R3-10-75, R3-10-77 through R3-10-87, R3-10-89, and R3-10-91 repealed effective November 20, 1987.*

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(Authority: A.R.S. § 3-3101 et seq.)

*Title 3, Chapter 8, Article 2, Sections R3-8-201 through R3-8-208 renumbered to Title 3, Chapter 3, Article 10, Sections R3-3-1001 through R3-3-1008 (Supp. 91-4).*

*New Article 7 adopted effective July 13, 1989. (Supp. 89-3).*

*Article 2, consisting of Sections R3-2-201 through R3-8-208, transferred from the Industrial Commission, Title 4, Chapter 13, Article 7, Sections R4-13-701 through R4-13-708, pursuant to Laws 1990, Ch. 374, § 445 (Supp. 91-3).*

*Laws 1981, Ch. 149, effective January 1, 1982, provided for the transfer of the Office of Fire Marshal from the Industrial Commission to the Department of Emergency and Military Affairs, Division of Emergency Services (Supp. 82-2).*

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## ARTICLE 1. GENERAL PROVISIONS

**R3-3-101. Definitions**

In addition to the definitions in A.R.S. §§ 3-341 and 3-361, the following terms apply to this Chapter:

“Acute toxicity” means adverse physiological effects that result from a single dose or single exposure to a chemical; or any poisonous effect produced by a single dose or single exposure to a chemical within a short period of time, usually less than 96 hours.

“ADEQ” means the Arizona Department of Environmental Quality.

“Adulterate” means to change a pesticide so that:

Its strength or purity falls below the standard of quality stated on the labeling under which it is sold,

Any substance has been substituted wholly or in part for the pesticide, or

Any constituent of the pesticide has been wholly or in part abstracted.

“Agricultural aircraft pilot” or “AAP” means any individual who pilots an agricultural aircraft to apply a pesticide.

“Agricultural commodity” means any plant, animal, plant product, or animal product produced for commercial or research purposes.

“Agricultural establishment” means any farm, ranch, forest, nursery, or greenhouse.

“Agricultural purpose” means use of a pesticide on an agricultural commodity. It excludes the sale or use of pesticides, in properly labeled packages or containers, for either home use, or use in swimming pools or spas.

“Agricultural use pesticide” means a pesticide product bearing a label requiring compliance with the Worker Protection Standard, and as prescribed by the agricultural use requirements on the label.

“Aircraft” means any mechanism used in flight.

“ALJ” means, according to A.R.S. § 41-1092, an individual or the Director who sits as an administrative law judge, who conducts administrative hearings in a contested case or an appealable agency action, and who makes decisions regarding the contested case or appealable agency action.

“Animal” means all vertebrate and invertebrate species, including, but not limited to, humans and other mammals, birds, fish and shellfish. A.R.S. § 3-341(3)

“Application site” means the specific location, crop, object, field, or other area to which a pesticide is or is intended to be applied.

“Applicator” means any individual who applies, or causes to have applied, any pesticide on an agricultural establishment or golf course.

“Associate Director” means the Associate Director of the Environmental Services Division.

“Authorized activities” means, for compliance with A.R.S. § 3-365(D), any organized activities scheduled at a school or child care facility that use the school or child care facility or the school or child care grounds and for which the sponsors or organizers of the activity have received the written approval of

a responsible administrative official of the school or child care facility.

“Buffer zone” means an area of land that allows pesticide deposition and residues to decline to a level that poses a reasonable certainty of no harm to a defined area.

“Bulk release” means the release of any pesticide or mixture of pesticides that poses a potential risk to property, human health, or the environment in volumes greater than those prescribed by the pesticide label for the application site. A pesticide dripping from a spray nozzle or minor splashing during mixing is not a bulk release.

“Certification plan” means an EPA authorized plan under 40 CFR § 171.303 (82 FR 1042, January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171/subpart-D/section-171.303>) for the certification of pesticide applicators to comply with the provisions of FIFRA. This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.

“Certified applicator” means any individual who is certified by the Department to use or supervise the use of any restricted use pesticide as a private, golf or commercial applicator.

“CEU” means continuing education unit.

“Child care facility” means any facility in which child care is regularly provided for compensation for five or more children not related to the proprietor and is licensed as a child care facility by the Arizona Department of Health Services. A.R.S. § 36-881(3). Child care facilities are commonly known as day care centers.

“Commercial applicator” or “PUC” means a certified applicator (whether or not the applicator is a private applicator with respect to some uses) who uses or supervises the use of a restricted use pesticide for any purpose or on any property other than for producing an agricultural commodity on property owned or controlled by:

The applicator;

The applicator’s employer; or

Another person, if the application is performed without compensation, other than trading of personal services between producers of agricultural commodities.

“Contamination” means a concentration of pesticide sufficient to violate state or federal water, soil, food, feed, or air contamination standards, except if legally applied.

“Continued pesticide application” means the continuance of an interrupted application of the same pesticide to the same application site within the same section, township, and range within the same reporting period.

“Custom application equipment” means aircraft, drones, remote-controlled equipment, and ground equipment used for pesticide application by a custom applicator.

“Custom applicator” or “CAL” means any person, except a person regulated by the PMD, who applies pesticides for hire, by drone, or by aircraft.

“Defoliation” means killing or artificially accelerating the drying of plant tissue with or without causing abscission.

“Device” means any instrument or contrivance that is intended to be used for trapping, destroying, repelling, or mitigating any

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pest or any other form of plant or animal life, other than a human being and a bacterium, virus, or other microorganism on or in a living human being or other living animal. Device does not include firearms, mechanical traps, or equipment used for the application of pesticides if the application equipment is sold separately.

“Diluent” means any substance added to a pesticide before application to reduce the concentration of the active ingredient in the mixture.

“Direct release” means to apply a pesticide outside the boundaries of an application site, at the time of application, while the valve controlling the normal flow of pesticide from the application device is in the open position and the application device is not within the confines of the application site. Direct release does not mean the drift or discharge of a pesticide caused by a mechanical malfunction of the application device that is beyond the control of the operator. Direct release does not mean a release caused by accident, or done to avoid an accident that would have resulted in greater harm than that caused by the pesticide release.

“Disposal” means discarding a pesticide or pesticide container that results in the deposit, dumping, burning, or placing of the container or unused pesticide on land or into the air or water.

“Drift” means the physical movement of pesticide through the air at the time of a pesticide application from the application site to any area outside the boundaries of the application site. Drift does not include movement of a pesticide or associated degradation compounds to any area outside the boundaries of an application site if the movement is caused by erosion, run off, migration, volatility, or windblown soil particles that occur after application, unless specifically addressed on the pesticide label with respect to drift control requirements.

“Drone” means a remote-controlled pilotless aircraft or small flying device used to apply pesticides.

“Drone Pilot License” or “DPL” means any individual who pilots a drone to apply a pesticide.

“EPA” means the United States Environmental Protection Agency.

“Experimental use permit” means a permit issued by the EPA, or the Department according to A.R.S. § 3-350.01, to a person for the purpose of experimentation, which includes the accumulation of information necessary for the registration of a pesticide.

“Exposure” means the inhalation or ingestion of a pesticide, or eye or skin contact with a pesticide.

“FAA” means the Federal Aviation Administration.

“FIFRA” means the Federal Insecticide, Fungicide and Rodenticide Act, 7 U.S.C. §§ 136 et seq. (as amended P.L. 117-328, December 29, 2022, <https://www.govinfo.gov/content/pkg/COMPS-10326/uslm/COMPS-10326.xml>). This material is incorporated by reference throughout the Chapter, is on file with the Department and includes no later amendments or editions.

“Fumigant” means a substance or mixture of substances that produces gas vapor or smoke intended to control a pest in stored agricultural commodities or to control burrowing rodents.

“Golf applicator” or “PUG” means an applicator who uses or supervises the use of a restricted use pesticide for the maintenance of the ornamental and turf areas of the golf course that is owned or controlled by the applicator or the applicator’s employer.

“Handler” means any person, including a self-employed person:

Who is employed for any type of compensation by an agricultural establishment or commercial pesticide handling establishment to which this Article applies and who is:

Mixing, loading, transferring, or applying pesticides.

Disposing of pesticides or pesticide containers.

Handling opened containers of pesticides.

Acting as a flagger.

Cleaning, adjusting, handling, or repairing the parts of mixing, loading, or application equipment that may contain pesticide residues.

Assisting with the application of pesticides.

Entering a greenhouse or other enclosed area after the application and before the inhalation exposure level listed in the labeling has been reached or one of the ventilation criteria established under 40 CFR § 170.110(c)(3) of the Worker Protection Standard (August 21, 1992, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-170/subpart-B/section-170.110>) The incorporated reference is on file with the Department and does not include any later amendments or editions, or in the labeling has been met:

To operate ventilation equipment.

To adjust or remove coverings used in fumigation.

To monitor air levels.

Entering a treated area outdoors after application of any soil fumigant to adjust or remove soil coverings such as tarpaulins.

Performing tasks as a crop advisor:

During any pesticide application.

Before the inhalation exposure level listed in the labeling has been reached or one of the ventilation criteria established under 40 CFR § 170.110(c)(3) of the Worker Protection Standard (August 21, 1992, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-170/subpart-B/section-170.110>), or in the labeling has been met. The incorporated reference is on file with the Department and does not include any later amendments or editions.

During any restricted-entry interval.

The term does not include any person who is only handling pesticide containers that have been emptied or cleaned according to pesticide product labeling instructions or, in the absence of such instructions, have been subjected to triple-rinsing or its equivalent.

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“Health care institution” means any institution that provides medical services, nursing services, health screening services, and other health-related services, and is licensed by the Arizona Department of Health Services.

“Highly toxic pesticide” means a pesticide with an acute oral LD<sub>50</sub> of 50 milligrams per kilogram of body weight or less, dermal LD<sub>50</sub> of 200 milligrams per kilogram of body weight or less, or inhalation LD<sub>50</sub> of 0.2 milligrams per liter of air or less, and the label bears the signal words “danger” and “poison” and shows a skull and crossbones.

“Immediate family” includes only spouse, children, stepchildren, foster children, parents, stepparents, foster parents, brothers, and sisters.

“Individual” means a human being.

“*Insect*” means any of the numerous small invertebrate animals generally having the body more or less obviously segmented, for the most part belonging to the class insecta, comprising six-legged, usually winged forms, as for example, beetles, bugs, bees, and flies, and to other allied classes of arthropods whose members are wingless and usually have more than six legs, as for example, spiders, mites, ticks, centipedes and wood lice. A.R.S. § 3-341(14)

“Integrated Pest Management” or “IPM” means a sustainable approach to managing pests that uses any combination of biological, chemical, cultural, genetic, manual, or mechanical tools or techniques in a way that minimizes health, environmental, and economic risks.

“*Label*” means the written, printed or graphic matter on, or attached to, the pesticide or device, or the immediate container thereof, and the outside container or wrapper of the retail package, if there is any, of the pesticide or device. A.R.S. § 3-341(15)

“Labeling” means all labels and other written, printed or graphic matter:

Upon the pesticide or device or any of its containers or wrappers.

Accompanying the pesticide or device at any time.

*To which reference is made on the label or in literature accompanying the pesticide or device, except when accurate, non-misleading reference is made to current official publications of the United States departments of agriculture or interior, the United States public health service, state experiment stations, state agricultural colleges or other similar federal institutions or official agencies of the state or other states authorized by law to conduct research in the field of pesticides.* A.R.S. § 3-341(16).

“LD<sub>50</sub>” means a statistically derived estimate of a single dose of pesticide that can be expected to cause death in 50 percent of laboratory test animals as determined by an EPA approved procedure. The LD<sub>50</sub> value is expressed in terms of weight of test substance per unit weight of the test animal (mg/kg)

“Livestock” means clovenhoofed animals, horses, mules, or asses.

“PCA” or “agricultural pest control advisor” means any individual who, as a requirement of, or incidental to, the individual’s employment or occupation:

Offers a written recommendation to a regulated grower or to any public or private agency concerning the control of any agricultural pest,

Claims to be an authority or general advisor on any agricultural pest or pest condition, or

Claims to be an authority or general advisor to a regulated grower on any agricultural pest.

“*Person*” means any individual, partnership, association, corporation or organized group of persons whether incorporated or not. A.R.S. § 3-341(19)

“Pest” means:

Any weed, insect, vertebrate pest, nematode, fungus, virus, bacteria or other pathogenic organisms.

*Any other form of terrestrial or aquatic plant or animal life, except virus, bacteria or other microorganism on or in living humans or other living animals, which the director declares to be a pest for the purpose of enforcement of this Article.* A.R.S. § 3-341(20)(b)

“*Pesticide*” means any substance or mixture of substances intended to be used for defoliating plants or for preventing, destroying, repelling or mitigating insects, fungi, bacteria, weeds, rodents, predatory animals or any form of plant or animal life which is, or which the director may declare to be, a pest which may infest or be detrimental to vegetation, humans, animals or households or which may be present in any environment. A.R.S. § 3-361(6)

“Pesticide container” means any container with an interior surface that is in direct contact with a pesticide.

“Pesticide Grower Permit” or “PGP” means a permit issued by the Department that allows a qualifying person to act as a regulated grower.

“*Pesticide use*” means the sale, processing, storing, transporting, handling or applying of a pesticide and disposal of pesticide containers. A.R.S. § 3-361(7)

“PMD” means the Pest Management Division of the Arizona Department of Agriculture.

“Private applicator” or “PUP” means a certified applicator who uses or supervises the use of a restricted use pesticide for producing an agricultural commodity on property owned or controlled by:

The applicator;

The applicator’s employer; or

Another person, if the pesticide is applied without compensation, other than trading of personal services between producers of agricultural commodities.

“Property boundary” means the legal boundary of the land on which a child care facility, health care institution, residence, or school sits, unless another boundary is established by a written agreement with the owner of the child care facility, health care institution, residence, or school. Under a written agreement, the parties shall not establish a boundary that is less than ten feet from the child care facility, health care institution, residence, or school.

“Ready-to-use” means a registered pesticide, in the manufacturer’s original container, that does not require dilution by the end user.

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“Regulated grower” means a person who acquires or purchases pesticides or contracts for the application of pesticides to agricultural commodities, onto an agricultural establishment, or onto a golf course as a part of the person’s normal course of employment or activity as an owner, lessee, sublessee, sharecropper, or manager of the land to which the pesticide is applied.

“Reporting period” means no later than the Thursday following the calendar week in which an application is completed.

“Residence” means a dwelling place where one or more individuals are living.

“Responsible individual” means an individual at a seller’s location who is a certified applicator or is licensed as a PCA in Arizona by the Department, that has demonstrated competency in safe pesticide handling, and is aware they are designated by the seller under R3-3-203.

“Restricted use pesticide” means a pesticide classified as such by the EPA. A.R.S. § 3-361(8).

“School” means a public institution established for the purposes of offering instruction to pupils in programs for pre-school children with disabilities, kindergarten programs or any combination of grades one through twelve. A.R.S. § 15-101(19). School includes a private institution with membership in the North Central Association of Colleges and Schools serving students in kindergarten programs or any combination of grades one through twelve.

“Seller” means any person selling or offering for sale a restricted use pesticide or other type of pesticide intended to be used for an agricultural purpose.

“Service container” means a container filled with a pesticide by an applicator and is transported to an application site where the pesticide will be applied. A service container is not intended to be used as a container for the sale or distribution of a pesticide, and is not intended for the long-term storage of a pesticide, except for cases of an emergency where the integrity of the original packaging of a pesticide is compromised that would lead to a bulk release of a pesticide.

“Small scale test” means a test using a pesticide on land or water acreage as described at 40 CFR § 172.3(c)(1) or (2) (59 FR 45611, Sept. 1, 1994, as amended at 71 FR 35546, June 21, 2006; 73 FR 75599, Dec. 12, 2008, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-172/subpart-A/section-172.3>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.

“Spot application” means a treatment in an area other than a greenhouse or nursery operation that is restricted to an area of an application site that is less than the entire application site.

“Tag” means a custom application equipment license issued by the Department to a custom applicator licensee.

“Triple rinse” means to flush out a container at least three times, each time using a volume of water, or other diluent as specified on the label, equal to a minimum of 10 percent of the container’s capacity or a procedure allowed by the label that produces equivalent or better results.

“Unreasonable adverse effect” means any unreasonable risk to a human being or the environment, taking into account the economic, social, and environmental costs and benefits of the

use of any pesticide, or a human dietary risk from residues that result from a use of a pesticide in or on any food as documented by the Department through its investigation.

“Weed” means any plant which grows where not wanted. A.R.S. § 3-341(24)

“Worker Protection Standard” or “WPS” means the regulations as prescribed in 40 CFR §§ 170.1 et seq., excluding 40 CFR §§ 170.401(c)(4) and 170.501(c)(4) (as amended October 30, 2020, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-170>). This material is incorporated by reference, on file with the Department and does not include any later amendments or editions.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-101 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-102. Licensing Time-frames**

- A. Overall time-frame. The Department shall issue or deny a license within the overall time-frames listed in Table 1 after receipt of the complete application. The overall time-frame is the total of the number of days provided for the administrative completeness review and the substantive review.
- B. Administrative completeness review.
  1. The administrative completeness review time-frame established in Table 1 begins on the date the Department receives the application. The Department shall notify the applicant in writing within the administrative completeness review time-frame whether the application or request is incomplete. The notice shall specify what information is missing. If the Department does not provide notice to the applicant within the administrative completeness review time-frame, the Department considers the application complete.
  2. An applicant with an incomplete license application shall supply the missing information within the completion request period established in Table 1. The administrative completeness review time-frame is suspended from the date the Department mails the notice of missing information to the applicant until the date the Department receives the information.
  3. If the applicant fails to submit the missing information before the expiration of the completion request period, the Department shall close the file, unless the applicant requests an extension. An applicant whose file has been closed may obtain a license by submitting a new application.
- C. Substantive review. The substantive review time-frame established in Table 1 shall begin after the application is administratively complete.
  1. If the Department makes a comprehensive written request for additional information, the applicant shall submit the additional information identified by the request within the additional information period provided in Table 1. The substantive review time-frame is suspended from the date of the Department request until the information is received by the Department. If the applicant fails to provide the information identified in the written request



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within the additional information period, the Department shall deny the license.

2. The Department shall issue a written notice granting or denying a license within the substantive review time-frame. If the application is denied, the Department shall send the applicant written notice explaining the reason for

the denial with citations to supporting statutes or rules, the applicant's right to seek a fair hearing, and the time period in which the applicant may appeal the denial.

**Historical Note**

Adopted effective October 8, 1998 (Supp. 98-4).

**Table 1. Time-frames (Calendar Days)**

License	Authority	Administrative Completeness Review	Response to Completion Request	Substantive Completeness Review	Response to Additional Information	Overall Time-frame
Pesticide Grower Permit (PGP)	A.R.S. § 3-363 A.A.C. R3-3-201	14	14	56	14	70
Pesticide Seller Permit (PSP)	A.R.S. § 3-363 A.A.C. R3-3-203	14	14	56	14	70
Agricultural Aircraft Pilot License (AAP)	A.R.S. § 3-363 A.A.C. R3-3-204	14	14	56	14	70
Drone Pilot License (DPL)	A.R.S. § 3-363 A.A.C. R3-3-204	14	14	56	14	70
Custom Applicator License (CAL)	A.R.S. § 3-363 A.A.C. R3-3-205	14	14	63	14	77
Application Equipment Tag	A.R.S. § 3-363 A.A.C. R3-3-206	14	14	56	14	70
Agricultural Pest Control Advisor (PCA) License	A.R.S. § 3-363 A.A.C. R3-3-207	14	14	63	14	77
Commercial Applicator Certification (PUC)	A.R.S. § 3-363 A.A.C. R3-3-208	14	14	63	14	77
Private Applicator Certification (PUP)	A.R.S. § 3-363 A.A.C. R3-3-208	14	14	63	14	77
Golf Applicator Certification (PUG)	A.R.S. § 3-363 A.A.C. R3-3-208	14	14	63	14	77
Experimental Use Permit	A.R.S. § 3-350.01 A.A.C. R3-3-212	14	14	28	14	42
Pesticide Registration	A.R.S. § 3-351 A.A.C. R3-3-702	14	14	91	14	105
License to Manufacture or Distribute Commercial Feed	A.R.S. § 3-2609 A.A.C. R3-3-902	14	14	42	14	56
Commercial Fertilizer License	A.R.S. § 3-272	14	14	42	14	56
Specialty Fertilizer Registration	A.A.C. R3-3-802	14	14	56	14	70
Agricultural Safety Trainer Certification	A.R.S. § 3-3125 A.A.C. R3-3-1003	28	14	28	14	56
<b>ARIZONA NATIVE PLANTS</b>						
Notice of Intent Confirmation Notice of Intent	A.R.S. § 3-904 A.A.C. R3-3-1102	14	14	14	14	28
• Salvage Assessed Native Plant Permits	A.R.S. § 3-906 A.A.C. R3-3-1104	14	14	14	14	28
• Salvage Restricted Native Plant Permits		14	14	14	14	28
• Scientific Permits		14	14	14	14	28
Non-commercial salvage	A.R.S. § 3-906	14	14	14	14	28
Annual Permits for Harvest-Restricted Native Plants	A.R.S. § 3-907 A.A.C. R3-3-1104	14	14	14	14	28

**Historical Note**

Adopted effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 2663, effective June 8, 2004 (Supp. 04-2). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**ARTICLE 2. PERMITS, LICENSES, AND CERTIFICATION****R3-3-200. General; Applications; Renewals; Fees; Examinations; Exemptions**

- A. An applicant for certification, license or permit shall submit the appropriate completed application to the Department

accompanied by the appropriate fee prescribed in Table 1. Fees, for each year or portion of the year during which the certification, license or permit is valid.

- B. Applicants for a PGP, PSP, AAP, DPL, CAL, PCA or Certified Applicator are not transferable, and expire on December 31.
- C. Certifications, Licenses, or Permits are:

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1. Valid for the year issued for new Certified Applicator or PCA applicants, except for those issued between October 1 and December 31 which are valid until December 31 of the next calendar year;
  2. Valid for one or two years, for all other applicants depending on the renewal period selected by the applicant; and
  3. Renewed for all categories of certification for the same renewal period.
- D. Education and CEU Requirements.**
1. Prior to submitting a new application for a PCA license, applicants shall complete the educational requirements according to R3-3-207.
  2. Prior to submitting a renewal application for a PCA license or certified applicator, applicants shall complete any CEU requirements pertinent to the category or categories in which renewal is being applied for.
  3. It is the applicant's responsibility to take CEUs pertinent to the category or categories for which the applicant is seeking to renew certification.
  4. The Department may screen renewal applications to ensure the CEU courses taken by the applicant are pertinent to the category or categories for which the applicant is seeking to renew licensure.
- E. Examinations.** In addition to the specific requirements found in R3-3-203 through R3-3-208, the following general provisions apply to this Article:
1. The Department shall administer examinations required under this Article by appointment at every Environmental Services office.
  2. An applicant shall demonstrate knowledge and understanding by scoring at least 75 percent on a written examination for each examination taken under this Article.
  3. An individual who fails an examination may retake it no more than two times in a six-month period and shall not retake an examination until at least seven days have elapsed from the date of the last examination.
  4. The Director may deny a certification or license after an opportunity for an administrative hearing is given, for any individual who is found cheating during the examination process and shall be prohibited from re-taking any examination required under this Article for no less than one year.
  5. The Director may revoke a certification or license after an opportunity for an administrative hearing is given, for an individual who is found cheating on an examination and shall be prohibited from re-taking any examination required under this Article for no less than one year.
  6. Cheating includes one or more of the following:
    - a. Computer or mobile device usage to search for answers to exam questions or to copy exam questions;
    - b. Use of copied exam answers in any form; or
    - c. Any other means in which the answers to the exam questions are obtained without using the knowledge of the exam taker.
- F. Renewal; expired license or certification.**
1. An applicant may renew an expired license without retaking the written examinations under R3-3-207 provided the applicant:
    - a. Within the licensing period, complies with the CEU requirements in R3-3-207;
    - b. Submits a completed application within 11 months after the expiration date of the license;
    - c. Does not provide any pest control-related service from the date the license expired until the date the renewal is effective;
    - d. Pays the license fee plus a \$10 late fee for each month the certification has been expired, with the late fee not exceeding \$110 (11 months); and
    - e. Obtains the required CEU's while the license is active.
  2. An applicant may renew an expired certification without retaking the written examinations under R3-3-208 provided the applicant:
    - a. Has satisfied the CEU requirements in R3-3-208(E)(3), within the current certification period;
    - b. Submits a completed renewal application within 11 months after the expiration date;
    - c. Does not provide any pesticide-related service from the date the certification expired until the date the renewal is effective;
    - d. Pays the renewal fee plus a \$10 late fee for each month, with the penalty not to exceed \$110 (11 months); and
    - e. Obtains the required CEU's while the certification is current.
  3. Applicants with expired certifications greater than 11 months shall complete the requirements for initial certification, including retaking and passing the applicable written examinations prescribed in this Section.4. Notwithstanding R3-3-200 (F)(1) or (2), in addition to any penalties or fines imposed for committing a violation according to Section R3-3-502(C)(1) or (G)(4), for operating with an expired license or certification, the applicant shall take any written examinations required to renew a PCA license or Certified Applicator.
- G. License and Fee Exemptions**
1. A person who applies pesticides in buildings or for structural pest control purposes is not required to apply for or possess any license or certification from the Department under this Article.
  2. A person who sells, offers for sale, delivers, or offers for delivery a general use pesticide, to be used for private, noncommercial use in or around the home or a person who sells general use pesticides for swimming pool or spa maintenance is not required to apply for or possess a seller's permit from the Department.
  3. A state, federal, tribal, or other governmental employee, who makes pest control recommendations or applies or supervises the use of restricted use pesticides while engaged in the performance of official duties shall meet the requirements of this Article, but is not required to pay a fee for any agricultural license, certification, or permit under this Article when used solely for work related purposes.
  4. A person who only furnishes information concerning label requirements governing a registered pesticide is not required to apply for or possess a PCA license from the Department.

**Historical Note**

New Section made by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**Table 1. Fees**

License	Administrative Rule	Fee
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Pesticide Grower Permit (PGP)	R3-3-201	\$20 per year
Pesticide Seller Permit (PSP)	R3-3-203	\$100 per year
Agriculture Aircraft Pilot License (AAP)	R3-3-204	\$50 per year
Drone Pilot License (DPL)	R3-3-204	\$50 per year
Custom Applicator License (CAL)	R3-3-208(E)	\$100 per year
Agriculture Pest Control Advisor (PCA)	R3-4-207	\$50 per year
Certified Applicator (PUP, PUC & PUG)	R3-3-208	\$50 per year

**Historical Note**

Table 1 Fees made by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-201. Pesticide Grower Permit (PGP)**

- A. In addition to the provisions found under R3-3-200, the following apply to this Section.
- B. A regulated grower shall not order, purchase, take delivery of, use, or recommend the use of any pesticide for an agricultural purpose or golf course without a valid pesticide grower permit (PGP), issued by the Department.
- C. A person applying for a PGP, initial or renewal, shall provide the following information on a form obtained from the Department:
1. Name and signature of the applicant;
  2. Date of the permit application;
  3. Name, address, email address, if applicable, and daytime telephone number of the company or agricultural establishment where the applicant may be reached;
  4. Permit renewal period;
  5. Sections, townships, ranges, and acres of the land where pesticides may be applied;
  6. The names and certification numbers of certified private or golf applicators, or commercial applicators acting as private applicators, who are employed by the PGP; and
  7. For individual applicants, information and documentation concerning lawful presence required under ARS § 41-1080, if not on file.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-202. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-201 (Supp. 91-4). Former Section R3-3-202 renumbered to R3-3-203; new R3-3-202 made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Repealed by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-203. Pesticide Seller Permit (PSP); Responsible Individual**

- A. In addition to the provisions found under R3-3-200, the following apply to this Section.
- B. A person shall not act as a pesticide seller without a valid Pesticide Seller Permit (PSP), issued by the Department.

- C. A seller shall obtain a PSP for each physical location where the seller sells or offers for sale any restricted use pesticide or agricultural use pesticide.
- D. A person applying for a PSP, initial or renewal, shall provide the following information on a form obtained from the Department:
1. Name and signature of the responsible individual, and certification or license number;
  2. Date of the permit application;
  3. Name, physical address, mailing address, email address, if applicable, and daytime telephone number of the location selling a restricted use pesticide or a pesticide for an agricultural purpose;
  4. Permit renewal period;
  5. Name, email address, and daytime telephone number of the Arizona contact for each out-of-state seller, if applicable;
  6. Address where records required to be maintained under R3-3-401 will be kept;
  7. Whether the applicant has had a similar license, permit, or certification revoked, suspended, or denied in this or any other jurisdiction during the three years before the date of application; and
  8. The current seller permit number, if applicable.
- E. The Department shall not renew a seller permit unless the seller is in compliance with the provisions established in subsection (F), if applicable.
- F. A seller shall designate a different responsible individual for each physical location in this state that sells or offers for sale any restricted use pesticide or agricultural use pesticide. If a responsible individual terminates employment at an assigned location, the seller shall designate another responsible individual within 30 calendar days and notify the Department of the replacement.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-203 (Supp. 91-4). Former Section R3-3-203 renumbered to R3-3-204; new R3-3-203 renumbered from R3-3-202 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-204. Agricultural Aircraft Pilot License (AAP); Drone Pilot License (DPL)**

- A. In addition to the provisions found under R3-3-200, the following apply to this Section.
- B. An individual shall not act as an agricultural aircraft pilot or drone pilot without:
1. A valid agricultural aircraft pilot license (AAP) for aircraft pilots, or drone pilot license (DPL) for drone, issued under this Section, and

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2. If application work will be done for hire or exchange of services, a valid commercial applicator certification issued under R3-3-208.
- C.** The Department shall not issue or renew an AAP or DPL, and an existing AAP or DPL is invalid unless the applicant or license holder:
1. Has a valid commercial pilot's certificate issued by the FAA as prescribed under 14 CFR §§ 137.1 et seq. (amended March 5, 2018, <https://www.ecfr.gov/current/title-14/chapter-I/subchapter-G/part-137>). This material is incorporated by reference, is on file with the Department and does not include any later amendments or editions; or
  2. Has a valid drone pilot's certificate for a DPL that has been issued by the FAA under 14 CFR §§ 107.1 et seq. (amended January 15, 2021, <https://www.ecfr.gov/current/title-14/chapter-I/subchapter-F/part-107/subpart-A>). This material is incorporated by reference, is on file with the Department and does not include any later amendments or editions.
- D.** An individual applying for an AAP or DPL, initial or renewal, shall provide the following information on a form obtained from the Department:
1. Name and signature of the applicant;
  2. Date of application;
  3. Address, email address, and daytime telephone number of the applicant;
  4. License renewal period;
  5. Name, physical address, mailing address, email address, and daytime telephone number of the applicant's employer, if applicable;
  6. As applicable, a current copy of the applicant's:
    - a. Commercial pilot certificate issued by the FAA for an AAP applicant, if not previously filed with the Department; or
    - b. Drone pilot's certificate issued by the FAA for a DPL applicant, if not previously filed with the Department.
  7. Applicant's commercial applicator certification number;
  8. Whether the applicant has had a similar certification or license revoked, suspended, or denied in this or any other jurisdiction during the three years before the date of application and the nature of the violation; and
  9. Information and documentation indicating that the individual's presence in the United States is authorized under federal law according to A.R.S. § 41-1080, if not on file.
1. Name and signature of the applicant;
  2. Date of the license application;
  3. Name, physical address, mailing address, email address, if applicable, and daytime telephone number of the business;
  4. License renewal period;
  5. Whether the application is for ground or air custom application, or both;
  6. Names and current certification numbers of the commercial applicators employed by the business;
  7. Evidence of insurance coverage, showing the name of the insurance carrier, policy number, policy term, policy limits, and any applicable exclusions;
  8. Whether the applicant has had a similar license revoked, suspended, or denied in this or any other jurisdiction during the last three years, and the nature of the violation;
  9. The name and contact information for a contact person at the business if different than the applicant; and
  10. For individual applicants, information and documentation indicating that the individual's presence in the United States is authorized under federal law according to A.R.S. § 41-1080, if not on file.
- D.** The Department shall not issue or renew a CAL and an existing CAL is invalid unless the applicant or license holder:
1. Is a commercial applicator or employs at least one individual who is certified as a commercial applicator under R3-3-208; and
  2. Maintains or the business that employs the applicator or license holder maintains public liability, drift, and property damage insurance coverage with an aggregate amount of at least \$300,000 during the licensing period. The applicant or license holder shall provide evidence of insurance coverage to the Department upon initial application, for each renewal, or upon request of the Department;
- E.** A CAL holder may:
1. Temporarily relinquish a CAL if the custom applicator:
    - a. Advises the Department of termination of the insurance prescribed in subsection (D)(2), and the effective date of termination; and
    - b. Ceases to act as a custom applicator on the termination date.
  2. Reinstates the CAL within the same licensing time period, without again paying the fee as prescribed in under R3-3-200(A), if the custom applicator:
    - a. Purchases insurance as prescribed in subsection (D)(2), and
    - b. Notifies the Department of the effective date of the insurance.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-204 (Supp. 91-4). Former Section R3-3-204 renumbered to R3-3-205; new R3-3-204 renumbered from R3-3-203 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-205. Custom Applicator License (CAL)**

- A.** In addition to the provisions found under R3-3-200, the following apply to this Section.
- B.** A person shall not act as a custom applicator without a valid CAL issued by the Department.
- C.** A person applying for a CAL, initial or renewal, shall provide the following information on a form obtained from the Department:

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-205 (Supp. 91-4). Former Section R3-3-205 renumbered to R3-3-206; new R3-3-205 renumbered from R3-3-204 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-206. Custom Application Equipment Tag; Fee**

- A.** In addition to the provisions found under R3-3-200, the following apply to this Section.
- B.** A custom applicator shall not use custom application equipment unless the equipment has a valid tag. The custom appli-

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cator licensee shall place and maintain a valid tag so that it is prominently displayed on the pesticide application equipment.

**C.** A person applying for a tag shall provide the following information on a form obtained from the Department:

1. Name and signature of the applicant;
2. Date of the application;
3. Address, email address, if applicable, and daytime telephone number of the applicant;
4. Name, physical address, mailing address, email address, if applicable, and daytime telephone number of the business, if applicable;
5. Manufacturer, make, model and serial number, and if an aircraft or drone, the FAA registration number ("N" number for aircraft, or drone with an operating weight of over 55 lbs. total, including payload; or "FA" number for drone with an operating weight up to 55 lbs. total, including payload) of the application equipment; and
6. The name and contact information for a contact person at the business if different than the applicant.

**D.** The Department shall not issue or renew a tag and an existing tag is invalid if the custom applicator license is invalid.

**E.** An applicant shall submit the completed application to the Department, accompanied by a \$25 fee for each piece of equipment, for each year or portion of the year during which the tag is valid.

**F.** A tag expires on December 31, and is valid for the same time period as the custom applicator license.

**G.** A custom applicator licensee shall not transfer a tag except as follows:

1. If equipment with a valid tag, is destroyed, rendered unusable, or transferred out of the state, the custom applicator licensee may transfer the tag to another piece of equipment.
2. If equipment with a valid tag, is leased, sold, or traded, the custom applicator licensee shall transfer the tag with the equipment to the lessee or new owner.
3. Before transferring a tag, the custom applicator licensee shall notify the Department that the equipment with the valid tag is being transferred and identify the person to whom the equipment with the valid tag is being transferred or identify the piece of equipment to which the tag is being transferred, or the tag is invalid.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-206 (Supp. 91-4). Former Section R3-3-206 renumbered to R3-3-207; new R3-3-206 renumbered from R3-3-205 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-207. Agricultural Pest Control Advisor (PCA) License; Exemption**

**A.** In addition to the provisions found under R3-3-200, the following apply to this Section.

**B.** An individual shall not act as a PCA without a valid PCA license issued by the Department. To advise in any of the categories listed in subsection (I), a PCA shall pass the specific examination associated with the category.

**C.** An individual, without a valid PCA license, applying for a PCA license shall provide the following information on a form obtained from the Department:

1. The applicant's name, address, email address, daytime telephone number, social security number, and signature;
2. Date of the application;
3. Name, physical address, mailing address, email address, and daytime telephone number of the applicant's employer, if applicable;
4. Examinations that the applicant has passed by category;
5. Whether the applicant has had a similar license revoked, suspended, or denied in this or any other jurisdiction during the last three years, and the nature of the violation resulting in the revocation, suspension, or denial; and
6. Information and documentation indicating that the individual's presence in the United States is authorized under federal law according to A.R.S. § 41-1080, if not on file.

**D.** An individual applying for a PCA license, except an individual who holds or has held a PCA license in this state within the previous five years shall meet one of the following five sets of qualifications:

1. College degree.
  - a. Possess a bachelor's degree (B.A. or B.S.), master's degree or doctorate degree in any subject; and
  - b. Have completed 42 semester hours (63 quarter units) of college-level curricula as specified in subsection (E).
2. Master's degree in a biological science.
  - a. Possess a master's degree in a biological science;
  - b. Have 12 months of work experience related to a core area listed in subsection (E); and
  - c. Have a letter from the institution, a faculty member, or a supervisor where the individual obtained the work experience certifying the time spent and describing the type of experience obtained by the individual.
3. Doctorate degree in a biological science.
  - a. Possess a doctorate degree in a biological science; and either
  - b. Meet the qualifications in subsection (D)(2)(b) and (D)(2)(c); or
  - c. Have a letter of recommendation from the faculty member that supervised the dissertation or the division head of the discipline.
4. Other education with unlicensed experience.
  - a. Have completed 42 semester hours (63 quarter units) of college-level curricula as specified in subsection (E);
  - b. Have 24 months of work experience related to a core area listed in subsection (E); and
  - c. Have a letter from the institution, a faculty member, or a supervisor where the individual obtained the work experience certifying the time spent and describing the type of experience obtained by the individual.
5. Other education with licensed experience.
  - a. Be currently licensed as a pest control advisor (PCA) or equivalent in another state; and
  - b. Have completed 42 semester hours (63 quarter units) of college-level curricula as specified in subsection (E), except that each year of verifiable licensed experience under subsection (D)(5)(a) within the previous 5 years qualifies for two semester hours up to 10 hours. The semester hours based on licensed experience do not reduce the minimum hours required from each individual core area.



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- c. The applicant shall provide proof of the equivalency of a license from another state.
- E. The 42 semester hours (63 quarter units) of college-level curricula specified in subsection (D) shall come from the core areas shown in Table 2, with at least the minimum indicated hours (or units) coming from each individual core area. A single course shall not count toward the minimum hours of more than one core area. At least one course from the pest management systems and methods core area shall emphasize integrated pest management principles. Each course completed must be awarded credit with a minimum passing grade of a "C" or a 2.0 GPA, or a passing score if taken on a pass or fail basis.
- F. Alternative curricula credits.
  1. A current crop advisor certificate issued by the American Society of Agronomy qualifies for three semester hours in one of the following core areas: physical, biological and earth sciences and mathematics; crop health; or production systems.
  2. Non-traditional courses such as a senior project, an internship, cooperative work experience, independent study, a dissertation or a thesis qualify for three semester hours in one of the core areas of crop health, pest management systems and methods, or production systems, as applicable.
  3. For applicants with a bachelor's, master's, or doctorate degree, at least one year of full-time related work experience qualifies for three semester hours in one of the core areas of pest management systems and methods or production systems, as applicable.
- G. In addition to the information required by subsection (C), an applicant shall submit to the Department:
  1. An official transcript verifying the courses completed and the degrees granted to the applicant;
  2. Documentation verifying alternative curricula relied on under subsection (F). Documentation of subsection (F)(2) and (F)(3) shall include a letter certifying completion and describing the activity from the institution, a faculty member or supervisor; and
  3. If applicable, the letter required for licensure under subsection (D).
- H. Renewal.
  1. The Department shall not renew a PCA license unless, before the expiration of the current license, the licensee completes 15 CEUs for each year of the renewal period or passes any applicable examination prescribed in subsection (I). The licensee shall complete CEU credit during the calendar years the current license is in effect. CEUs earned that are in excess of the requirements do not carry forward for use with future renewals.
  2. To obtain credit, the applicant shall provide the Department with documentation of completion of the CEU course.
  3. For license renewal, the license may only be renewed if the required CEUs are obtained and the renewal application and fees are received by the Department within the specified time period.
- I. Examinations. In addition to the core examination as prescribed in R3-3-208(E), an applicant shall demonstrate knowledge and understanding of integrated pest management in any of the following categories:
  1. Weed control,
  2. Invertebrate control,
  3. Nematode control,
  4. Plant pathogen control,
  5. Vertebrate pest control,
  6. Plant growth regulators, or
  7. Defoliation.
- J. Exemption. An individual operating in an official capacity for a college or university, providing recommendations in a not-for-profit capacity, or merely furnishing information concerning general and labeling usage of a registered pesticide is not considered an authority or general advisor for the purposes of this Chapter.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-207 (Supp. 91-4). Former Section R3-3-207 repealed; new R3-3-207 renumbered from R3-3-206 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 3855, effective January 28, 2014 (Supp. 13-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**Table 2. Core Areas**

Core Area	Examples of Subjects	Sem. Hours	Qtr. Units
Physical, biological, and earth sciences, and mathematics	Inorganic chemistry; organic chemistry; biochemistry; plant biology or botany; general ecology; biology; genetics; plant physiology; zoology; post-algebra mathematics	12	18
Crop health	Soils and irrigation; vegetation management or weed science; plant pathology; entomology; plant nutrition or fertility; nematology; vertebrate management	6	9
Pest management systems and methods	Applied courses in entomology, plant pathology, vegetation management or weed science, and other pest management disciplines; pesticides or use of pesticides; pest control equipment systems; alternative cropping systems; sustainable or organic agricultural systems; biological control	3	4.5
Production systems	Horticulture; viticulture; forestry; agronomy; crop, vegetable, fruit or animal sciences; other production systems (e.g., wildlife production, cattle production)	3	4.5

**Historical Note**

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Table 2 Core Areas made by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-208. Applicator Certification (PUP, PUG, PUC); Categories; Competency; Examination; Renewal**

- A. In addition to the provisions found under R3-3-200, the following applies to this Section.
- B. An individual shall not act as a private (PUP), golf (PUG), or commercial (PUC) applicator unless the individual is 18 years of age and certified by the Department.
- C. An individual shall take and pass both the core exam and the appropriate category exam, or exams, they are seeking to show competency to become a certified applicator.
- D. Application. An individual applying for either PUP, PUG, or PUC applicator certification shall pay the applicable fee as prescribed in R3-3-200(A) and submit a completed application to the Department containing the following information on a form obtained from the Department:
  1. The applicant's name, address, email address if applicable, daytime telephone number, Social Security number, date of birth, and signature;
  2. Date of the application;
  3. If applicable, name, physical address, mailing address, email address, and daytime telephone number of the applicant's employer;
  4. Whether the application is for a PUP, PUG, or PUC applicator certification;
  5. Which category or categories the individual seeks certification;
  6. Whether the applicant has had a similar certification revoked, suspended, or denied in this or any other jurisdiction during the last three years, and the nature of the violation; and
  7. Information and documentation indicating that the individual's presence in the United States is authorized under federal law according to A.R.S. § 41-1080, if not on file.
- E. Examinations and Competency Standards.
  1. The Department shall ensure that the core examination tests the knowledge and understanding of 40 CFR § 171.103 for a PUC or PUG applicator license, or 40 CFR § 171.105 for a PUP applicator license, as amended January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171>. This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.
  2. Exam Categories and Competency Standards:
    - a. For commercial applicators:
      - i. The exam categories shall be as prescribed in 40 CFR § 171.101(a) through (e), and (i) through (o) (39 FR 36449, October 9, 1974 as amended by 82 FR 1029, January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.
      - ii. Notwithstanding subsection (D)(5)(a)(i), the exam categories as prescribed in 40 CFR § 171.101(a)(2), (k), (l), and (m) shall not be mandatory for certification until January 1, 2026 (39 FR 36449, October 9, 1974 as amended by 82 FR 1029, January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.
    - b. For private applicators:
      - i. The categories shall be as prescribed in 40 CFR § 171.105(a)(11) and (b) through (e), (39 FR 36449, October 9, 1974 as amended by 82 FR 1029, January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171>) This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.
      - ii. Notwithstanding subsection (D)(5)(b)(i), the competency standards prescribed in 40 CFR § 171.105(b) through (d) shall not be mandatory for certification until January 1, 2026, 39 FR 36449, October 9, 1974 as amended by 82 FR 1029, January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.
    - c. For golf applicators:
      - i. The categories shall be as prescribed in 40 CFR § 171.101(c), (e), and (n), (39 FR 36449, October 9, 1974 as amended by 82 FR 1029, January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171>) This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions; and
      - ii. The competency standards shall be prescribed in 40 CFR § 171.103(c) and (d)(3), (5), and (14), (39 FR 36449, October 9, 1974 as amended by 82 FR 1029, January 4, 2017, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.
  3. Certifications issued or renewed under this Article prior to February 6, 2023 are not required to comply with the

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examination and competency standards until the individual is renewing a private, golf, or commercial applicator certification. This provision shall expire on December 31, 2026.

**F. Renewal; CEU requirements.**

1. An applicant for renewal of an applicator certification shall select a one or two-year renewal period.
2. An applicant shall submit the completed application accompanied by the applicable fee for a one-year renewal or double the fee for a two-year renewal.
3. CEU requirements.
  - a. The Department shall not renew a private applicator or golf applicator certification unless, prior to the expiration of the current certification, the applicator completes three CEUs pertinent to the category or categories for which the applicant is seeking to renew licensure for each year of the renewal period.
  - b. The Department shall not renew a commercial applicator certification unless, prior to expiration of the current certification, the applicator completes six CEUs pertinent to the category or categories for which the applicant is seeking to renew for each year of the renewal period.
  - c. All CEU credit requirements shall be completed during the certification period, prior to renewal. CEU credits earned in excess of the requirements do not carry forward for use in subsequent renewals.
  - d. To obtain credit, the Department shall be provided with documentation of completion of the CEU course.

**G. Reciprocal Certification**

1. The Director may waive the examination requirements in whole or in part for an individual who is certified as an applicator by another State, Federal, or Tribal agency under an approved EPA certification plan.
  - a. A applicant must apply for Arizona reciprocal certification.
    - i. The applicant shall provide the information as prescribed in subsection (D).
    - ii. The applicant shall submit the Department required form to their state, federal, or tribal agency for verification of certification.
    - iii. Upon verification of the competency standards for each category of certification requested, the Department may issue a like category applicator license.
    - iv. The Department shall terminate an applicator's certification upon notification that the applicator's original certification has been terminated in the originating state, for any reason.
    - v. The applicant may request a hearing if the Department denies an application for a reciprocal certification based on the competencies approved by another state, federal, or tribal agency.
2. Anyone certified through reciprocal certification must notify the Department of termination of the originating-state's certification. Failure to notify the Department within three business days after the effective date of termination may result in revocation of the Arizona certification, and the applicant may not reapply for Arizona certification for a twelve-month period.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).

Renumbered from R3-10-208 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 18 A.A.R. 2481, effective November 10, 2012 (Supp. 12-3).

Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 22 A.A.R. 367, effective April 5, 2016 (Supp. 16-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-209. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-209 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Section repealed by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-210. Additional Grounds for Revocation, Suspension, or Denial of a License, Permit, or Certification**

**A.** The Director may deny, or after an opportunity for an administrative hearing, suspend or revoke a license, permit, or certification of any person who:

1. Fails to demonstrate sufficient reliability, expertise, integrity, and competence in engaging in pesticide use, which is considered misuse and is a violation of state laws or regulations relevant to the State certification plan;
2. Submits an inaccurate application for a license, permit, or certification;
3. Has had a similar license, permit, or certification revoked, suspended, or denied in this or any other jurisdiction during the three years before the date of application;
4. Fails to pay fines, penalties and fees;
5. Falsifies records required to be maintained by the certified applicator;
6. Is convicted of a criminal charge under Section 14(b) of FIFRA;
7. Is ordered to pay a civil penalty under Section 14(a) of FIFRA; or
8. Commits a violation of any of the following: A.R.S. §§ Title 3, Chapter 2, Articles 5 and 6 and Chapter 17 or 3 A.A.C. 3, Articles 1 through 5 and 10 which are relevant to the State certification plan.

**B.** Upon notice of a denial, the applicant may request, in writing, that the Director provide an administrative hearing under A.R.S. Title 41, Chapter 6, Article 10 to appeal the denial of the license, permit, or certification.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-210 (Supp. 91-4). Former Section R3-3-210 repealed; new R3-3-210 renumbered from R3-3-211 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-211. CEU Course Approval; Subject Approval**

**A.** CEU course approval.

1. A person who wishes to have the Department determine whether a course qualifies for CEU credit shall submit the following information to the Department:

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- a. Name, address, email address, if applicable, and telephone number of the course's sponsor;
    - b. Signature of the sponsor or the sponsor's representative;
    - c. Course outline, listing the subjects and indicating the amount of time allocated for each subject;
    - d. Brief description of the information covered within each subject;
    - e. Brief biography of the presenter, demonstrating the presenter's qualifications;
    - f. Fees charged for attending the course;
    - g. Date and location of each session; and
    - h. Whether the course is open to the public.
  2. A person who requires prior notification of the number of CEUs that can be earned by completing an approved course before it is held shall submit the information required in subsection (A)(1) to the Department at least 14 business days before the course is held.
  3. The Department may modify the number of CEUs earned for a CEU course if the CEU course varies significantly in content or length from the approved curriculum. If the Department modifies the number of CEUs earned, the Department shall send a letter of modification to the course organizer, who shall be requested to inform all individuals who attended the course.
- B. Subject approval.** The Department shall provide enough information so that the applicator can determine if the CEUs are pertinent to the categories in which they are seeking renewal. The Department shall grant one hour of CEU credit for every 50 minutes of actual instruction in an approved program relating to agricultural pest control or any of the following subjects:
1. Those listed in R3-4-208(E);
  2. IPM; or
  3. Any other pesticide or pesticide use subject approved by the Associate Director.
- Historical Note**  
Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-211 (Supp. 91-4). Former Section R3-3-211 renumbered to R3-3-210; new R3-3-211 renumbered from R3-3-212 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).
- R3-3-212. Experimental Use Permit**
- A. Definitions**
1. "For the purpose of experimentation" means for research or testing purposes, including research or testing performed in order to accumulate information necessary to register under Section 3 of FIFRA and the regulations thereunder a pesticide not currently registered or a registered pesticide for a use not previously approved in the registration of the pesticide.
  2. "Research agency" means any organization engaged in research pertaining to the use of pesticides, including for the purpose of experimentation.
  3. "Structural pest management application" means a pesticide application covered by A.R.S. §§ 3-3601 et seq.
- B. A research agency or educational institution may use a pesticide that is not federally registered or use a federally registered pesticide for a use not previously approved in the registration of the pesticide for the purpose of experimentation:**
1. Under a valid experimental use permit issued by the Department, or
  2. If the testing will only occur on the grounds of a college or university agricultural center or campus or a research agency owned research facility, then a permit is not required.
- C. An applicant for an experimental use permit shall provide the following information to the Department:**
1. A copy of the EPA-approved experimental use permit issued according to Section 5 of FIFRA or, for applicants exempt from the requirement of a federal experimental use permit under 40 CFR § 172.3 (59 FR 45611, Sept. 1, 1994, as amended at 71 FR 35546, June 21, 2006; 73 FR 75599, Dec. 12, 2008, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-172/subpart-A/section-172.3>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions;
  2. A statement of which federal exemption applies and an affidavit certifying that the experimental use will be in compliance with the applicable exemption;
  3. A statement of the purpose for which the experimental use permit will be used;
  4. Name, address, email address, and daytime telephone number of the person supervising the experimental use application;
  5. Name, address, email address, and daytime telephone number of the PGP and PCA, or the qualifying party if it is a structural pest management application, that are involved in the application of the experimental use pesticide;
  6. County, section, township, range, and field description, if needed, of the intended application site, or the street address if it is a structural pest management application;
  7. The crop and acreage to be treated, the amount (quantity, weight, volume or other appropriate unit of measure) of the agricultural commodity to be treated, or the number of structures if it is a structural pest management application;
  8. Total amount of active ingredient to be applied in this state;
  9. Application rate of formulation per acre or other appropriate measure for a structural pest management application;
  10. Method of application;
  11. Name, address, email address, and telephone number of the applicator applying the pesticide;
  12. Time period during which the application will be made; and
  13. Any special experimental use permit conditions imposed by the EPA, if applicable.
- Historical Note**  
Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-212 (Supp. 91-4). Former Section R3-3-212 renumbered to R3-3-211; new R3-3-212 made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).
- Appendix A. Repealed**
- Historical Note**  
New Appendix made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Appendix A

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subsection (B) CFR citation corrected from 40 CFR.4 to 40 CFR 171.4 at the request of the Department, Office File No. M09-448, filed December 8, 2009 (Supp. 09-4). Repealed by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**ARTICLE 3. PESTICIDE USE, SALES, AND EQUIPMENT****R3-3-301. General**

- A.** A person shall not use, apply, or instruct another to apply a pesticide in a manner or for a use inconsistent with the pesticide labeling except that:
1. A pesticide may be applied at a dosage, concentration, or frequency less than that specified on the pesticide labeling unless the labeling specifically prohibits deviation from the specified dosage, concentration, or frequency.
  2. A pesticide may be applied against any target pest not specified on the labeling if the application is to an application site specified on the pesticide labeling, unless the labeling specifically prohibits use against the pest.
  3. A pesticide may be applied by any method of application not prohibited by the pesticide labeling unless the labeling specifically states that the pesticide may be applied only by the methods specified on the labeling.
  4. A pesticide may be mixed with a fertilizer if the labeling does not prohibit the mixture.
  5. A pesticide may be used in any manner that is consistent with Sections 5, 18, or 24 of FIFRA.
- B.** A person shall not use, apply, or store or instruct another to use, apply, or store a pesticide unless the pesticide is:
1. Registered with the Department and the EPA,
  2. Previously registered with the Department and the EPA and cancelled or suspended by the EPA with a current end-use provision in effect, or
  3. Registered with the Department for FIFRA 25(b) products.
- C.** Subsection (B) does not apply to a:
1. Pesticide registrant that temporarily stores pesticides produced for shipment out of the state;
  2. Person who uses a pesticide in Arizona under an Arizona issued experimental use permit; or
  3. Person who is using a pesticide for experimental purposes on the grounds of a college or university agricultural center or campus, or a company-owned research facility.
- D.** A person shall not sell, offer for sale, barter or otherwise supply any pesticide:
1. That has been altered, diluted, or mixed;
  2. That has been repackaged at an establishment not registered with the EPA; or
  3. Is not registered with the Department according to Article 7 of this Chapter.
- E.** A person shall not allow drift that causes any unreasonable adverse effect.
- F.** A person shall not cause the direct release of a pesticide and an individual shall not instruct an applicator in a manner to cause the direct release of a pesticide causing any unreasonable adverse effect.
- G.** Regulated grower responsibility.
1. After a pesticide is applied to an application site on an agricultural establishment, the regulated grower shall not harvest a crop from the application site, or permit livestock to graze the application site in violation of any provision of the pesticide labeling.
  2. Before a pesticide application, a regulated grower shall ensure that all individuals and livestock subject to the

regulated grower's control are outside the application site.

- H.** Emergency pest control measures. A person acting under a government-sponsored emergency program, shall not apply, cause, or authorize another to apply or cause a pesticide to come into contact with an individual, animal, or property outside the boundaries of the application site.
- I.** If possible when applying pesticides by aircraft or drone, a pilot shall fly crosswind, unless an obstacle does not permit it, and shall begin the application at the downwind side of the application site so that the pesticide is dispersed on the return swathe.
- J.** A person shall not apply a highly toxic pesticide, other than a pesticide registered by the EPA for ultra-low volume application, in a volume that is less than one gallon per acre in the final spray form. The content of that gallon shall be at least 50 percent water.
- K.** A buffer zone may receive direct application or drift of pesticides as permitted by law.
- L.** Requirements for Direct Supervision of Noncertified Applicators by Certified Applicators. Supervision of noncertified applicators shall be as prescribed in 40 CFR § 171.201(39 FR 36449, Oct. 9, 1974, as amended by FR 1040, January 4, 2018, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171/subpart-C/section-171.201>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-301 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-302. Form 1080; Requirement for Written Recommendation**

- A.** Effective January 1, 2026 all Form 1080s must be on a form approved by the Department, made available by the Department, or electronically submitted through the Department's Form 1080 internet portal. A PCA or regulated grower shall provide the following information in sequential order as indicated in subsections (A)(1) through (25):
1. Name and permit number of the seller;
  2. Date the recommendation is written;
  3. Name and permit number of the PGP upon whose application site the pesticide will be applied;
  4. County where the application site is located;
  5. Pest conditions present;
  6. Whether the application site is within a pesticide management area under R3-3-304;
  7. Anticipated date of harvest;
  8. Restricted entry interval;
  9. Label days to harvest;
  10. Date recommended for the pesticide application;
  11. Specific application site being treated;
  12. Township, range, and section of the application site;
  13. Number of acres or application sites in each section being treated;
  14. Additional field description, if any;
  15. Brand name and EPA registration number of the pesticide to be applied or number of the pesticide regulated under Section 18 of FIFRA to be applied;



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16. Rate and unit of measure per acre or dilution per 100 gallons;
  17. Total quantity of pesticide concentrate to be applied;
  18. Total acres to be treated and total volume per acre or total number of application sites to be treated;
  19. Whether the application includes an active ingredient that appears on the ADEQ groundwater protection list and is soil-applied as defined in A.A.C. R18-6-301;
  20. Whether a supplemental label is required;
  21. Method of pesticide application;
  22. Label restrictions or special instructions, if any;
  23. Name of the custom applicator making the application;
  24. Anticipated pesticide delivery location; and
  25. Signature of the regulated grower or PCA and credential number of the PGP or PCA making the recommendation.
- B.** A custom applicator shall not apply a pesticide unless the custom applicator has received a signed copy of the recommendation from the PCA or the regulated grower on the Form 1080 before the application. The custom applicator shall apply the pesticide according to the recommendation on the Form 1080 unless the recommendation conflicts with the pesticide label or labeling, in which case the custom applicator shall note these deviations on the Form 1080 and apply the pesticide according to the pesticide label or labeling, or as provided in R3-3-301(A).
- C.** Before the application of a pesticide recommended by a PCA, the PCA shall notify the regulated grower, or the regulated grower's representative, of the scheduled application date. If the application date or time changes from that scheduled with the regulated grower, the custom applicator shall notify the regulated grower of the revised date and time of the application.
- D.** After completing the application, the custom applicator shall sign the pesticide application report portion of Form 1080 to verify that the pesticide was applied according to the recommendation and provide the following information in writing on the form:
1. Date and start and end time of each application;
  2. Date and time of the first and last spot application and a general description of the location, if applicable;
  3. Wind direction and velocity;
  4. Tag number, if applicable;
  5. Name and credential number of the grower or custom applicator business;
  6. Signature and credential number of the applicator; or name of the application equipment operator, and if a restricted use pesticide is applied, the signature and credential number of the certified applicator; and
  7. Any deviation from the recommendation.
- E.** Reporting shall be as prescribed in R3-3-404.
- F.** Non-certified applicator records. When supervising a non-certified private, golf, or commercial applicator of a restricted use pesticide, records shall be kept as required in 40 CFR § 171.201(e) (39 FR 36449, Oct. 9, 1974 as amended by 82 FR 1040, January 4, 2018, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-171/subpart-C/section-171.201>). This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
 Renumbered from R3-10-302 (Supp. 91-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-303. Experimental Use**

- A.** At least 24 hours before the application, the person supervising the application shall provide the Department with the following information:
1. Exact date, time and location of the intended application by calling and leaving a message on the pesticide hotline answering machine, 1-800-423-8876; and
  2. Any changes to the experimental permit information that was provided according to R3-3-212.
- B.** An applicator shall not apply an experimental use pesticide in a manner other than that specified by the experimental use permit or other Department-approved labeling that is provided to the applicator. The applicator shall ensure that the labeling is at the application site when the application occurs.
- C.** An applicator involved in an experimental use pesticide application shall comply with R3-3-302 as applicable.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
 Renumbered from R3-10-303 (Supp. 91-4). Section repealed; new Section renumbered from R3-3-306 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-304. Pesticide Management Areas; Criteria for Designation**

- A.** The Associate Director shall annually publish a list of all locations within the state that are designated as pesticide management areas under A.R.S. § 3-366. The list is available at every Environmental Services Division office.
- B.** The Director shall designate a location as a pesticide management area if all of the following evaluation criteria are met:
1. The distance between the application site and the property boundary of any residence, school, child care facility, or health care institution is less than 1/4 mile;
  2. A pesticide is applied by aircraft;
  3. A pesticide complained about under subsection (B)(4) is highly toxic or odoriferous; and
  4. The Department receives complaints alleging pesticide misuse within a 12-month period from at least five or five percent, whichever is greater, of the residences located less than 1/4 mile from the application site or a complaint from any school, child care facility, or health care institution located less than 1/4 mile from the application site.
- C.** If, upon a written request from a person, or upon the Department's initiative, the Director determines that a pesticide management area no longer meets all of the criteria listed in subsection (B), the Director may remove the pesticide management area from the Department's annual list.
- D.** A person may petition the Department at any time to add or delete an area to or from the list of pesticide management areas. The petitioner shall address all of the criteria listed in subsection (B). The Director shall make a decision on each petition no later than 90 days from the date the petition was submitted.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
 Renumbered from R3-10-304 (Supp. 91-4). Section repealed; new Section renumbered from R3-3-308 and amended by final rulemaking at 10 A.A.R. 276, effective

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March 6, 2004 (Supp. 04-1).

**R3-3-305. Pesticide Sales**

- A.** A seller shall only sell, offer for sale, deliver, or offer for delivery any restricted use pesticide to a person who:
1. Has a valid private, golf or commercial applicator certification issued by the Department for the use of a restricted use pesticide in the appropriate category;
  2. Works under the direct supervision of a person who has a valid private, golf or commercial applicator certification issued by the Department for the use of a restricted use pesticide in the appropriate category; or
  3. Has a valid certification from California, Nevada, Utah, Colorado, New Mexico or from an Arizona Indian tribe that allows the person to use a restricted use pesticide.
- B.** If a pesticide is sold for an agricultural purpose, in Arizona, the seller shall only sell, offer for sale, deliver, or offer for delivery any pesticide for an agricultural purpose after determining that the pesticide will be used by a person who has a PGP issued by the Department.
- C.** If a pesticide is sold for an agricultural purpose, the seller shall write the permit numbers of the seller and PGP on each sale and delivery ticket or invoice, and on each pesticide container or carton. If a pallet is delivered to an individual purchaser, the seller may write the seller and PGP numbers on the outside of the shrink-wrapped pallet.
- D.** A seller shall register with the Department the name and address of each salesperson and PCA employed for the purpose of selling pesticides in this state.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-305 (Supp. 91-4). Section repealed; new Section renumbered from R3-3-309 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-306. Receipt of Restricted Use Pesticides by Noncertified Persons**

- A.** A person shall not sell, offer for sale, deliver, or offer for delivery a restricted use pesticide to another person other than a certified applicator without having first obtained written documentation from a certified applicator or a noncertified recipient that the material is to be applied by or under the supervision of a certified applicator.
- B.** The seller shall obtain one of the following types of written documentation to satisfy the requirement in subsection (A):
1. A photocopy or fax of the certificate issued to the certified applicator who will be applying or supervising application of the restricted use pesticide and:
    - a. A statement signed by the certified applicator, authorizing and identifying the noncertified individual to purchase or receive the restricted use pesticide for the certified applicator; or
    - b. A copy of a signed contract or agreement, authorizing and identifying the noncertified person to receive the restricted use pesticide for the certified applicator; or
  2. A form on file with the seller that contains the following information:
    - a. Name of any individual authorized to receive the restricted use pesticides for the certified applicator;

- b. Relationship of an authorized individual to the certified applicator (partner, employee, co-worker, or immediate family);
- c. List of the restricted use pesticides an authorized individual is allowed to receive, specifying the trade name and:
  - i. EPA registration number;
  - ii. State special local need registration number issued by the Department; or
  - iii. Emergency exemption number, issued by the EPA under Section 18 of FIFRA, if applicable.
- d. Signature of the authorized individual and the date signed; and
- e. Certified applicator's full name, signature, work address, work phone number, certification number, and certification categories.

- C.** A seller shall request proof of identification from any noncertified individual accepting restricted use pesticides on behalf of a certified applicator if the individual is unknown to the seller.
- D.** A noncertified individual who receives a restricted use pesticide on behalf of a certified applicator shall sign all sale documents for restricted use pesticides.
- E.** If, at the time of the sale of the restricted use pesticide, the noncertified individual receiving the pesticide satisfies the requirements of subsection (B) by presenting a signed statement, contract, or agreement, the seller shall maintain on file a copy of the signed statement, contract, or agreement.
- F.** The seller shall retain records of all sales or deliveries made and maintain the documents required by this Section for at least two years from the date of sale.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-306 (Supp. 91-4). Former Section R3-3-306 renumbered to R3-3-303; new R3-3-306 renumbered from R3-3-310 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-307. Aircraft and Drones; Agricultural Aircraft and Drone Pilots**

- A.** A person shall not operate an aircraft to apply pesticides in this state unless the aircraft has a valid tag issued under R3-3-206 and a valid Federal Aviation Administration airworthiness certificate issued according to 14 CFR §§ 21.171 et seq. (29 FR 14569, October 24, 1964, as amended by 74 FR 53384, Oct. 16, 2009, <https://www.ecfr.gov/current/title-14/chapter-I/subchapter-C/part-21/subpart-H>. This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.).
- B.** A person shall not operate a drone to apply a pesticide in this state unless the drone has a valid tag issued under R3-3-206 and a valid registration issued according to 14 CFR § 48.1 (80 FR 78645, Dec. 16, 2015, as amended by Doc. No. FAA-2018-1084, 84 FR 3673, Feb. 13, 2019, <https://www.ecfr.gov/current/title-14/chapter-I/subchapter-C/part-48>. This material is incorporated by reference, on file with the Department, and does not include any later amendments or editions.)
- C.** A custom applicator shall not permit an individual who does not hold a valid agricultural aircraft pilot license and a valid commercial applicator certification to apply pesticides by aircraft.

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- D. A custom applicator shall not permit an individual who does not hold a valid agricultural drone pilot license and a valid commercial applicator certification to apply pesticides by drone.

**Historical Note**

Adopted effective January 17, 1989 (Supp. 89-1). Renumbered from R3-10-307 (Supp. 91-4). Former Section R3-3-307 repealed; new R3-3-307 renumbered from R3-3-312 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-308. Pesticide Containers and Pesticides; Storage and Disposal**

- A. Each person storing pesticides or non-triple rinsed pesticide containers shall:
1. Provide a secure, well-ventilated storage location;
  2. Verify that the containers are nonleaking and closed if not in use; and
  3. Conspicuously post a sign at the entrance to the storage area warning others that pesticides are stored inside.
- B. A person shall not place misleading wording or markings on a service container that are not related to the pesticide in the container.
- C. A person using a service container to store or transport a pesticide concentrate or registered ready-to-use pesticide, shall place a durable and legible label or tag on the service container that lists:
1. Name, email address, if applicable, and telephone number of the applicator or custom applicator using the pesticide;
  2. Brand or trade name of the pesticide;
  3. EPA registration number;
  4. Name and percentage of the active ingredient;
  5. Dilution, if any, in the service container;
  6. EPA-assigned signal word (danger, warning, or caution) for the registered label; and
  7. The phrase "KEEP OUT OF REACH OF CHILDREN."
- D. A person shall not store or transport any pesticide in a container that has been used for food, feed, beverages, drugs, or cosmetics, or, because of shape, size, or marking is identified with food, feed, beverages, drugs, or cosmetics.
- E. A person shall not dump, negligently store, or leave unattended any pesticide, service container, or pesticide container or part of a container, at any place or under any condition that will create a hazard to an individual, an animal, or property.
- F. A person shall not dispose of any pesticide or pesticide container except according to label directions and all applicable laws.
- G. Before a person disposes of any pesticide container, the person shall ensure that the following steps are taken:
1. After emptying each pesticide container other than a pressurized container, a paper bag, or a container designed for reuse with the same pesticide and described in R3-3-309, the container is triple rinsed and:
    - a. The rinsate is not discharged into the environment unless the discharge is performed according to label directions, and applicable laws;
    - b. The rinsate is placed into a service container or the application equipment for use on an application site, or the rinsate is disposed as allowed by the label;

- c. Each container is punctured or crushed after it is triple rinsed to render the container incapable of holding any material; and
2. A pesticide container that is a combustible bag or package is thoroughly emptied and either:
    - a. Folded and tied into bundles or otherwise secured, or
    - b. Enclosed securely in a secondary container that is labeled as containing pesticide residue.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-308 (Supp. 91-4). Former Section R3-3-308 renumbered to R3-3-304; new R3-3-308 renumbered from R3-3-313 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-309. Returnable, Reusable, Recyclable, and Reconditionable Pesticide Containers**

- A. A pesticide container, as defined in R3-3-101, labeled as a returnable, reusable container, or for which the label contains provisions for recycling or reconditioning, may be shipped according to label directions to a dealer, distributor, formulator, or a reconditioning or recycling facility that is operated in accordance with applicable laws.
- B. If a pesticide container is being held for shipment under subsection (A), the person holding the container shall, immediately after use, place it in a secure environment, inaccessible for any use other than shipment according to label directions.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-309 (Supp. 91-4). Former Section R3-3-309 renumbered to R3-3-305; new R3-3-309 renumbered from R3-3-314 and amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-310. Fumigation Use**

- A. An individual shall not perform a fumigation unless the individual is a certified fumigant applicator or a certified fumigant applicator is physically present in the immediate vicinity supervising the individual performing the fumigation.
- B. An individual storing, handling, or applying a fumigant shall follow all label requirements. If the label does not specify warning requirements, the individual shall comply with the following provisions:
1. Before the fumigation begins, warning signs shall be posted in visible locations on or in the immediate vicinity of all entrances to and on every side of the space or area being fumigated.
  2. Warning signs shall be printed in red on white background and shall:
    - a. State the English and Spanish words "DANGER/PELIGRO";
    - b. Contain a skull and crossbones symbol if shown on the product label;
    - c. State "Area or commodity under fumigation. DO NOT ENTER/NO ENTRE"; and
    - d. State the name of the fumigant, the date and time the fumigant was injected, and the name, email address, if applicable, and telephone number of the certified applicator.
- C. A certified fumigant applicator who engages in or who supervises another in the fumigation process shall ensure that the

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label requirements are followed, including requirements relating to the use of personal protective equipment and posting required warning signs.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-310 (Supp. 91-4). Former Section R3-3-310 renumbered to R3-3-306; new R3-3-310 made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-311. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-311 (Supp. 91-4). Section repealed by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-312. Renumbered****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-312 (Supp. 91-4). Section renumbered to R3-3-307 by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-313. Renumbered****Historical Note**

Adopted effective January 17, 1989 (Supp. 89-1). Renumbered from R3-10-313 (Supp. 91-4). Section renumbered to R3-3-308 by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-314. Renumbered****Historical Note**

Adopted effective January 17, 1989 (Supp. 89-1). Renumbered from R3-10-314 (Supp. 91-4). Section renumbered to R3-3-309 by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**ARTICLE 4. RECORDKEEPING AND REPORTING****R3-3-401. Pesticide Seller Records**

- A.** A seller of any restricted use pesticide, or any agricultural use pesticide shall maintain all records showing the receipt, sale, delivery, or other disposition of the pesticide or device sold for at least two years from the date of sale. If a seller intends to change the location of the records, the seller shall file a signed statement with the Department before the move stating the new address.
- B.** When any agricultural use pesticide, or a restricted use pesticide is sold, delivered, or otherwise disposed of, a seller shall maintain the following records and information:
  1. Bill of lading or other similar record of the receipt of the pesticide at the selling establishment;
  2. Seller's dated sales receipt, delivery receipt, or invoice of the transaction, delivery, or other disposition of the pesticide;
  3. Name and address of the purchaser;
  4. PGP number, or the PMD license number of the purchaser, if applicable;
  5. State special local need registration number issued under Section 24 of FIFRA, if applicable;
  6. Emergency exemption permit number granted by the EPA under Section 18 of FIFRA, if applicable;
  7. Experimental use permit number, if applicable;

8. Pesticide brand name and the EPA registration number; and
9. Quantity of the pesticide sold to the purchaser.

- C.** In addition to the information required in subsection (B), when a restricted use pesticide is sold, delivered, or otherwise disposed of for use by a certified applicator, a seller shall maintain records that contain the following information:
  1. Name and address of the residence or principal place of business of each person to whom the restricted use pesticide is sold, delivered, or otherwise disposed of, and any records required under R3-3-306;
  2. Certified applicator's name, address, certification number, and the expiration date of the applicator's certification; and
  3. Categories in which the applicator is certified, if applicable.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-401 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-402. Private and Golf Applicator Records; Restricted Use Pesticide**

- A.** Following an application to an application site of a restricted use pesticide, a pesticide registered under Section 18 of FIFRA, or an experimental use permitted pesticide, a private applicator shall complete an application record on a form approved by the Department, which includes the following:
  1. Name of the private applicator and the applicator's certification number; as required,
  2. Name and permit number of the seller;
  3. Name of the pesticide applied and its EPA registration number;
  4. Date and time of application;
  5. Name of regulated grower;
  6. Method of application;
  7. Crop name or site and the number of acres treated with the pesticide;
  8. Rate per acre of the active ingredient or formulation of the pesticide;
  9. Total volume of pesticide used per acre; and
  10. County, township, range, and section of the field that received the application.
- B.** Following an application to a non-field of a restricted use pesticide, a pesticide registered under Section 18 of FIFRA, or an experimental use permitted pesticide, a private applicator or golf applicator shall complete an application record on a form approved by the Department, that includes the following:
  1. The information requested under subsection (A)(1) through (A)(6);
  2. Item treated;
  3. Rate per item treated;
  4. Total volume used in the application; and
  5. Application site location by county, township, range and section, or by physical address.
- C.** A private applicator and golf applicator shall retain records required by this Section for at least two years from the date of the private application.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).

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Renumbered from R3-10-402 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-403. Bulk Release Report**

- A.** An applicator shall notify the Department at the Pesticide Hotline, 1-800-423-8876, as soon as practical after a bulk release, but no later than three hours after the bulk release. If the bulk release is on a public highway or railway, or results in the death of an individual, the applicator shall immediately call 911, then report the incident to the ADEQ's Environmental Emergency Response Unit by calling (602) 390-7894, within 24 Hours.
- B.** Within 30 days after a bulk release, the applicator shall provide a written report to the Department listing all details of the release, including:
1. Location and cause of the release;
  2. Disposition of the pesticide released;
  3. Measures taken to contain the bulk release;
  4. Name and EPA registration number of the pesticide released;
  5. Name, email address, if applicable, and telephone number of the applicator's contact person;
  6. Date and time of the release;
  7. Specific environment into which the release occurred;
  8. Known human exposure to the pesticide, if observed; and
  9. Estimated amount of pesticide or pesticide mixture released.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-403 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-404. Form 1080; Reports to the Department**

- A.** A custom applicator shall submit to the Department, by mail or fax, a completed and signed Form 1080, as prescribed in R3-3-302.
- B.** A regulated grower shall submit to the Department, by mail or fax, a completed and signed Form 1080, as prescribed in R3-3-302, for application of a pesticide containing an active ingredient that appears on the ADEQ groundwater protection list, and is soil-applied, as defined in A.A.C. R18-6-301.
- C.** A custom applicator or regulated grower may report continued pesticide applications and spot applications within the same reporting period on a single Form 1080.
- D.** A custom applicator or a regulated grower shall submit the Form 1080 to the Department during the reporting period.
- E.** A PCA or custom applicator shall retain a copy of each Form 1080 for at least two years from the date of the application.

**Historical Note**

Adopted effective January 17, 1989 (Supp. 89-1). Renumbered from R3-10-404 (Supp. 91-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-405. Disposal Records; Agricultural Pesticide Concentrate**

An applicator shall maintain the following information for two years:

1. EPA registration number, product name, active ingredient, and amount of agricultural pesticide concentrate disposed of;
2. Date of disposal;
3. Method of disposal; and
4. Specific location of the disposal site, or name of licensed disposal contractor.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**ARTICLE 5. NONEXCLUSIVE LISTS OF SERIOUS, NONSERIOUS, AND DE MINIMIS VIOLATIONS****R3-3-501. Serious Violations**

The following is a nonexclusive list of acts that are serious violations if exposure to the pesticide produces a substantial probability that death or serious physical harm could result, unless the violator did not, and could not with the exercise of reasonable diligence, as documented in the investigative record, know of such safety or human health risk, in which case the violation is nonserious:

1. Storing a pesticide or pesticide container improperly,
2. Dumping or disposing a pesticide or pesticide container in violation of this Chapter,
3. Leaving a pesticide or pesticide container unattended,
4. Spraying or applying a pesticide in a manner inconsistent with labeling instructions, or
5. Adulterating a pesticide.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-501 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-502. Nonserious Violations**

- A.** General violations. The following is a nonexclusive list of acts that are nonserious violations if the violation has a direct or immediate relationship to safety, health, or property damage, but does not constitute a de minimis violation or a serious violation, unless the violator did not, and could not with the exercise of reasonable diligence, know of such safety, health, or property damage risk in which case the violation is de minimis. A person shall not:

1. Improperly store, dump, or leave unattended any pesticide, pesticide container or part of a pesticide container, or service container.
2. Make a false statement or misrepresentation in an application for a permit, license, or certification, or a permit, license, or certification renewal.
3. Falsify any records or reports required to be made under Articles 2 through 4 of this Chapter.
4. Operate an aircraft, drone, or ground equipment in a faulty, careless, or negligent manner during the application of a pesticide.
5. Apply or instruct another to apply a pesticide so that it comes into contact with:
  - a. An individual;
  - b. An animal; or
  - c. Property, other than the application site being treated.
6. Use, apply, or instruct another to apply a pesticide in a manner or for a use inconsistent with its pesticide label or labeling except as provided by R3-3-301(A).



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7. Unless being used under an approved EUP or being used on research facility, use, sell, apply, store, or instruct another to use, sell, apply, or store a pesticide:
    - a. That is not registered with the Department and the EPA, or
    - b. Outside the EPA authorized end-use provision if previously registered with the Department and the EPA and cancelled or suspended by the EPA.
  8. Fail to provide accurate or approved labeling when registering a pesticide.
  9. Using a restricted use pesticide without proper certification, or under the direct supervision of a properly certified applicator, when allowed.
- B. Seller violations.** A seller shall not:
1. Sell pesticides without a valid seller's permit issued by the Department according to R3-3-203;
  2. Provide a restricted use pesticide to a regulated grower or applicator who does not have a valid applicator certification;
  3. Fail to maintain records required under Articles 2 through 4 of this Chapter;
  4. Fail to maintain complete sales records of restricted use pesticides required under Articles 3 and 4 of this Chapter;
  5. Adulterate a pesticide;
  6. Make false or misleading claims about a pesticide to any person;
  7. Modify a label or labeling without proper authorization;
  8. Provide a pesticide to a person not authorized according to R3-3-306; or
  9. Provide an agricultural use pesticide to a person who does not have a valid PGP.
- C. PCA violations.** A PCA shall not:
1. Act as a PCA without a valid agricultural pest control advisor license issued by the Department according to R3-3-207,
  2. Make a false or fraudulent statement in any written recommendation about the use of a pesticide,
  3. Make a recommendation regarding the use of a pesticide in a specific category in which the individual is not licensed, or
  4. Make a written recommendation for the use of a pesticide in a manner inconsistent with its pesticide label or the exceptions as provided in R3-3-301(A).
- D. Agricultural aircraft pilot and drone pilot violations.** A pilot or drone pilot shall not apply a pesticide by aircraft or drone without a valid agricultural aircraft pilot license or drone pilot license, as applicable, issued by the Department according to A.A.C. R3-3-204.
- E. Custom applicator violations.** A custom applicator shall not:
1. Allow application equipment to be operated in a careless or reckless manner during the application of a pesticide,
  2. Make a custom application without a valid custom applicator's license issued by the Department according to R3-3-205,
  3. Make a custom application of a restricted use pesticide without supervision by a person with a valid commercial applicator certification issued by the Department according to R3-3-208,
  4. Allow an aircraft or drone to be operated during the application of a pesticide by an individual who does not have a valid agricultural aircraft pilot license (APL) or drone pilot license (DPL), as applicable, issued by the Department according to R3-3-204, or
5. Apply a pesticide without a written Form 1080 as prescribed in R3-3-302(A).
- F. Regulated grower violations.** A regulated grower shall not:
1. Purchase, apply, or use an agricultural use pesticide without a valid Pesticide Grower Permit (PSP) issued by the Department according to R3-3-201;
  2. Purchase, store, or apply a restricted use pesticide without being a certified applicator in the appropriate category;
  3. Purchase, store, or apply any restricted use pesticide on a golf course without being a golf applicator; or
  4. Allow a pesticide application on a golf course without having the proper protective equipment required by the label available to the applicator.
- G. Certified applicator violations.** A certified applicator shall not:
1. Allow the unsupervised application of a restricted use pesticide,
  2. Fail to maintain complete records required under Articles 2 through 4 of this Chapter, or
  3. Use a restricted use pesticide without a valid commercial applicator, private applicator, or golf applicator restricted use pesticide certification issued by the Department according to R3-3-208.
  4. Use a restricted use pesticide without restricted use pesticide certification in the proper category.
- H. Exemptions.** The following incidents are not pesticide use violations under this Section:
1. Exposure of an individual involved in the application who is wearing proper protective clothing and equipment;
  2. Exposure of an unknown trespassing individual, animal, or property that the applicator, working in a prudent manner, could not anticipate being at the application site; or
  3. Exposure of a person, animal, or property if the application is made according to a government-sponsored emergency program.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
 Renumbered from R3-10-502 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by exempt rulemaking at 19 A.A.R. 3130, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-503. De Minimis Violations**

- A. Seller violations.** It is a de minimis violation if a seller:
1. Fails to record seller and PGP numbers on containers, cartons, and delivery tickets;
  2. Fails to register the seller's responsible individual; or
  3. Fails to maintain complete records as required under Articles 2 through 4 of this Chapter.
- B. PCA violations.** It is a de minimis violation if a PCA:
1. Fails to put recommendations in writing as prescribed at R3-3-302(A),
  2. Fails to provide complete information required on written recommendations under R3-3-302,
  3. Fails to maintain complete records as required under Articles 2 through 4 of this Chapter, or
  4. Fails to obtain CEU credits pertinent to the categories license renewal is sought.
- C. Custom applicator violations.** It is a de minimis violation if a custom applicator:
1. Fails to maintain complete records required under Articles 2 through 4 of this Chapter, or

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2. Fails to file reports as required under Articles 3 and 4 of this Chapter.
- D.** Regulated grower violations. It is a de minimis violation if a regulated grower:
  1. Fails to maintain complete records as required under Articles 2 through 4 of this Chapter; or
  2. Fails to file reports as required under Article 4 of this Chapter including whether the application includes a pesticide containing an active ingredient that appears on the ADEQ groundwater protection list, and is soil-applied, as defined in A.A.C. R18-6-301.
- E.** Certified applicator violations. A certified applicator shall not:
  1. Fail to file reports as required under Articles 3 and 4 of this Chapter; or
  2. Fail to obtain CEU credits pertinent to the categories that certification renewal is sought.
- F.** A third de minimis violation in a three-year period is a nonserious violation.
- G.** Exemptions. The following incidents are not a violation under this Section:
  1. Exposure of an individual involved in the application who is wearing proper protective clothing and equipment;
  2. Exposure of an unknown trespassing individual, animal, or property that the applicator, working in a prudent manner, could not anticipate being at the application site; or
  3. Exposure of a person, animal, or property if the application is made according to a government-sponsored emergency program.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
 Renumbered from R3-10-503 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-504. Mitigation**

- A.** A violation listed in R3-3-501 is a nonserious violation if:
  1. The violator did not, and could not with the exercise of reasonable diligence, know of the safety or human health risk involved; or
  2. The release is done to avoid an accident that would have resulted in greater harm than that caused by the pesticide release or is caused by mechanical malfunction beyond the control of the operator.
- B.** A violation listed in R3-3-502 is a de minimis violation if:
  1. The violator did not, and could not with the exercise of reasonable diligence, know of the safety, health, or property damage risk involved; or
  2. The release is done to avoid an accident that would have resulted in greater harm than that caused by the pesticide release or is caused by mechanical malfunction beyond the control of the operator.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
 Renumbered from R3-10-504 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**R3-3-505. Unlisted Violations**

- A.** The Department shall classify a violation of Articles 2 through 4 of this Chapter or of A.R.S. Title 3, Chapter 2, Article 6 that is not listed in R3-3-501, R3-3-502, or R3-3-503 as a serious,

nonserious, or de minimis violation depending upon the specific factual circumstances surrounding the violation.

- B.** A third de minimis violation of the same or similar type in a three-year period is a nonserious violation.
- C.** According to A.R.S. § 3-370, in addition to the civil penalties prescribed by the section, a person who knowingly or willfully commits a violation of this Article may be charged as follows:
  1. For any nonserious violation of this Article that results in the harm to the environment or economy that results in the loss of \$10,000 or less may be found guilty of a class 1 misdemeanor; or
  2. For any serious violation of this Article that results in the harm to human or animal health, the environment, or the economy of \$10,000 or more may be found guilty of a class 6 felony.
- D.** In addition, the Director may deny, suspend or revoke an applicator certification for one or more of the following violations:
  1. Misuse of a pesticide;
  2. Falsifying records as required under Article 4 of this Chapter;
  3. A criminal conviction under section 14(b) of FIFRA;
  4. A final order imposing a civil penalty under section 14(a) of FIFRA; or
  5. A violation of State laws or regulation relevant to the State certification plan.

**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
 Renumbered from R3-10-505 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-506. Penalty and Fine Point System**

- A.** The ALJ shall assess points, as applicable, against a violator for the violation of each pesticide rule or statute, or the Associate Director shall assess points, as applicable, for the violation of each pesticide rule or statute upon entering into a negotiated settlement as a result of an informal settlement conference under A.R.S. § 41-1092.06, in accordance with the following point system. From each of subsections (A)(1) through (6), one choice shall be selected, unless otherwise appropriate, based upon supporting evidence in the record of the proceeding before the ALJ or Associate Director. Points shall be totaled for the violation of each pesticide rule or statute.
  1. Health effects.
 

a. No evidence of human exposure to pesticides and no evidence of the substantial probability of human exposure to pesticides.	0
b. Substantial probability of human exposure to pesticides but treatment not required by a physician, nurse, paramedic, or physician's assistant.	5-10
c. Evidence of human exposure to pesticides but treatment not required by a physician, nurse, paramedic, or physician's assistant.	11-20
d. Human exposure to pesticides that required treatment by a physician, nurse, paramedic, or physician's assistant, but which did not result in pesticide poisoning.	21-30

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- e. Human exposure to pesticides that required either hospitalization for less than 12 hours or treatment as an outpatient for five consecutive days or less by a physician, nurse, paramedic, or physician's assistant for pesticide poisoning. 31-45
- f. Human exposure to pesticides that required either hospitalization for 12 hours or longer, or treatment as an outpatient for more than five consecutive days by a physician, nurse, paramedic, or physician's assistant for pesticide poisoning. 46-100
- g. Human exposure to pesticides resulting in death from pesticide poisoning (serious violation unless otherwise documented in the investigative record). 101-180
- 2. Environmental consequences and property damage. (Select one or more as evidence indicates.)
  - a. No evidence of substantial probability of environmental or property damage. 0
  - b. Substantial probability of water contamination. 5-10
  - c. Evidence of water source contamination. 11-20
  - d. Substantial probability of soil contamination causing economic damage. 5-10
- e. Evidence of soil contamination causing economic damage. 11-20
- f. Substantial probability of nontarget bird kills. 5-10
- g. Evidence of nontarget bird kills. 11-20
- h. Substantial probability of nontarget fish kills. 5-10
- i. Evidence of nontarget fish kills. 11-20
- j. Nontarget kills involving game or furbearing animals as defined by A.R.S. § 17-101(B). 10-20
- k. Any property damage (nonserious violation only under A.R.S. § 3-361(4)). 10-20
- l. Air contamination causing official evacuation by federal, state, or local authorities. 10-20
- m. Killing one or more threatened or endangered species. 15-20
- n. Killing one or more domestic animals. 15-20
- 3. Culpability
  - a. Knowing. Knew or reasonably should have known of the safety, health or property damage risk. 5-10
  - b. Willfully. Actual knowledge or belief that the conduct would violate the law but engages in misconduct. 20-50

- 4. Prior violations or citations. Violations or citations within three years from the date the violation was committed. (Select one or more as evidence indicates.)

Prior violation history	Current violation Non-serious	Current violation Serious
None	0	0
One or more De minimis	5	0
One Nonserious	10	5
One Nonserious, same or substantially similar to current violation	20	10
Two Nonserious	30	15
Two Nonserious, same or substantially similar to current violation	40	20
Three Nonserious	60	30
Three Nonserious, same or substantially similar to current violation	70	35
Additional Nonserious: same or substantially similar to current violation, points per each additional violation beyond three	10	5
One Serious	20	10
One Serious, same or substantially similar to current violation	40	20
Two Serious	60	30
Two Serious, same or substantially similar to current violation	80	40
Three Serious	120	60
Three Serious, same or substantially similar to current violation	140	70
Additional Serious: same or substantially similar to current violation, points per violation	20	10

- 5. The length of time a violation has been allowed to continue by the violator after notification by the Department.
  - a. Less than one day. 0
  - b. One day but less than one week. 1-10
  - c. One week but less than one month. 11-20
  - d. One month but less than two months. 21-30
  - e. Two months or more. 31-40
- 6. Wrongfulness of conduct
  - a. Conduct resulting in a violation that does not cause any immediate damage to public health, safety, or property. 4-5
  - b. Conduct resulting in a violation that the evidence establishes may have a substantial probability of an immediate effect upon public health, safety, or property. 6-8

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- c. Conduct resulting in a violation that the evidence establishes had an immediate effect upon public health, safety, or property, but does not fall within subsection (6)(e). 9-10
- d. Conduct causing the substantial probability of serious physical injury, hospitalization, or sustained medical treatment for an individual, or degrading the pre-existing environmental quality of the air, water, or soil so as to cause a substantial probability of a threat to the public health, safety, or property. 20-35
- e. Conduct resulting in serious physical injury, hospitalization, or sustained medical treatment for an individual, or degrading the pre-existing environmental quality of the air, water, or soil so as to cause a substantial probability of a threat to the public health, safety, or property. 36-50

**B.** The ALJ or Associate Director, after determining points according to subsection (A) shall assess a fine or penalty, or fine and penalty, for each violation in accordance with the following schedules:

1. Nonserious violation as defined under A.R.S. § 3-361.
  - a. 53 points or less. A fine of \$50 to \$150; a penalty of one to three months' probation, with a condition of violating probation being one to three hours of continuing education.
  - b. 54 to 107 points. A fine of \$151 to \$300; a penalty of four to six months' probation with a condition of violating probation being one to 10 days' suspension.
  - c. 108 points or more. A fine of \$301 to \$500; a penalty of seven to 12 months' probation with a condition of violating probation being 15 to 30 days' suspension or revocation for a period of up to one year.
2. Serious violation as defined under A.R.S. § 3-361.
  - a. 46 points or less. A fine of \$1,000 to \$2,000; a penalty of one to three months' probation with a condition of violating probation being five to 10 days' suspension for a nonserious violation or 15 to 30 days' suspension for a serious violation.
  - b. 47 to 93 points. A fine of \$2,001 to \$5,000; a penalty of four to six months' probation with a condition of violating probation being 15 to 30 days' suspension for a nonserious violation and 31 to 90 days' suspension for a serious violation.
  - c. 94 points or more. A fine of \$5,001 to \$10,000; a penalty of probation for seven to 12 months with a condition of violating probation being two to four months' suspension for a nonserious violation and four to 12 months' suspension for a serious violation, or revocation for the remainder of the license year and an additional period of one to three years.
3. The first de minimis violation is not considered a violation of probation.

**Historical Note**

Adopted effective September 13, 1989 (Supp. 89-3). Renumbered from R3-10-506 (Supp. 91-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**ARTICLE 6. REPEALED****R3-3-601. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-601 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-602. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-602 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-603. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-603 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-604. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-604 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-605. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-605 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-606. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-606 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-607. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-607 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-608. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-608 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-609. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-609 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-610. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4). Renumbered from R3-10-610 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-611. Repealed**

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**Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-611 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-612. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-612 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-613. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-613 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-614. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-614 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-615. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-615 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-616. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-616 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-617. Repealed****Historical Note**

Adopted effective November 20, 1987 (Supp. 87-4).  
Renumbered from R3-10-617 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**ARTICLE 7. PESTICIDE****R3-3-701. Definitions**

In addition to the definitions in A.R.S. § 3-341, the following terms apply to this Article:

“Discontinuation” means when the registrant is no longer distributing a pesticide into Arizona.

“Official sample” means any sample of pesticide taken by the Associate Director, or the Associate Director’s agent, and designated as official.

“Pest” means, in addition to the pests declared in A.R.S. § 3-341(20), all birds, mammals, reptiles, amphibians, fish, slugs, snails, crayfish, roots, and plant parts.

**Historical Note**

Former rule 1; Former Section R3-3-01 repealed, new Section R3-3-01 adopted effective January 18, 1978 (Supp. 78-1). Amended effective December 29, 1978 (Supp. 78-6). Section R3-3-701 renumbered from R3-3-01 (Supp. 91-4). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4,

2024 (Supp. 24-1).

**R3-3-702. Pesticide Registration; Fee**

- A.** Registration. Any person registering a pesticide shall comply with the ADEQ pre-registration requirements according to A.A.C. R18-6-102, prior to submitting a pesticide registration according to this Article, and provide the following documents and information on a form provided by the Department with a nonrefundable \$100 fee for each pesticide, for each year of the registration:
1. The name, address, telephone number, and signature of the applicant;
  2. The name and address of the company appearing on the label;
  3. The tax identification number or Social Security number of an individual applying;
  4. The date of the application;
  5. The brand and name of the pesticide being registered;
  6. The EPA registration number of the pesticide if applicable;
  7. The analytical methods for any analyses of residues for the active ingredients of the pesticide, when requested by the Department;
  8. The toxicological and safety data, when requested by the Department;
  9. The name and telephone number of the person providing the analytical methods, and toxicological and safety data;
  10. One pesticide label for any pesticide not previously registered;
  11. The material safety data sheet for each pesticide; and
  12. The license time-period option.
- B.** A pesticide registration is nontransferable, expires on December 31, and shall, at the option of the applicant, be valid for one or two years.
- C.** If an applicant elects a two-year pesticide registration, any additional pesticide registered during that two-year registration shall have the same registration end-date as any other pesticide currently registered by that applicant with the Department.

**Historical Note**

Former rule II; Former Section R3-3-02 renumbered and amended as Section R3-3-01, former Sections R3-3-11 and R3-3-12 renumbered and amended as Section R3-3-02 effective January 18, 1978 (Supp. 78-1). Amended subsection (C) effective January 1, 1979, subsection (D) effective January 1, 1982 (Supp. 78-6). Editorial corrections, subsection (B), paragraphs (6) through (9) (Supp. 79-6). Amended by deleting subsection (D) effective March 5, 1982 (Supp. 82-2). Section R3-3-702 renumbered from R3-3-02 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2). New Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by exempt rulemaking at 16 A.A.R. 1334, effective June 29, 2010 (Supp. 10-2). Amended by exempt rulemaking at 17 A.A.R. 1759, effective July 20, 2011 (Supp. 11-3). Amended by exempt rulemaking at 20 A.A.R. 2452, effective July 24, 2014 (Supp. 14-3). Amended by final exempt rulemaking at 23 A.A.R. 1940, effective August 9, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 24 A.A.R. 2222, effective August 3, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 25 A.A.R. 2084, effective August 27, 2019 (Supp. 19-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024

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(Supp. 24-1).

**R3-3-703. General Provisions**

- A.** Discontinued pesticides. In addition to the requirements for discontinued pesticides established in A.R.S. § 3-351(K), any person holding a pesticide found in the channels of trade following the two-year discontinuation period shall be responsible to register or dispose of the pesticide.
- B.** Sampling.
1. The Associate Director, or the Associate Director's agent, may sample, inspect, and analyze any pesticide distributed within the state to determine whether the pesticide is in compliance with the provisions of this Article and laws pertaining to this Article, or if a complaint has been filed with the Department.
  2. The analytical results of pesticide formulations as listed on a label shall comply with the allowed deviations listed in R3-3-704(B).
  3. The results of an official analyses of any pesticide not in compliance with the allowed deviations listed in R3-3-704(B) shall be sent to the Associate Director, to the registrant, or other responsible person. Upon request, and within 30 days, the Associate Director shall provide the registrant or other responsible person a portion of the noncompliant pesticide sample.

- C.** Prohibited acts. No person shall purchase a pesticide to repack the pesticide for distribution and sale without relabeling the repackaged container and complying with the provisions of FIFRA and 40 CFR §§ 156.3 et seq. (amended December 12, 2008, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-156>) and 40 CFR §§ 157.20 et seq. (amended December 12, 2008, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-157>). This material is incorporated by reference, is on file with the Department and includes no later amendments or additions.

**Historical Note**

Section R3-3-703 renumbered from R3-3-03 (Supp. 91-4). New Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-704. Labels**

- A.** Within two weeks of a pesticide label revision, a registrant shall provide the Department with one pesticide label that has been revised since the pesticide was originally registered.
- B.** The Associate Director may request a copy of a pesticide label if the label on file is older than three years.

**C.** Table of allowed deviations of analytical results from label claims for active ingredients in pesticide formulas is as follows:

Claim %	HCV <sup>(1)</sup> %	HSD <sup>(2)</sup>	Allowed Deviations for “uniform” <sup>(3)</sup> samples		Allowed Deviations for “non-uniform” <sup>(4)</sup> samples	
			Claim - 3HSD	Claim + 6HSD	Claim - 4HSD	Claim + 8HSD
0.001	11.31	0.00011	0.00066	0.00168	0.00055	0.00191
0.005	8.88	0.00044	0.0037	0.0077	0.0032	0.0086
0.008	8.27	0.00066	0.0060	0.0120	0.0054	0.0133
0.01	8.00	0.00080	0.0076	0.0148	0.0068	0.0164
0.03	6.78	0.0020	0.024	0.042	0.022	0.046
0.06	6.11	0.0037	0.049	0.082	0.045	0.089
0.10	5.66	0.0057	0.083	0.13	0.077	0.145
0.40	4.59	0.018	0.34	0.51	0.33	0.55
0.80	4.14	0.033	0.70	1.00	0.67	1.06
1.0	4.00	0.040	0.88	1.24	0.84	1.32
2.0	3.60	0.072	1.78	2.43	1.71	2.58
4.0	3.25	0.13	3.61	4.78	3.48	5.04
6.0	3.05	0.18	5.45	7.10	5.27	7.47
10.0	2.83	0.28	9.15	11.70	8.87	12.26
15.0	2.66	0.40	13.80	17.39	13.40	18.19
20.0	2.55	0.51	18.47	23.06	17.96	24.08
25.0	2.46	0.62	23.15	28.70	22.54	29.93
30.0	2.40	0.72	27.84	34.32	27.12	35.75
35.0	2.34	0.82	32.54	39.92	31.72	41.56
40.0	2.30	0.92	37.25	45.51	36.33	47.35
45.0	2.26	1.01	41.96	51.09	40.94	53.12
50.0	2.22	1.11	46.67	56.66	45.56	58.88
60.0	2.16	1.30	56.11	67.78	54.82	70.37
70.0	2.11	1.48	65.57	78.86	64.09	81.82
80.0	2.07	1.65	75.04	89.93	73.38	93.24
90.0	2.03	1.83	84.51	100.97	82.68	104.63

(1) HCV(%) = Horwitz Coefficients of Variation =  $2 (1 - 0.5 \log (\text{claim \%}/100))$

(2) HSD = Horwitz Standard Deviation =  $(\text{Claim \%}) \text{ HCV \%}/100$

(3) “Uniform” samples are homogeneous products which can be analyzed by established procedures. In most cases, validated analytical methods are available for these samples.

(4) “Non-uniform” samples are non-homogeneous samples or products which are difficult to sample or subsample. These products may not be uniformly mixed or packaged and include some special formulations like natural products. These types of samples include fertilizer containing pesticides, pesticides in pressurized containers, strips, plastic bands, collars, grain and other carriers. Natural product formulations such as rotenone and pyrethrin are also included in this group. When it is necessary to use methods which are not validated for accuracy, precision, and reproducibility in a specific matrix, the “non-uniform” guidelines may be used for allowed deviations. The Department may use judgment in placing a sample into the “uniform” or “non-uniform” category.

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**Historical Note**

Former rule IV; Former Section R3-3-04 renumbered and amended as Section R3-3-01 effective January 18, 1978 (Supp. 78-1). Section R3-3-704 renumbered from R3-3-04 (Supp. 91-4). New Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-705. Renumbered****Historical Note**

Former rule V; Repealed effective January 18, 1978 (Supp. 78-1). Section R3-3-705 renumbered from R3-3-05 (Supp. 91-4).

**R3-3-706. Renumbered****Historical Note**

Former rule VI; Repealed effective January 18, 1978 (Supp. 78-1). Section R3-3-706 renumbered from R3-3-06 (Supp. 91-4).

**R3-3-707. Renumbered****Historical Note**

Section R3-3-707 renumbered from R3-3-07 (Supp. 91-4).

**R3-3-708. Renumbered****Historical Note**

Former rule VIII; Repealed effective January 18, 1978 (Supp. 78-1). Section R3-3-708 renumbered from R3-3-08 (Supp. 91-4).

**R3-3-709. Renumbered****Historical Note**

Former Administrative rule 1; Repealed effective January 18, 1978 (Supp. 78-1). Section R3-3-709 renumbered from R3-3-09 (Supp. 91-4).

**R3-3-710. Renumbered****Historical Note**

Section R3-3-710 renumbered from R3-3-10 (Supp. 91-4).

**R3-3-711. Renumbered****Historical Note**

Adopted effective November 30, 1977 (Supp. 77-6). Former Section R3-3-11 renumbered and amended as Section R3-3-02 effective January 18, 1978 (Supp. 78-1). Section R3-3-711 renumbered from R3-3-11 (Supp. 91-4).

**R3-3-712. Renumbered****Historical Note**

Adopted effective November 30, 1977 (Supp. 77-6). Former Section R3-3-12 renumbered and amended as Section R3-3-02 effective January 18, 1978 (Supp. 78-1). Section R3-3-712 renumbered from R3-3-12 (Supp. 91-4).

**ARTICLE 8. FERTILIZER MATERIALS****R3-3-801. Definitions**

In addition to terms and definitions in the Official Publication, which is incorporated by reference, on file with the Department, and does not include any later amendments or editions, and the definitions in A.R.S. § 3-262, the following term applies to this Article:

“Official Publication” means the “*Official Publication - AAPFCO*” of the Association of American Plant Food Control Officials, No. 76, 2023. A copy is available for inspection at the Department located at 1110 West Washington Street, Suite 450, Phoenix, AZ 85007, or online subscription may be purchased online at [aapfco.org/publications.html](http://aapfco.org/publications.html).

**Historical Note**

Former rule I; Former Section R3-3-21 repealed, former Section R3-3-24 renumbered and amended as Section R3-3-21 effective January 12, 1978 (Supp. 78-1). Amended effective March 23, 1979 (Supp. 79-2). Section R3-3-801 renumbered from R3-3-21 (Supp. 91-4). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-802. Licensure; Specialty Fertilizer Registration; Fees**

- A. Commercial fertilizer license. Any person applying for a commercial fertilizer license, under A.R.S. § 3-272, to manufacture or distribute commercial fertilizer, shall provide the following information on the license application provided by the Department with a nonrefundable fee of \$125 for each year of the license:
  1. The name, title, and signature of the applicant;
  2. The date of the application;
  3. The distributor or manufacturer name, mailing address, telephone, and email address;
  4. The tax identification number or Social Security number of an individual applying;
  5. The physical location, telephone, and email address of the distributor or manufacturer, if different than subsection (A)(3);
  6. The name, address, telephone, and email address of the distributor or manufacturer where inspection fees are paid, if different than subsection (A)(3); and
  7. The license time-period option.
- B. A commercial fertilizer license is nontransferable, expires on June 30, and shall, at the option of the applicant, be valid for one or two years.
- C. Specialty fertilizer registration.
  1. Any manufacturer or distributor whose name appears on a specialty fertilizer label shall provide the following information to the Department with a nonrefundable fee of \$50 per brand and grade of specialty fertilizer for each year of the registration:
    - a. The name, address, telephone number, email address and signature of the applicant;
    - b. The name and address of the company on the label;
    - c. The date of the application;
    - d. The grade, brand, and name of the specialty fertilizer;
    - e. The current specialty fertilizer label; and
    - f. The registration time-period option.
  2. A specialty fertilizer registration is nontransferable, expires on June 30, and shall, at the option of the applicant, be valid for one or two years.

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3. If an applicant elects a two-year specialty fertilizer registration, any additional fertilizer registered during that two-year registration shall have the same registration end-date as other fertilizer currently registered by that applicant with the Department.

**Historical Note**

Former rule II; Former Section R3-3-22 repealed, former Section R3-3-25 renumbered and amended as Section R3-3-22 effective January 12, 1978 (Supp. 78-1). Section R3-3-802 renumbered from R3-3-22 (Supp. 91-4). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by exempt rulemaking at 16 A.A.R. 2026, effective September 21, 2010 (Supp. 10-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-803. Tonnage Reports; Inspection Fee**

- A. Quarterly tonnage reports and inspection fee.
  1. The inspection fee for all commercial fertilizers, including specialty fertilizers, sold or distributed in Arizona is 25¢ per ton. The tonnage shall be rounded to the nearest whole ton.
  2. Any applicant applying for and receiving a new license after March 15, June 15, September 15, or December 15 is not required to file a quarterly tonnage report for the quarter in which the license application is issued. Any commercial fertilizer distributed in the final two weeks of the initial application quarter shall be included on the next full quarterly report. Any person who distributed commercial fertilizer without a license as required under A.R.S. § 3-272 shall pay all past due inspection fees and late penalties before a license is issued.
  3. Any licensee not estimating annual tonnage shall file the following information on a quarterly statement provided by the Department no later than the last day of January, April, July, and October of each year for the preceding calendar quarter and pay the inspection fees and any penalties, if applicable:
    - a. If the inspection fee is being passed on to the purchaser:
      - i. The assigned number and name of the currently licensed company;
      - ii. The commercial fertilizer by code or grade;
      - iii. The amount of commercial fertilizer in whole tons;
      - iv. The name, title, telephone number, and signature of the licensee or the licensee's authorized representative; and
      - v. The date of the report.
    - b. If the licensee pays tonnage fees for the distribution of a commercial fertilizer:
      - i. The grade;
      - ii. The amount of commercial fertilizer distribution by county;
      - iii. If the commercial fertilizer is dry, whether it is a bulk agricultural product, a bagged agricultural product, or a non-agricultural product;
      - iv. If the commercial fertilizer is liquid, whether it is an agricultural or non-agricultural product;
      - v. The name, title, telephone number, and signature of the licensee or the licensee's authorized representative; and
      - vi. The date of the report.

- B. Estimated tonnage report. A licensee may estimate the annual fertilizer material tonnage if it is 400 tons or less per year and the licensee does not pass the inspection fee responsibility to the purchaser.

1. The licensee shall submit the estimated annual commercial fertilizer tonnage report to the Department with the annual inspection fee no later than July 31 of each year. The tonnage report shall contain:
  - a. The estimated tonnage of commercial fertilizer to be distributed;
  - b. The grade;
  - c. The amount of distribution by county;
  - d. If the commercial fertilizer is dry, whether it is a bulk agricultural product, a bagged agricultural product, or a non-agricultural product;
  - e. If the commercial fertilizer is liquid, whether it is an agricultural or non-agricultural product;
  - f. The name, title, telephone number, and signature of the licensee or the licensee's authorized representative; and
  - g. The date of the report.
2. The licensee shall submit the inspection fee according to subsection (A)(1), which shall be for the amount declared in subsection (B)(1)(a), but not less than \$8 per year. The fee must be included with the annual tonnage report submitted to the Department no later than July 31 of each year. Adjustments for overestimates or underestimates for a licensee with 400 tons or less of actual tonnage sales shall be made on the next year's estimating form. Adjustments of underestimates of licensees with actual tonnage sales more than 400 tons shall be made no later than July 31 of each year.
3. The licensee shall verify the accuracy of the previous year's tonnage estimates to actual tonnage sales and submit the tonnage verification no later than July 31 of each year.
4. Overestimation of tonnage.
  - a. The Department shall not refund any inspection fee based on an overestimation if the licensee does not re-license in the subsequent year;
  - b. If a licensee applies for a license in the subsequent year, the Department shall apply any overestimation to the subsequent year's tonnage fees.

**Historical Note**

Former rule III; Former Section R3-3-23 repealed, former Section R3-3-32 renumbered as Section R3-3-23 effective January 12, 1978 (Supp. 78-1). Amended effective March 23, 1979 (Supp. 79-2). Section R3-3-803 renumbered from R3-3-23 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2). New Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by exempt rulemaking at 16 A.A.R. 2026, effective September 21, 2010 (Supp. 10-3). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-804. General Provisions**

- A. Labeling.
  1. The grade numbers for primary nutrients that accompany the brand name of a commercial fertilizer shall be listed on the label in the following order: total nitrogen, available phosphate, and soluble potash. Other guaranteed nutrient values shall not be included with the grade numbers unless:



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- a. The guaranteed nutrient value follows the grade number;
  - b. The guaranteed nutrient value is immediately preceded with the name of the claimed nutrient to which it refers in the guaranteed analysis; and
  - c. The name printed on the label is as prominent as the numbers.
2. The materials from which claimed nutrients are derived shall be listed on the label.
  3. No grade is required for fertilizer materials that claim no primary plant nutrient (i.e., 0-0-0).
  4. All guaranteed nutrients, except phosphate and potash, shall be stated in terms of elements.
  5. The label shall include the brand name of a fertilizer. Misleading or confusing numerals shall not be used in the brand name on the label.
  6. Fertilizer material not defined in the Official Publication may be used as fertilizer material if a definition or other method of analysis and agronomic data for fertilizer material is approved by the Associate Director.

**B. Claims and misleading statements.**

1. Any nutrient claimed as a fertilizer material shall be accompanied by a minimum guarantee for the nutrient. An ingredient shall not be claimed as a nutrient unless a laboratory method of analysis approved by the Associate Director exists for the nutrient.
2. Scientific data supporting the claim of improved efficacy or increased productivity shall be made available for inspection to the Associate Director upon request.
3. If the name of a fertilizer material is used as part of a fertilizer brand name, such as blood, bone or fish, the guaranteed nutrients shall be derived from or supplied entirely by the named fertilizer material.
4. Fertilizer material subject to this Article and applicable laws shall not bear false or misleading statements.

**C. Deficiencies.**

1. The value of a nutrient deficiency in a fertilizer material shall take into account total value of all nutrients at the guaranteed level and the price of the fertilizer material at the time of sale.
2. A deficiency in an official sample of mixed fertilizer resulting from non-uniformity is not distinguishable from a deficiency due to actual plant nutrient shortage and is subject to official action.

**D. All investigational allowances shall be conducted as prescribed in the Official Publication.****E. Leased fertilizer material storage containers shall be clearly labeled with the following:**

1. Grade numbers;
2. Brand name, if applicable; and
3. The statement, "Leased by (Name and address of lessor) to (Name and address of lessee)."

**Historical Note**

Former rule IV; Former Section R3-3-24 renumbered and amended as Section R3-3-21, new Section R3-3-24 adopted effective January 12, 1978 (Supp. 78-1). Section R3-3-804 renumbered from R3-3-24 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2). New Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-805. Repealed****Historical Note**

Former rule V; Former Section R3-3-25 renumbered and amended as Section R3-3-22, new Section R3-3-25 adopted effective January 12, 1978 (Supp. 78-1). Section R3-3-805 renumbered from R3-3-25 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-806. Repealed****Historical Note**

Former rule VI; Former Section R3-3-26 repealed, new Section R3-3-26 adopted effective January 12, 1978 (Supp. 78-1). Section R3-3-806 renumbered from R3-3-26 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-807. Repealed****Historical Note**

Former rule VII; Former Section R3-3-27 repealed, new Section R3-3-27 adopted effective January 12, 1978 (Supp. 78-1). Section R3-3-807 renumbered from R3-3-27 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-808. Repealed****Historical Note**

Former rule VIII; Former Section R3-3-28 repealed effective January 12, 1978 (Supp. 78-1). New Section R3-3-28 adopted effective March 23, 1979 (Supp. 79-2). Section R3-3-808 renumbered from R3-3-28 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-809. Repealed****Historical Note**

Former rule IX; Former Section R3-3-29 repealed effective January 12, 1978 (Supp. 1). New Section R3-3-29 adopted effective March 23, 1979 (Supp. 79-2). Section R3-3-809 renumbered from R3-3-29 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-810. Repealed****Historical Note**

Former rule X; Former Section R3-3-30 repealed effective January 12, 1978 (Supp. 78-1). New Section R3-3-30 adopted effective March 23, 1979 (Supp. 79-2). Section R3-3-810 renumbered from R3-3-30 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-811. Repealed****Historical Note**

Former Administrative rule 1; Amended effective December 14, 1979 (Supp. 79-6). Section R3-3-811 renumbered from R3-3-31 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-812. Renumbered****Historical Note**

Adopted effective August 31, 1977 (Supp. 77-4). Former Section R3-3-32 renumbered as Section R3-3-23 effective January 12, 1978 (Supp. 78-1). Section R3-3-812

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renumbered from R3-3-32 (Supp. 91-4).

**ARTICLE 9. COMMERCIAL FEED****R3-3-901. Definitions**

In addition to the definitions in A.R.S. § 3-2601, the following terms apply to this Article:

*“Commercial feed” means all materials, except whole seeds unmixed or physically altered entire unmixed seeds, that are distributed for use as feed or for mixing in feed. Commercial feed includes raw agricultural commodities distributed for use as feed or for mixing in feed when the commodities are adulterated within the meaning of section 3-2611. A.R.S. § 3-2601(3)*

“Lot” means any distinct, describable, and measurable quantity that contains no more than 100 tons.

“Official Publication” means the publication “Official Publication” (2023), that contains the latest approved documents of the Association of American Feed Control Officials. This material is incorporated by reference, is on file with the Department and includes no later amendments or additions. A copy is available for inspection at the Department located at 1110 West Washington Street, Suite 450, Phoenix, AZ 85007, or online subscription may be purchased online at <https://www.aafco.org/Publications>.

“Pneumatic probe sampler” means a device for taking samples of grain and other particulate material from the bottom of a bin comprises two concentric tubes spaced sufficiently apart to permit passage of the material when entrained in a stream of air. The outer longer tube has a serrated edge to enable it to penetrate dense sections, while the inner, shorter tube is provided with helical vanes. Air, blown down the outer tube is caused to swirl in a vortex by the helical vanes, thereby entraining material lodged near the bottom of the outer tube. The air, together with entrained material, passes up the inner tube and is conducted to a cyclone separator to recover the sample. (U.S. Patent, US3580084A, May 25, 1971, Expired.)

**Historical Note**

Former rule I; Former Section R3-3-41 renumbered and amended as Section R3-3-42, new Section R3-3-41 adopted effective January 12, 1978 (Supp. 78-1). Amended effective April 13, 1978 (Supp. 78-2). Amended effective February 3, 1981 (Supp. 81-1). Section R3-3-901 renumbered from R3-3-41 (Supp. 91-4). Amended by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-902. Licensure; Fee; Ammoniation**

- A.** Any person applying for a commercial feed license to manufacture or distribute commercial feed shall provide the following information and a nonrefundable fee of \$10 for each year of the license:
1. A copy of the label of each commercial feed product intended for distribution within the state or not already filed by the applicant with the Department; and
  2. The following information on the license application provided by the Department:
    - a. The name, title, and signature of the applicant;
    - b. The distributor or manufacturer name, mailing address, telephone, and email address;

- c. The tax identification number or Social Security number of an individual applying;
- d. The date of the application;
- e. The physical location, telephone, and email address of the distributor or manufacturer, if different than subsection (A)(2)(b);
- f. The name, address, telephone, and email address of the distributor or manufacturer where inspection fees are paid, if different than subsection (A)(2)(b); and
- g. The license time-period option.

- B.** A commercial feed license is nontransferable, expires on June 30, and shall, at the option of the applicant, be valid for one or two years.
- C.** Ammoniation. Any person who ammoniates feed or feed material for distribution or sale shall obtain a commercial feed license and is responsible for all testing, labeling, or other requirements pertaining to commercial feed, unless the feed is ammoniated on the premises of the person using the ammoniated feed.

**Historical Note**

Former rule II; Former Section R3-3-42 renumbered and amended as Section R3-3-43, former Section R3-3-41 renumbered and amended as Section R3-3-42 effective January 12, 1978 (Supp. 78-1). Section R3-3-902 renumbered from R3-3-42 (Supp. 91-4). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-903. Tonnage Reports; Inspection Fee**

- A.** Quarterly tonnage report and inspection fee.
1. The inspection fee for all commercial feed sold or distributed in Arizona is 20¢ per ton. The tonnage shall be rounded to the nearest whole ton.
  2. Any applicant applying for and receiving a new license after March 15, June 15, September 15, or December 15 is not required to file a quarterly tonnage report for the quarter in which the license application is issued, but shall report the tonnage on the following quarterly tonnage report. Any person who distributed commercial feed without a license as required under A.R.S. § 3-2609 shall pay all past due inspection fees and late penalties before a license is issued.
  3. Any licensee not estimating annual tonnage shall file the following information on a quarterly statement provided by the Department no later than the last day of January, April, July, and October of each year for the preceding calendar quarter and pay the inspection fees and any penalties, if applicable:
    - a. If the inspection fee is being passed on to the purchaser:
      - i. The commercial feed license number issued according to this Article and name of the currently licensed company;
      - ii. The amount of commercial feed in whole tons and by type, indicating whether the commercial feed is bagged or bulk;
      - iii. The name, title, telephone number, and signature of the licensee or the licensee’s authorized representative; and
      - iv. The date of the report.

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- b. If the licensee pays a tonnage fee for the distribution of a commercial feed:
      - i. The amount of commercial feed in whole tons and by type, indicating whether the commercial feed is bagged or bulk;
      - ii. The name, title, telephone number, and signature of the licensee or the licensee's authorized representative; and
      - iii. The date of the report.
  - B. Estimated tonnage report. A licensee may estimate the annual commercial feed tonnage if it is 400 tons or less per year and the licensee does not pass the inspection fee responsibility to the purchaser.
    - 1. The licensee shall submit the estimated annual commercial feed tonnage report to the Department with the annual inspection fee no later than July 31 of each year. The tonnage report shall contain:
      - a. The estimated tonnage of commercial feed to be distributed;
      - b. The amount of commercial feed in whole tons and by type, indicating whether the commercial feed is bagged or bulk;
      - c. The name, title, telephone number, and signature of the licensee or the licensee's authorized representative; and
      - d. The date of the report.
    - 2. The licensee shall submit the inspection fee according to subsection (A)(1), which shall be for the amount declared in subsection (B)(1)(a), but not less than \$8 per year. The fee must be included with the annual tonnage report submitted to the Department no later than July 31 of each year. Adjustments for overestimates or underestimates for licensees with 400 tons or less of actual tonnage sales shall be made on the next year's estimating form. Adjustments of underestimates of licensees with actual tonnage sales more than 400 tons shall be made no later than July 31 of each year.
    - 3. The licensee shall verify the accuracy of the previous year's tonnage estimates to actual tonnage sales and submit the tonnage verification no later than July 31 of each year.
    - 4. Overestimation of tonnage.
      - a. The Department shall not refund any inspection fee based on an overestimation if the licensee does not re-license in the subsequent year;
      - b. If a licensee applies for a license in the subsequent year, the Department shall apply any overestimation to the subsequent year's tonnage fees.
- A. A person shall not sell, offer for sale, store, transport, receive, trade or barter, any milk or milk product for commercial feed unless the milk or milk product:
  - 1. Meets Grade A milk standards as specified in A.A.C. R3-2-802;
  - 2. Is produced as prescribed in A.A.C. R3-2-805; or
  - 3. Is decharacterized with food coloring approved under the Federal Food, Drug, and Cosmetic Act, according to 21 CFR §§ 73.1 et seq. (amended November 10, 2022, <https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-73>) and 21 CFR §§ 74.101 et seq. (amended April 5, 1993, <https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-74/subpart-A>). This material is incorporated by reference, is on file with the Department and does not include any later amendments or editions, and the decharacterization:
    - a. Does not affect nutritive value; and
    - b. Matches the color on the Color Requirement card. Any person decharacterizing milk and milk products may obtain a Color Requirement card from the Arizona Department of Agriculture, at 1010 W. Washington Street, Phoenix, Arizona 85007, or by requesting by mail at 1802 West Jackson Street, #78, Phoenix Arizona 85007.
- B. Labeling. All milk or milk product commercial feed labels shall be approved by the Associate Director before use.
  - 1. The principal display panel of a decharacterized milk or milk product commercial feed container shall prominently state "WARNING - NOT FOR HUMAN CONSUMPTION" in capital letters. The letters shall be at least 1/4 inch on containers of 8 oz. or less and at least 1/2 inch on all other containers.
  - 2. The container label shall also bear the statement "This product has not been pasteurized and may contain harmful bacteria" in letters at least 1/8 inch in height.
- C. Milk or milk products intended for commercial feed shall not be displayed, sold, or stored at premises where food is sold or prepared for human consumption, unless it meets Grade A standards or is decharacterized and properly labeled as required in subsection (B).

**Historical Note**

Former rule IV; Former Section R3-3-44 repealed, former Section R3-3-43 renumbered and amended as Section R3-3-44 effective January 12, 1978 (Supp. 78-1). Amended effective February 3, 1981 (Supp. 81-1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-904 renumbered from R3-3-44 (Supp. 91-4). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-905. Labeling; Precautionary Statements**

- A. Ingredient statement.
  - 1. Each ingredient or collective term for the grouping of ingredients not defined in the Official Publication shall be a common name.
  - 2. All labels for commercial feed and customer-formula feed containing cottonseed or a cottonseed product shall separately list the ingredients in the ingredient statement in addition to any collective term listed.
- B. Labeling and expression of guarantees.
  - 1. All labeling and expression of guarantees shall comply with the commercial feed-labeling guide, medicated com-

**Historical Note**  
Former rule III; Former Section R3-3-43 renumbered and amended as Section R3-3-44, former Section R3-3-42 renumbered and amended as Section R3-3-43 effective January 12, 1978 (Supp. 78-1). Amended effective February 3, 1981 (Supp. 81-1). Section R3-3-903 renumbered from R3-3-43 (Supp. 91-4). Section repealed; new Section adopted by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-904. Milk and Milk Products Decharacterized for Use as Commercial Feed**

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mercial feed labeling, and expression of guarantees requirements prescribed in the Official Publication.

2. All feed with an expired "use by" or "expiration" date shall be removed from consumer access, and are not permitted for sale.
3. The label shall include the brand or product name, and shall indicate the intended use of the feed. The label shall not contain any false or misleading statements.
4. Directions for use and precautionary statements.
  - a. All labeling of whole cottonseed, commercial feed, and customer-formula feed containing any additive (including drugs, special purpose additives, or non-nutritive additives) shall clearly state its safe and effective use. The directions shall not require special knowledge of the purpose and use of the feed.
  - b. Directions for use and precautionary statements shall be provided for feed containing non-protein nitrogen as specified in R3-3-906.
  - c. All whole cottonseed or commercial feed, and customer-formula feed delivered to the consumer shall be accompanied by an accurate label, invoice, weight ticket or other documentation approved by the Department. The documentation shall be left with the consumer and shall contain the following:
    - i. "This feed contains 20 or less ppb aflatoxin and may be fed to any animal;" or
    - ii. "WARNING: This feed contains more than 20 ppb but not more than 300 ppb aflatoxin and shall not be fed to lactating animals whose milk is intended for human consumption."
    - iii. "DANGER: This feed has not been tested for aflatoxin and shall not be used as a feed until tested and found compliant with all state laws."
  - d. A distributor of whole cottonseed or cottonseed product intended for further processing, planting seed, or for any other purpose approved by the Director, shall document in writing to the Department that:
    - i. The lot of whole cottonseed or cottonseed product will not be used as commercial feed until the lot is tested and compliant with all state laws; and
    - ii. The documentation prescribed in subsection (B)(3)(c) is not required.
  - e. The distributor shall maintain the documentation for one year.
  - f. The lot of whole cottonseed or cottonseed product shall be labeled as follows: "WARNING: This material has not been tested for aflatoxin and shall not be distributed for feed or fed to any animal until tested and brought into full compliance with all state laws."

**Historical Note**

Former rule V; Former Section R3-3-45 repealed, new Section R3-3-45 adopted effective January 12, 1978 (Supp. 78-1). Amended effective February 3, 1981 (Supp. 81-1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-905 renumbered from R3-3-45 (Supp. 91-4). Amended by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective

March 4, 2024 (Supp. 24-1).

**R3-3-906. Non-protein Nitrogen**

- A. Urea and other non-protein nitrogen products are acceptable ingredients in commercial feed for ruminant animals as a source of equivalent crude protein.
  1. If commercial feed contains more than 8.75% of equivalent crude protein from all forms of non-protein nitrogen or if the equivalent crude protein from all forms of non-protein nitrogen exceeds 1/3 of the total crude protein, the label shall include directions for the safe use of the feed and the following precautionary statement: "Caution: Use as Directed."
  2. The directions for use and the precautionary statement shall be printed and placed on the label so that an ordinary person under customary conditions of purchase and use can read and understand the directions.
- B. Non-protein nitrogen products are acceptable ingredients in commercial feeds distributed to non-ruminant animals as a source of nutrients other than equivalent crude protein. The maximum equivalent crude protein from non-protein nitrogen sources in non-ruminant rations shall not exceed 1.25% of the total daily ration.
- C. A medicated feed label shall contain feeding directions or precautionary statements, or both, with sufficient information to ensure that the feed is properly used.

**Historical Note**

Former rule VI; Former Section R3-3-46 repealed, new Section R3-3-46 adopted effective January 12, 1978 (Supp. 78-1). Amended effective January 29, 1979 (Supp. 79-1). Amended effective February 3, 1981 (Supp. 81-1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-906 renumbered from R3-3-46 (Supp. 91-4). Amended by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-907. Repealed****Historical Note**

Former rule VII; Former Section R3-3-47 repealed, former Section R3-3-54 renumbered as Section R3-3-47 effective January 12, 1978 (Supp. 78-1). Amended by adding subsection (F) effective July 20, 1984 (Supp. 84-4). Section R3-3-907 renumbered from R3-3-47 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-908. Repealed****Historical Note**

Former rule VIII; Former Section R3-3-48 repealed, new Section R3-3-48 adopted effective January 12, 1978 (Supp. 78-1). Amended for spelling correction, subsection (E), effective January 29, 1979 (Supp. 79-1). Amended by adding subsection (J) effective July 20, 1984 (Supp. 84-4). Section R3-3-908 renumbered from R3-3-48 (Supp. 91-4). Repealed effective April 11, 1994 (Supp. 94-2).

**R3-3-909. Repealed****Historical Note**

Former rule IX; Former Section R3-3-49 repealed, new Section R3-3-49 adopted effective Jan. 12, 1978 (Supp. 78-1). Amended by adding subsection (D) effective February 3, 1981 (Supp. 81-1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-909 renumbered from R3-3-49 (Supp. 91-4). Section repealed by final rulemak-

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ing at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-910. Drug and Feed Additives****A. Drug and feed additive approval.**

1. Before a label is approved by the Associate Director for commercial feed containing additives (including drugs, other special purpose additives, or non-nutritive additives), the distributor may be required to submit evidence demonstrating the safety and efficacy of the commercial feed when used according to the label directions if the material is not recognized as a commercial feed.
2. If a complaint has been filed with the Department, the distributor may be required to submit evidence demonstrating the safety and efficacy of the commercial feed when used according to the label directions.

**B. Evidence of safety and efficacy of a commercial feed may be:**

1. If the commercial feed containing additives conforms to the requirements of "Food Additives Permitted in Feed and Drinking" in the Official Publication; or
2. If the commercial feed is a substance generally recognized as safe and is defined in the Official Publication or listed as a "Substances Generally Recognized as Safe in Animal Feeds" in the Official Publication.

**Historical Note**

Former rule X; Former Section R3-3-50 repealed, new Section 3-3-50 adopted effective January 12, 1978 (Supp. 78- 1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-910 renumbered from R3-3-50 (Supp. 91-4). Amended by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-911. Repealed****Historical Note**

Former rule XI: Former Section R3-3-51 repealed, new Section R3-3-51 adopted effective January 12, 1978 (Supp. 78- 1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-911 renumbered from R3-3-51 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-912. Repealed****Historical Note**

Former rule XII: Former Section R3-3-52 repealed. New Section R3-3-52 adopted effective January 12, 1978 (Supp. 78-1). Section R3-3-912 renumbered from R3-3-52 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

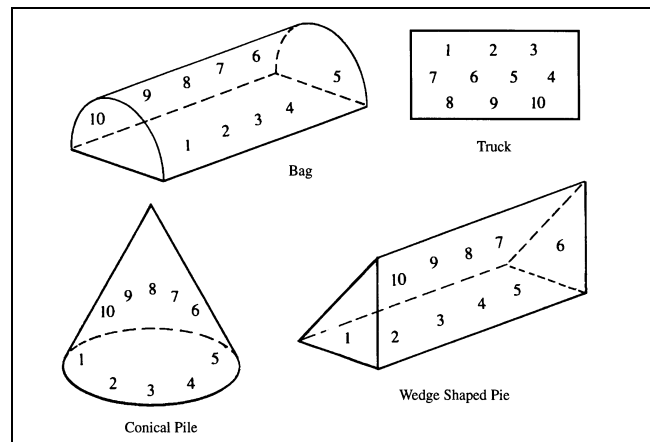
**R3-3-913. Sampling Methods**

- A. Sampling commercial feed.** The methods of sampling commercial feed shall comply with the procedures established in the Official Method, 965.16 Sampling of Animal Feed, in the "Official Methods of Analysis of AOAC International, 22nd Edition (2023)", which is incorporated by reference, on file with the Department, and does not include any later amendments or editions of the incorporated matter. Copies are available for inspection at the Department located at 1110 West Washington Street, Suite 450, Phoenix, AZ 85007, or may be purchased from AOAC International, 2275 Research Boulevard, Suite 300, Rockville, Maryland 20850, or by purchasing

a print copy or subscribing online at <https://members.aoac.org/bookstore/>.

**B. Sampling whole cottonseed.**

1. Sample size - A gross sample not less than 30 pounds shall be taken from a lot. The gross sample shall consist of not less than 10 probes evenly spaced or 10 stream sample passes taken following the procedure prescribed in subsection (B)(4)(b).
2. Sample container - The sample container shall consist of a clean cloth, burlap, or paper or plastic mesh bags. The sample shall be delivered to the laboratory within 48 hours (excluding weekends and holidays), stored in a dry, well-aerated location, and the results of the analysis reported by a certified laboratory within five working days from receipt of sample.
3. Sampling equipment. Sampling equipment includes:
  - a. Scale, graduated in one-half pound increments, and any of the following:
  - b. Corkscrew trier, approximately 50 inches in length and capable of taking at least a three-pound sample,
  - c. Pneumatic probe sampler,
  - d. Stream sampler: A container at least 8 inches x 5 inches x 5 1/2 inches attached to a pole that enables the sampler to pass the container through falling streams of cottonseed,
  - e. Automatic stream samplers or other sampling equipment if scientific data documenting its ability to obtain a representative sample is approved by the Associate Director,
  - f. Canister style shop vacuum system of no less than 1.5 hp capable of holding 12 gallons, modified to hold a 15 ft. length of vacuum hose attached to a 13 ft. length of 3/4 inch PVC pipe.
4. Sampling procedure.
  - a. If a corkscrew trier or pneumatic probe sampler is used, at least 10 evenly spaced probes shall be taken per lot. The probed samples shall be taken according to the following patterns:



The probes shall penetrate at least 50 inches, and at least two of the 10 probes per sample shall reach the bottom of the lot being sampled. The probe shall be inserted at an angle perpendicular to the face of the lot.

- b. If a canister style shop vacuum system is used, at least 15 evenly spaced probes shall be taken per lot. The sampling patterns specified in subsection

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(B)(4)(a) shall be modified to allow for the additional samples.

- c. Stream samples shall be taken while the cottonseed is being discharged, if there is a uniform discharge flow over a set period of time. The sample shall consist of at least 10 evenly timed and spaced passes through the discharge flow, resulting in the sample size specified in subsection (B)(1).
- d. The gross sample shall be weighed to the nearest 1/2 pound but shall not be reduced in size. If any gross sample does not meet the minimum 30 pound weight, that gross sample shall be discarded and the sampling procedure repeated from the beginning. If the canister style shop vacuum gross sample is not at least 10 pounds, the sample shall be discarded and the sampling procedure repeated from the beginning.
- e. The Associate Director shall approve any modified sampling procedure if scientific data is provided that documents that representative samples will be obtained through the modified sampling procedure.

**Historical Note**

Former Administrative Rule 1. Former Section R3-3-53 repealed effective January 12, 1978 (Supp. 78-1). New Section R3-3-53 adopted as an emergency effective October 10, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). Amended as an emergency effective October 11, 1978, pursuant to A. R. S. § 41-1003, valid for only 90 days (Supp. 78-5). New Section R3-3-53 adopted effective February 3, 1981 (Supp. 81-1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-913 renumbered from R3-3-53 (Supp. 91-4). Patterns omitted in Supp. 98-4 under subsection (C)(4)(a) have been corrected to reflect filed rules (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-914. Repealed****Historical Note**

Adopted effective August 31, 1977 (Supp. 77-4). Former Section R3-3-54 renumbered as Section R3-3-47 effective January 12, 1978 (Supp. 78-1). New Section R3-3-54 adopted as an emergency effective October 10, 1978, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 78-5). New Section R3-3-54 adopted effective February 3, 1981 (Supp. 81-1). Amended effective July 20, 1984 (Supp. 84-4). Section R3-3-914 renumbered from R3-3-54 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-915. Repealed****Historical Note**

Adopted effective December 14, 1979 (Supp. 79-6). Section R3-3-915 renumbered from R3-3-55 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective November 3, 1999 (Supp. 99-4).

**R3-3-916. Repealed****Historical Note**

Adopted effective July 20, 1994 (Supp. 84-4). Section R3-3-916 renumbered from R3-3-56 (Supp. 91-4). Section repealed by final rulemaking at 5 A.A.R. 4419, effective

tive November 3, 1999 (Supp. 99-4).

**ARTICLE 10. AGRICULTURAL SAFETY****R3-3-1001. Definitions**

In addition to the definitions set forth in A.R.S. § 3-3101 and as defined in the federal regulations under 40 CFR § 170.305 (as amended October 30, 2020, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-170/subpart-D/section-170.305>). This material is incorporated by reference, is on file with the Department and does not include any later amendments or editions), the following terms apply to this Article:

“Farm labor contractor” means any person who hires or contracts for the services of workers for any type of compensation, to perform activities related to the production of agricultural plants, but does not own or is not responsible for, the management or condition of an agricultural establishment.

“Flagger” means a person who indicates an aircraft spray swath width from the ground.

“Pest control advisor” means a crop advisor, as defined in the Worker Protection Standard, who assesses pest numbers or damage, pesticide distributions, or the status or requirements to sustain the agricultural plants. The term does not include a person who performs hand-labor tasks or handling activities.

“Restricted-entry interval” means the time after the completion of a pesticide application during which entry into a treated area is restricted as indicated by the pesticide product label.

“Restricted use pesticide” means a pesticide classified as such by the United States Environmental Protection Agency (A.R.S. § 3-361(8)).

“Worker Protection Standard” or “WPS” means the regulations as prescribed in 40 CFR §§ 170.1 et seq., excluding 40 CFR §§ 170.401(c)(4) and 170.501(c)(4) (as amended October 30, 2020, <https://www.ecfr.gov/current/title-40/chapter-I/subchapter-E/part-170>). This material is incorporated by reference, on file with the Department and does not include any later amendments or editions.

**Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section R3-3-1001 renumbered from R3-8-201 (Supp. 91-4).

Amended effective March 3, 1995 (Supp. 95-1).

Amended effective October 8, 1998 (Supp. 98-4).

Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1002. Repealed****Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section R3-3-1002 renumbered from R3-8-202 (Supp. 91-4). Section repealed, new Section adopted effective March 3, 1995 (Supp. 95-1). R3-3-1002 renumbered to R3-3-1003; new Section R3-3-1002 adopted effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Repealed by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1003. Worker and Handler Trainees; Records****A. Trainer requirements.**

1. A person applying for pesticide safety trainer certification shall:

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- a. Complete the Worker Protection Standard compliant pesticide safety training program administered by the Department; or
  - b. Hold a current PCA license or restricted use certification, issued by the Department for a PCA or certified applicator, as prescribed under R3-3-207 or R3-3-208.
2. An applicant shall submit a signed and dated affidavit to the Department verifying that each worker or handler will be trained according to the training requirements of the Worker Protection Standard. The affidavit shall include the applicant's name, address, email address, telephone and fax numbers, as applicable.
  3. Trainer certification is:
    - a. Nontransferable;
    - b. Valid for three years from the date issued under subsection (A)(1)(a), excluding the month in which the trainer was certified, and is renewable upon completion of the Worker Protection Standard compliant pesticide safety training program administered by the Department; or
    - c. Valid initially for one year from the date issued under subsection (A)(1)(b), excluding the month in which the trainer certification was issued; and
    - d. If the PCA license or restricted use certification remains current, is renewable for three years upon completion of the Worker Protection Standard compliant pesticide safety training administered by the Department.
  4. A trainer shall maintain the records required in subsection (B) for two years, excluding the month in which the verification card was issued.
  5. Upon request by the Department, the trainer shall make available worker and handler records prescribed in subsection (B) for inspection and copying by the Department.
  6. A trainer may issue a Worker Protection Standard training verification card to each handler or worker who successfully completes training, and shall maintain a record as required in subsection (B).
- B.** Training records shall include the following recorded in indelible ink:
1. Name and signature of the trained worker or handler;
  2. Training verification card number, if utilized;
  3. Issue and expiration date of the training verification card;
  4. A unique trainer-assigned identification number of the worker or handler;
  5. Name and signature of the trainer; and
  6. Address or location of where the training occurred, including city, county, and state.
- C.** A trainer shall permit the Assistant Director or designee to enter a place where worker safety training is being presented to observe and question trainers and attendees to determine compliance with the requirements of this Section.
- D.** The Department may suspend, revoke, or deny trainer certification if any of the following occur:
1. Failing to follow the worker and handler training requirements prescribed in 40 CFR §§ 170.401 and 170.501 of the WPS;
  2. Failing to maintain the training information prescribed in subsection (B);
  3. Failing to fulfill the requirements of the affidavit as prescribed in subsection (A)(2); or
  4. Having had a similar certification revoked, suspended, or denied in any jurisdiction within the last three years.

**Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section R3-3-1003 renumbered from R3-8-203 (Supp. 91-4). R3-3-1003 repealed; new Section R3-3-1003 renumbered from R3-3-1002 and amended effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1004. Notification Requirements for Farm Labor Contractors**

- A.** The owner or operator of an agricultural establishment shall provide the farm labor contractor who performs work on that agricultural establishment with:
1. The location of the agricultural establishment's central posting site; and
  2. The restrictions on entering the treated area as specified in 40 CFR § 170.120(d) of the WPS, if a treated area is within 1/4 mile of where workers will be working and the treated area is not posted as allowed or required in 40 CFR § 170.120(a), (b) and (c) of the WPS.
- B.** The farm labor contractor shall:
1. Post or provide the worker in writing, with the information in 40 CFR § 170.122 of the WPS, or shall post or provide the worker in writing, the specific location of the central posting site for each agricultural establishment on which the worker will be working;
  2. Provide the worker with restrictions on entering a treated area as specified in 40 CFR § 170.120(d) of the WPS if the treated area on the agricultural establishment where a worker will be working is within 1/4 mile of where the worker is working, and the treated area is not posted as allowed or required in 40 CFR § 170.120(a), (b) and (c) of the WPS.

**Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section R3-3-1004 renumbered from R3-8-204 (Supp. 91-4). Amended effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1005. Container Used For Mixing or Applying Pesticides**

- A.** All openings on containers used for applying pesticides shall be equipped with covers that prevent splashes and spills.
- B.** All containers shall:
1. Be translucent, or
  2. Have a means to indicate externally the internal liquid level in the container, or
  3. Have a filler hose nozzle that automatically stops the filling operation before the liquid pesticide mixture spills over the top of the container.
- C.** Any employer who mixes or applies any liquid pesticide mixture in a container with a capacity of more than 49 gallons shall have a handler present whenever pesticides are mixed or containers are filled to ensure that the liquid pesticide mixture does not spill over the top of the container.
- D.** Each handler, while mixing pesticides, shall protect the water supply from back-siphoning pesticide mixtures.

**Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section

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R3-3-1005 renumbered from R3-8-205 (Supp. 91-4).  
Section repealed; new Section adopted effective October 8, 1998 (Supp. 98-4).

**R3-3-1006. Agricultural Emergency**

- A.** Any grower, a group of growers, or designee may request the Assistant Director for an agricultural emergency.
- B.** Possibility of agricultural emergency.
- If during business hours information is obtained showing that a declaration of an agricultural emergency is necessary, the requesting party shall notify the Department immediately and provide the following information:
    - The cause of the emergency,
    - The area where the emergency may occur,
    - An explanation of why early entry is necessary,
    - Why other methods cannot be used to avoid the early entry, and
    - The justification that substantial economic loss will occur.
  - The Assistant Director shall render a decision to the requesting party on whether an agricultural emergency exists, if the grower or requesting party submits written evidence that includes the information in subsection (B)(1), within four hours of receiving the information.
  - If a grower or requesting party does not submit the written documentation in subsection (B)(1) or if the Assistant Director questions the validity or adequacy of the written evidence of the emergency, the Assistant Director shall investigate a grower's entry into the restricted-entry interval area and advise the requesting party of the reasons for the denial of the agricultural emergency.
  - If the information in subsection (B)(1) is given orally, the requesting party shall notify the Department immediately and provide the Assistant Director with written evidence of the emergency within five days. The Assistant Director shall, within 10 business days of receipt of the written evidence of the emergency or completion of the investigation, issue a letter to the requesting party confirming or denying the request for an agricultural emergency.
- C.** Occurrence of agricultural emergency.
- If information is obtained after business hours, or during a weekend or holiday, showing that a declaration of agricultural emergency is necessary, the requesting party shall inform the Department, orally, the next business day following the emergency and provide the following information, in writing, within 72 hours of the emergency or notification:
    - The cause of the emergency,
    - The area where the emergency occurred,
    - A brief explanation of why early entry was necessary,
    - Why other methods could not be used to avoid the early entry, and
    - The justification that substantial economic loss would have occurred.
  - If a grower or requesting party does not submit the written evidence of the emergency in subsection (B)(1) or if the Assistant Director questions whether the written evidence of emergency could have occurred before the emergency, or the validity or adequacy of the written evidence of the emergency, the Assistant Director shall investigate a grower's entry into the restricted-entry interval area and advise the requesting party of the reasons for the denial.

- The Assistant Director shall within 10 business days of receipt of the evidence of emergency or completion of the investigation issue a letter to the requesting party confirming or denying the request for the agricultural emergency.

**Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section R3-3-1006 renumbered from R3-8-206 (Supp. 91-4). Section repealed; new Section adopted effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1007. Violations and Civil Penalties**

- A.** Serious violations. The base penalty for any serious violation is \$500 and no adjustment shall be made for mitigating circumstances. The penalty for a violation in which a person is killed or permanently disabled shall be the maximum allowed in A.R.S. §§ 3-3113 and 3-3114.
- B.** Nonserious violations. The Assistant Director shall calculate the base penalty for a nonserious violation and determine the civil penalty amount based on the factors prescribed in A.R.S. § 3-3113(I). If there are contributing or mitigating circumstances, the points may be adjusted, provided the adjustment is documented.

**VIOLATION GRAVITY FACTOR**

(1 - Lowest; 4 - highest)

VIOLATION	GRAVITY
Central Posting	1 - 2
Training	1 - 4
Decontamination	1 - 4
Personal Protective Equipment	1 - 4
Pesticide Application and Notice	1 - 4
Pesticide Application Restrictions	2 - 4
Other Requirements	1 - 4

- C.** Size-of-business. The Assistant Director shall use:
- The maximum number of employees at any one time during the previous 12 months from the date of notice, including only the Arizona branch offices to determine the size business category; or
  - A site-specific employee count, if the violation does not endanger employees at other locations of the business; or
  - The number of persons trained by a trainer during the previous 12 months that violate the training provisions of R3-3-1003.

**SIZE OF BUSINESS**

Size Category	Number of Employees or (Number of People Trained)
I	1 - 10
II	11 - 75
III	76 - 150
IV	More than 150

- D.** Base penalty. The Assistant Director shall calculate the base penalty for the alleged violation by using the violation gravity factor established in subsection (B) and applying the size-of-business category established in subsection (C).

**BASE PENALTY**

Gravity Factor	Size Category			
	I	II	III	IV
1	\$250	\$300	\$350	\$400
2	\$300	\$350	\$400	\$450
3	\$350	\$400	\$450	\$500
4	\$500	\$500	\$500	\$500



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E. Combined or group violations. The Assistant Director may combine or group violations.

- Violations may be combined and assessed one penalty if the violation does not cause any immediate danger to public health or safety or damage to property. Example: Eight workers on a harvest crew have received no training and there is no evidence of exposure. This situation may result in only one training penalty being assessed against the employer.
- Violations may be grouped if they have a common element and it is apparent which violation has the highest gravity. The penalty for a grouped violation is assessed on the violation with the highest gravity. The penalty for a grouped violation is assessed according to the appropriate law or rule with the highest gravity. Example: Two crews from the same company are engaged in an improper handling activity and one crew is using a pesticide with a "danger" signal word, (skull and cross bones) while the other crew is using a pesticide with a "warning" signal word. This situation may result in the employer being assessed one penalty based on the penalty for the "danger" (skull and cross bones) violation.

**Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section R3-3-1007 renumbered from R3-8-207 (Supp. 91-4). Section repealed; new Section adopted effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1008. Penalty Adjustments**

A. The Assistant Director shall assign an appropriate number of points for each of the following five factors to increase the base penalty for a serious violation, or increase or decrease the base penalty for a nonserious violation.

- If the total adjustment points on a nonserious violation is less than 9, the base penalty is reduced; if it is more than 9, the base penalty is increased.
- If the total adjustment points on a serious violation is 3 or less, the base penalty shall be imposed; if it is more than 3, the base penalty is increased.
- If a violation is a repeated violation, as prescribed in R3-3-1011 for compliance history, a base penalty adjustment factor shall not be used to decrease the penalty.

**BASE ADJUSTMENT FACTORS****Pesticide Labeling**

Signal word "Danger" with skull and cross-bones	5
Signal word "Danger"	4
Signal word "Warning"	3
Signal word "Caution"	2
Indirect relation to the violation	1

**Harm to Human Health**

Actual Injuries or temporary reversible illness resulting in hospitalization or a variable but limited period of disability. (hospital care greater than 8 hours)	9
Actual Injuries or temporary reversible illness resulting in doctor care (doctor care required, less than 8 hours)	6
Minor supportive care only	2 - 4
Consequence potential	1 - 2
No relationship found	0

**Compliance History**

One or more violations in the previous 12 months	4
One or more violations in the previous 24 months	3
One or more violations in the previous 36 months	1
No violation history	0
<b>Culpability</b>	
Knowing or should have known	4
Negligence	2
Neither	0
<b>Good Faith</b>	0 - (-2)
Violation corrected within 14 days	-1
Violation corrected within 7 days	-2

B. The Assistant Director may reduce the base penalty for a non-serious violation, as determined in R3-3-1007(C), by as much as 80% depending upon the number of employees or trained persons, good faith, and history of previous violations.

**FINAL PENALTY CALCULATION**

	<b>Non-serious Violation</b>	<b>Serious Violation</b>
Number of Points	Penalty Adjustment	Penalty Adjustment
3 or below	Base -80%	Base Penalty
4	Base -65%	Base +10%
5	Base -50%	Base +20%
6	Base -35%	Base +30%
7	Base -20%	Base +40%
8	Base -5%	Base +50%
9	Base Penalty	Base +60%
10	Base +20%	Base +70%
11	Base +35%	Base +80%
12	Base +50%	Base +90%
13	Base +65%	Base +100%
14	Base +80%	Base +100%
15 or more	Base +100%	Base +100%

Example: A business employs 26 people in Town A and 14 people in Town B. In addition, 35 seasonal people are employed during the harvest. The total annual employee positions equal 75. The following violations are found during an inspection: (1) No training for 35 seasonal workers on the harvest crew; (2) No available decontamination supplies; (3) No safety poster at the central posting location; (4) No emergency telephone number posted, and no medical facility location posted at the central posting location; (5) No posted pesticide application information at the central posting location.

Step 1. Use the Violation Gravity Factor table to determine the gravity of the violation.

- |                                 |   |
|---------------------------------|---|
| (1) Training, 1-4 points        | 2 points, all 35 workers are combined;  |
| (2) Decontamination, 1-4 points | 3 points, no supplies were available and it has been 25 days since the most recent application; |

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(3) - (5) Central Posting, 1-2 points 1 point since the violations concerns the same factor, they are combined. (There is evidence that the old poster blew away and the pesticide application information is kept available in the secretary's desk, but it is not 'readily' available.)

Step 2. Use the Size of Business table to determine the size category. 35 employees falls into the size category II.

Step 3. Use the *Base Penalty* table to determine the base penalty. Use column II based on the Size of Business determination from Step 2.

Violation 1	Gravity factor of 2	Equals a base penalty of \$350;
Violation 2	Gravity factor of 3	Equals a base penalty of \$400;
Violation 3, 4, and 5	Gravity factor of 1	Equals a base penalty of \$300

Step 4. Using the *Base Adjustment Factors* table to calculate the adjustments, if any. In this case, the base adjustments are uniform in all categories except #4, culpability.

Pesticide	It was a indirect relationship because of the timing of the application and when the workers were in the treated area.	1 point.
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Harm to Human Health	There was no harm to health and the pesticide had not been applied recently.	1 point.
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Compliance History	This farm has no previous violation history.	0 points.
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Culpability	The supervisor attended a "train-the-trainer" course two years ago and should have been aware of the requirements of the worker protection standard. Therefore, for the first two violations the supervisor should have known about the requirements. For the last three violations, the central posting sight was not checked frequently enough to ensure compliance.	For violations 1 and 2, 4 points for knowing or should have known; For violations 3, 4, and 5, 2 points for negligence.
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Good Faith	The inspector came back five days later and the workers were trained the day of the first inspection, the poster was posted and everything was in compliance.	Since the employer corrected the violations quickly. -1 point.
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Step 5. Add the points for each violation from Step 4.

Violation 1	1 + 1 + 0 + = 5 points 4 + -1
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Violation 2	1 + 1 + 0 + = 5 points 4 + -1
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Violations 3, 4, and 5	1 + 1 + 0 + = 3 points 2 + -1
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Step 6. Using the Final Penalty Calculation table to determine the appropriate violation penalty adjustment that corresponds with the base adjustment factor point total. Use the definitions for nonserious or serious violations to determine the appropriate violation penalty adjustment column. In this case, use the nonserious penalty adjustment column.

Violation 1	5 points	Base - \$350 - 50% = \$175 = \$175
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Violation 2	5 points	Base - \$400 - 50% = \$200 = \$200
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Violation 3, 4, and 5	3 points	Base - \$300 - 80% = \$240 = \$60
Adjusted Penalty Total = \$435		

**Historical Note**

Adopted effective July 13, 1989 (Supp. 89-3). Section R3-3-1008 renumbered from R3-8-208 (Supp. 91-4). Section repealed; new Section adopted effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1009. Failure to Abate**

- A. The Director shall include in a citation for an alleged violation of this Article a reasonable time to abate the violation.
- B. When a cited person timely files a request for hearing to contest a violation, the abatement period does not begin to run until the entry of a final order as long as the request for hearing was initiated in good faith and not solely for delay or avoidance of penalties. If a person contests only the amount of the proposed penalty, the person shall correct the violation within the originally prescribed abatement period.
- C. If the Director has reason to believe the cited person has failed to correct the violation within the abatement period, the Director shall notify the person by mail of the failure, the proposed penalty, and the right to request a hearing.
- D. On a showing by a cited person of a good faith effort to comply with the abatement requirements of a citation and that the abatement has not been completed because of factors beyond the person's reasonable control, the Department shall issue an order affirming or modifying the abatement requirements in the citation after an opportunity for a hearing.

**Historical Note**

Adopted effective October 8, 1998 (Supp. 98-4). Section heading corrected at request of the Department, Office File No. M11-60, filed February 23, 2011 (Supp. 09-4). Section R3-3-1008 renumbered from R3-8-208 (Supp. 91-4). Section repealed; new Section adopted effective October 8, 1998 (Supp. 98-4). Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1010. Calculation of Additional Penalties For Unabated Violations**

- A. If the Director has reason to believe the cited person has failed to correct a serious or nonserious violation within the abatement period, the Director shall assess additional civil penalties on the cited person as follows:

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1. The Director shall use R3-3-1007 and R3-3-1008 to calculate an additional daily penalty for each unabated violation.
  2. The additional daily penalty shall neither be less than the original penalty for the cited violation or exceed \$1,000 per day per violation.
  3. The additional daily penalty shall be multiplied by the number of calendar days the violation has continued unabated beyond the abatement period.
- B.** Notwithstanding subsection (A), the Director may reduce or eliminate the additional penalty based on:
1. The extent that the violation has been abated,
  2. The cited person's good faith effort in correcting the violation, and
  3. Whether the abatement has not been completed because of factors beyond the cited person's reasonable control.

**Historical Note**

Adopted effective October 8, 1998 (Supp. 98-4).  
 Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1011. Repeated or Willful Violations**

- A.** The penalty for a repeated violation shall be calculated as follows:
1. The penalty for a repeated nonserious violation shall be doubled for the first repeated violation and tripled if the violation has been cited twice before.
  2. The penalty for a repeated serious violation shall be multiplied five times for the first repeated violation and seven times if the violation has been cited twice before.
  3. The penalty for a repeated serious violation in which someone is disabled or killed shall be multiplied 10 times for each repeated violation.
  4. A repeated violation having no initial penalty shall be assessed for the first repeated violation as determined by this Article.
  5. The penalty may be multiplied by 10, not to exceed the maximum penalty, if it is justified through appropriate documentation.
- B.** The Assistant Director may adjust the base penalty found under R3-3-1007(D) by a multiplier up to 10 for any willful violation.
- C.** The Assistant Director shall not use base adjustment factors in R3-3-1008 to reduce the penalty for any serious or nonserious willfully repeated violation.
- D.** Repeated violations are based on prior violations occurring within the previous three years.
- E.** The penalty for a repeated or willful violation shall not exceed \$10,000.

**Historical Note**

Adopted effective October 8, 1998 (Supp. 98-4).  
 Amended by final rulemaking at 30 A.A.R. 89 (January 19, 2024), effective March 4, 2024 (Supp. 24-1).

**R3-3-1012. Citation; Posting**

An employer shall post a citation prescribed at A.R.S. § 3-3110(C) for three days or until the violation is abated, whichever time period is longer.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 276, effective March 6, 2004 (Supp. 04-1).

**ARTICLE 11. ARIZONA NATIVE PLANTS****R3-3-1101. Definitions**

In addition to the definitions in A.R.S. § 3-901, the following terms apply to this Article:

"Authorized representative" means a project manager, project engineer, sub-contractor, or similar that is identified by the landowner on a Notice of Intent to Clear form, or amended form, as a person that has authorization from the landowner to salvage protected native plants on property owned or managed by the landowner.

"Certificate of inspection for interstate shipments" means a certificate to transport protected native plants out of the state.

"Collection" means a collection of one or more highly safeguarded native plants that are preserved, catalogued, and managed for the purpose of preserving that species of an Arizona native plant.

"Conservation" means prevention of exploitation, damage, destruction, or neglect of native plants while helping to ensure continued public use.

"Cord" means a specific type string or small rope issued by the Department for attaching tags and seals to protected native plants.

"Cord of wood" means a measurement of firewood equal to 128 cubic feet.

"Destroy" means to cause the death or irreparable damage of any protected native plant.

"Harvest restricted native plant permit" means a permit required to remove the by-products, fibers, or wood from a native plant listed in Appendix A, subsection (D).

"Highly safeguarded native plant" (A.R.S. § 3-903(B)(1)) means a group of plants that are threatened for survival or are in danger of extinction. Including the native plants listed in Appendix A, subsection (A) and those listed in the Endangered Species Act. The plants in this category may only be salvaged with the use of scientific or non-commercial salvage permits, tags and seals.

"Jurisdiction" means the applicability of the Arizona native plant laws of A.R.S. §§ 3-901 through 3-934 that apply within the boundaries of the state, except on designated Indian lands and federal lands. Federal land managers are to be cognizant of E.O. 13132 (64 FR 43255, August 10, 1999) when considering native plants on federal land. State law governs in areas within local political subdivision boundaries but does not prohibit more stringent native plant regulations or ordinances adopted by the political subdivision. Where the two are in conflict, state laws and rules supersede, or if complimentary, the most stringent of the two laws and rules shall apply.

"Original growing site" means a place where a plant is growing wild and is rooted to the ground or any property owned by the same landowner where a protected native plant is relocated or transplanted without an original transportation permit.

"Protected native plant" means any living plant or plant part listed in Appendix A and growing wild in Arizona.

"Protected native plant tag" means a tag issued by the Department to identify the lawful removal of a protected native plant, other than a saguaro cactus, from its original growing site.

"Saguaro tag" means a tag issued by the Department to identify a saguaro cactus being lawfully moved.

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“Salvage” means to remove a protected native plant that would otherwise be destroyed in the land development process or other actions that would threaten the survival of the species of plant.

“Salvage assessed native plant” means plants categorized in Appendix A, subsection (C), as described by A.R.S. § 3-903(B)(3), that are to be afforded the exclusive protections, involving the use of salvage tags and annual salvage permits, provided in this Article. The category contains native plants that are not subject to theft or vandalism, but nevertheless have salvage value.

“Salvage assessed native plant permit” means a permit required to remove a native plant listed in Appendix A, subsection (C).

“Salvage restricted native plant” means plants categorized in Appendix A, subsection (B), as described by A.R.S. § 3-903(B)(2), that are to be afforded the exclusive protections involving the use of salvage permits, tags, and seals provided in this Article. This category includes native plants that may be salvaged and transplanted but are nevertheless subject to high potential for damage by theft or vandalism.

“Salvage restricted native plant permit” means a permit required to remove a native plant listed in Appendix A, subsection (B).

“Securely tie” means to fasten in a tight and secure manner to prevent the removal of tags, seals, or cord for reuse.

“Small Native Plant” means any protected plant eight inches in height or less.

“State agency” has the same meaning as in A.R.S. § 3-901(3) it contains “any agency or political subdivision of the state.”

**Historical Note**

New Section recodified from R3-4-601 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1102. Protected Native Plant Destruction by a Private Landowner****A. Notice of intent.**

1. Before a protected native plant is destroyed, the private landowner shall provide notification of intended destruction, which shall include the following information to the Department on a form obtained from the Department:
  - a. Name, address, email address, and telephone number of the landowner;
  - b. Name, address, email address, and telephone number of the landowner’s agent, if applicable;
  - c. Valid documentation indicating land ownership, including but not limited to a parcel identification number, tax assessment, or deed;
  - d. Legal description, map, address, or other description of the area, including the number of acres to be cleared, in which the protected native plants subject to the destruction are located;
  - e. Earliest date of plant destruction; and
  - f. Landowner’s intent for the disposal or salvage of protected native plants on the land.
2. A landowner intending to destroy protected native plants on an area of less than one acre may submit the informa-

tion required in subsection (A)(1) to the Department verbally.

- B. A landowner shall not destroy a protected native plant until:
  1. The landowner receives a written confirmation from the Department that the notice has been received, and
  2. Notice is given to the Department within the following minimum time periods, starting from the time the notice was given to the Department:
    - a. Twenty days before the plants are destroyed over an area of less than one acre.
    - b. Thirty days before the plants are destroyed over an area of one acre or more but less than 40 acres.
    - c. Sixty days before the plants are destroyed over an area of 40 acres or more.
- C. The Department shall compile a list of names and contact information of salvagers or persons interested in native plant salvage. The persons on the list shall receive notifications of potential salvage opportunities. To be placed on the list, the salvager or other interested person shall submit to the Department’s licensing section the salvager or interested person’s name, email address, mailing address, telephone number, and payment of an annual \$35 nonrefundable fee. The Department shall send to all listed salvagers and interested persons an electronic copy of notices of intent (“NOI”), including those that indicate they are not allowing salvage. The electronic copy of the NOIs shall be sent out daily the next business day after the NOIs are received.
- D. A notice of intent is not required for the destruction of native plants on individually owned residential property of ten acres or less where initial building construction has already occurred.

**Historical Note**

New Section recodified from R3-4-602 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1103. Disposal and Salvage of Protected Native Plants by a State Agency**

- A. A state agency intending to remove or destroy protected native plants, over an area of state land exceeding one-quarter acre, the state agency shall notify the Department in writing at least sixty days before the plants are removed or destroyed with the following information on a form obtained from the Department:
  1. Legal description, map, address, or other description of the area, including the number of acres to be cleared, in which the protected native plants subject to the destruction are located;
  2. A description of the number and type of plants to be removed or destroyed;
  3. Earliest date of plant destruction; and
  4. The state agency’s intent for the disposal or salvage of protected native plants on the land.
- B. A state agency intending to remove or destroy protected native plants shall propose a method of disposal or transfer from the following list:
  1. Relocated or transported to a different location on the same property or to another property owned by the state, without obtaining a permit;
  2. Donated to another state agency or political subdivision, by obtaining a non-commercial salvage permit; or

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3. Donated to nonprofit organizations as provided in A.R.S. § 3-916;
  4. Salvaged or harvested by a member of the general public or a commercial dealer, if the person holds a salvage permit issued pursuant to R3-3-1104.
  5. Sold at a public auction, with appropriate cord sealing tags purchased and utilized by the buyer pursuant to R3-3-1106(B) and R3-3-1107;
  6. In situations where subsections (1) through (5) are not possible, the destruction or clearing of the land may begin 60 days after the notice, as prescribed in subsection (A), has been provided to the Department.
- C.** Any action by a state agency must occur within one year of the date disclosed in the notice.
- D.** A state agency filing a notice, as prescribed in subsection (A), to remove protected native plants are exempt from fees established for salvaged plants.
- E.** Notwithstanding subsection (B)(1) through (5), if the plants are highly safeguarded native plants, they shall first be made available to the holder of a valid scientific permit or a noncommercial salvage permit, by obtaining a current list of scientific permit and noncommercial salvage permit holders from the Department.
- F.** Pre-notification of intent shall not be required in an emergency, where imminent threat to the safety of a person or animal, or damage to personal or state property exists if protected native plants are not removed or destroyed by the state agency, provided the notice of intent is filed in conjunction with the removal or destruction of the native plant.
- i. Parcel identification number for the permitted site or other documents proving land ownership.
  2. Salvage restricted native plant permits and plant tags are valid for the calendar year in which they are issued. The tags expire at the end of the calendar year unless the permit is renewed.
  3. Exemptions. The following are exemptions for the requirements of this subsection.
    - a. Plants propagated or cultivated by human beings; or
    - b. Native plants collected or salvaged by a homeowners' association or any other community based organization if the plants are relocated in the community.
- C.** Salvage assessed native plant permits.
1. An applicant for a salvage assessed native plant permit shall submit the following information to the Department on a form obtained from the Department, as applicable, along with any applicable fees outlined in R3-3-1106:
    - a. Name, business name, address, email address, telephone number, and signature of the applicant;
    - b. Names of the salvage assessed plants to be collected.
  2. Salvage assessed native plant permits and plant tags are valid for the calendar year in which they are issued. The tags expire at the end of the calendar year unless the permit is renewed.
  3. Exemptions. The following are exemptions for the requirements of this subsection.
    - a. Plants propagated or cultivated by human beings; or
    - b. Native plants collected or salvaged by a homeowners' association or any other community based organization if the plants are relocated in the community.

**Historical Note**

New Section recodified from R3-4-603 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1104. Protected Native Plant Permits**

- A.** A person shall not collect, transport, possess, sell, offer for sale, dispose, or salvage protected native plants unless that person is 18 years of age or older and possesses an appropriate permit.
- B.** Salvage restricted native plant permits.
1. An applicant for a salvage restricted native plant permit shall submit the following information to the Department on a form obtained from the Department, as applicable, along with any applicable fees outlined in R3-3-1106:
    - a. Name, business name, address, email address, telephone number, and signature of the applicant;
    - b. Name and number of plants to be removed;
    - c. Purpose of the plant removal;
    - d. Whether the applicant has a conviction for a violation of a state or federal statute regarding the protection of native plants within the previous five years;
    - e. Name, address, email address, telephone number, and signature of the landowner where the plants will be removed;
    - f. Location of the permitted site and size of acreage;
    - g. Destination address where the plants will be transplanted or temporarily held before being sold, gifted, or otherwise distributed to a permanent location;
    - h. Legal and physical description of the location of the original growing site; and
  2. Permits and unused receipts issued under this subsection are non-transferable and must be in the possession of the permit holder during harvesting and transport.
  3. Receipts for harvest restricted materials that are sold must be transferred to a purchaser as proof of ownership.
  4. Exemptions. The following are exemptions for the requirements of this subsection.
    - a. Material harvested from lands managed by the federal government provided a person is in possession of a valid permit issued by the federal land management agency.
    - b. Material harvested with written permission from a private land owner or tenant, from other than state-owned land or other public land, and:
      - i. Is one-hundred pounds or less for Yucca or Nolina fiber; or
- D.** Harvest restricted native plant permit and receipts.
1. Any person harvesting the wood, fiber, or by-product of a plant listed in Appendix A, subsection (D), of more than one-hundred pounds, or more than two cords of wood, shall apply for a harvest restricted permit and receipts by submitting the following information to the Department, on a form obtained from the Department, along with any applicable fees outlined in R3-3-1106(C)(2):
    - a. Name, address, email address and telephone number of the applicant applying for the permit;
    - b. The legal land description where the harvesting will take place;
    - c. For wood products, the number of cords to be collected;
    - d. For Nolina or Yucca fiber, the numbers of pounds to be collected;
    - e. Name, address, email address, telephone number, and signature of land owner or owners.
  2. Permits and unused receipts issued under this subsection are non-transferable and must be in the possession of the permit holder during harvesting and transport.
  3. Receipts for harvest restricted materials that are sold must be transferred to a purchaser as proof of ownership.
  4. Exemptions. The following are exemptions for the requirements of this subsection.
    - a. Material harvested from lands managed by the federal government provided a person is in possession of a valid permit issued by the federal land management agency.
    - b. Material harvested with written permission from a private land owner or tenant, from other than state-owned land or other public land, and:
      - i. Is one-hundred pounds or less for Yucca or Nolina fiber; or

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- ii. Is two cords or less of wood.
  - c. The use of dead wood for campfires or cooking.
  - d. Dead harvest restricted plants, collected by a land owner or tenant.
- E. Scientific Permit. In addition to the requirements of R3-3-1105(A), the following application requirements apply:
  1. An applicant shall submit the following information to the Department on a form obtained from the Department, along with any applicable fees outlined in R3-3-1106:
    - a. Name, address, email address and telephone number of the company or research facility applying for the permit;
    - b. Name, title and experience of the person conducting the research project;
    - c. Purpose and intent of the research project;
    - d. Controls to be used;
    - e. Variables to be considered;
    - f. Time-frame for the project;
    - g. Anticipated results and plans for publication;
    - h. Reports and recordkeeping that will be used to monitor the project;
    - i. Project funding source;
    - j. Funding of the company or research facility;
    - k. Written authorization from the landowner for collection of the plants;
    - l. Date of the application; and
    - m. Signed affirmation by the applicant that the plants collected will not be sold or used for personal interests.
  2. A scientific permit is valid for the calendar year in which it is issued.
  3. A scientific permit holder may amend their permit anytime by submitting the updated information to the Department.
  4. An applicant may also submit proof of a current scientific permit issued by a federal agency or state political subdivision and any additional information to the requirements of R3-3-1104(E)(1) not provided in the existing scientific permit.
- F. Non-commercial Salvage Permit. In addition to the requirements of R3-3-1105(B), the following application requirements apply:
  1. An applicant shall submit the following information to the Department, on a form obtained from the Department, along with any applicable fees outlined in R3-3-1106:
    - a. Name, address, email address and telephone number of the applicant applying for the permit;
    - b. Proposed relocation site for the plants;
    - c. Written authorization from the landowner for collection of the plants;
    - d. The number, species, and description of the plants being salvaged;
    - e. Date of the application; and
    - f. Signed affirmation by the applicant that the plants collected will not be sold or used for personal interests.
  2. A non-commercial salvage permit is valid only for the transportation and the transplantation of the identified native plants indicated on the permit application. A non-commercial salvage permit holder may amend their permit anytime by submitting the updated information to the Department with written authorization from the landowner.
  3. A non-commercial salvage permit is valid for the calendar year in which they are issued. The tags expire at the end of the calendar year unless the permit is renewed.
  4. Plants propagated or cultivated by human beings are exempt from these requirements.
- G. Movement Permit. In addition to the saguaro tag obtained pursuant to R3-3-1106(C)(1)(a), any person moving or salvaging a saguaro cactus over four feet tall from a location other than its original growing location in Arizona and transplanting it to another location shall apply to the Department for a Movement Permit. The landowner from where the saguaro cactus is being moved shall provide the following information on the permit application, unless the applicant maintains a record of the original permit or verifies the Department has a record of a previous legal movement of the cactus by the applicant. Saguaro cactus that are propagated or cultivated by humans are exempt from this requirement.
  1. The name, mailing address, email address, telephone number, and signature of the landowner;
  2. The address or parcel identification number where the saguaro cactus is located;
  3. The name, mailing address, email address, and telephone number of the receiver;
  4. The name, mailing address, and telephone number of the carrier;
  5. The number, species, and description of the plant being removed;
  6. The parcel identification number of the property where the saguaro cactus is being moved; and
  7. The date of the application.
- H. Movement of protected native plants obtained outside Arizona.
  1. Any person moving a protected native plant obtained outside Arizona and transporting and planting it within the state shall declare the protected native plant at the nearest Department office location during normal business hours, office locations can be found by calling 602-542-3578 or by visiting the Department's website at <https://agriculture.az.gov/plantsproduce/native-plants>.
  2. To ensure compliance with A.A.C. R3-4-239, shipments originating from an area under quarantine for imported fire ants, the Department shall place the protected native plant under quarantine and direct the shipment to a certified quarantine holding area for inspection.
  3. After the plants have been declared, permit and seal fees have been paid, the permitting office shall issue a Movement Permit and appropriate number of seals.

**Historical Note**

New Section recodified from R3-4-604 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1105. Scientific Permits; Noncommercial Salvage Permits****A. Scientific Permit**

1. A person shall not collect, destroy, harm, or remove any highly safeguarded or other protected native plants for a research project unless that person holds a scientific permit issued pursuant to R3-3-1104(E). The removal and movement of the native plants shall be accomplished by a

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person experienced in native plant removal and transplantation:

- a. Whenever possible, the permittee shall take specimens in such a way as to not reduce the population by retrieving minimal tissue, leaving the roots intact for perennial plants or utilizing other scientifically acceptable methods for the protection of the environment and remaining native plants.
  - b. If not already required by another agency or institution, and whenever possible, if the permittee takes multiple specimens, the permittee shall deposit at least one specimen at an Arizona university plant conservatory. If it is not possible to deposit a specimen at an Arizona university plant conservatory, the permittee shall provide the justification to the Department for noncompliance with this provision.
2. A scientific permit shall be issued if the applicant provides documentation that demonstrates the following:
    - a. A plan, pre-approved by the landowner, to restore the removal site to a natural appearance;
    - b. The removal and movement of the native plants shall be accomplished by a person experienced in native plant removal and transplantation;
    - c. The native plants used in the project shall remain accessible to the Department;
    - d. The ecology of the project site is beneficial to the growth of the specific plants in the project;
    - e. Arrangements exist for a suitable permanent planting site for the surviving plants after the project's completion; and
    - f. Description of plant disposition and research hypothesis.
  3. In addition to the requirements listed in subsection (A)(2), the following requirements apply to highly safeguarded native plants:
    - a. Permits may be issued only for collection for scientific purposes of highly safeguarded native plants whose existence or location is threatened by intended destruction or a change in land usage, and
    - b. If the permit may enhance the survival of the affected species.

**B. Noncommercial salvage permit:**

1. Highly safeguarded native plants may only be collected for conservation by a person holding a noncommercial salvage permit issued pursuant to R3-3-1104(F).
2. A noncommercial salvage permit shall be issued if all of the following conditions are met through documentation provided to the Department:
  - a. The native plants used in the project shall be accessible to the Department after transplant, and
  - b. The relocation site is beneficial to the growth of the specific plants in the project.
3. In addition to the requirements listed in subsection (B)(2), the following requirements apply to highly safeguarded native plants:
  - a. Permits may be issued only for collection for non-commercial salvage purposes of highly safeguarded native plants whose existence or location is threatened by intended destruction or a change in land usage, and
  - b. If the permit may enhance the survival of the affected species.

effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1106. Protected Native Plant Program Fees**

**A. Permit fees.**

1. In addition to any applicable fees for interstate shipment requiring a single shipment nursery stock inspection certification issued pursuant to R3-4-301(D), a person removing and transporting protected native plants shall submit the following applicable fee to the Department with the permit application:
  - a. Salvage assessed native plant permit, annual use, \$35;
  - b. Harvest restricted native plant permit, annual use, \$35;
  - d. Certificate of inspection for interstate shipments, \$15;
  - c. All other native plant permits, one-time use, \$7.
2. Exemptions. Protected native plants are exempt from fees if:
  - a. The protected native plants intended for personal use by a landowner are taken from one piece of land owned by the landowner to another piece of land also owned by the landowner, remain on the property of the landowner, and are not sold or offered for sale;
  - b. The protected native plants are collected for scientific purposes;
  - c. A landowner donates the protected native plant to a scientific, educational, or charitable institution;
  - d. Exempted pursuant to A.R.S. § 3-915;
  - e. Donated to a home-owners association or nonprofit organizations as provided in A.R.S. § 3-916; or
  - f. Donated to a state agency or political subdivision, under a non-commercial salvage permit.

**B. Tag and harvesting fees.**

1. Any person obtaining a saguaro tag or other protected native plant tag or receipt shall submit the following applicable fee to the Department at the time a tag is obtained:
  - a. Saguaro, \$8 per plant;
  - b. Trees cut for wood and listed in the harvest restricted category, \$6 per cord of wood;
  - c. Small native plant, \$.50 per plant;
  - d. Any other protected native plant referenced in A.R.S. § 3-903(B) and (C) and listed in Appendix A, \$6 per plant.
2. The fee for harvesting *nolina* or *yucca* parts is \$6 per ton. Payment shall be made to the Department in the following manner:
  - a. Unprocessed *nolina* or *yucca* fiber shall be weighed on a state-certified bonded scale; and
  - b. The harvester shall submit payment and weight certificates to the Department no later than the tenth day of the month following each harvest.

**C. Seal fees.** A person obtaining a seal shall submit a \$.15 per plant fee to the Department at the time a seal is obtained.

**D. Arizona native plant law education.** In addition to the following fees, charges for printed materials or pamphlets shall be assessed based upon printing and mailing costs:

**Historical Note**

New Section recodified from R3-4-605 at 10 A.A.R. 726,

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1. A person attending a seminar or training course on Arizona native plant law shall pay a nonrefundable fee of \$14 to the Department before attending the class.
2. A person convicted of violating Arizona native plant laws and ordered by a court to attend a native plant educational class shall pay a nonrefundable fee of \$35 to the Department before attending the class. The Department shall provide written confirmation of satisfactory completion to a person ordered by a court to attend a class.

**Historical Note**

New Section recodified from R3-4-606 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1107. Tags, Seals, and Cord Use**

- A. Seals. Any person importing protected native plants shall obtain import seals from the Department and securely attach the seal directly to each protected native plant.
- B. Tag and cord attachment.
  1. A permittee shall attach a cord sealing tag to each protected native plant taken from its original growing site, using cord provided by the Department, before transport. No other type of rope, string, twine, or wire is allowed.
  2. The cord shall be securely tied around the plant, and the cord sealing tag placed directly over the knot in the cord and the ends pressed firmly together sealing the knot so that it cannot be removed without breaking the tag or cutting the cord.
  3. Upon loading the plant, every effort shall be made to allow visibility of the tag during transport.

**Historical Note**

New Section recodified from R3-4-607 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1108. Recordkeeping; Salvage Assessed and Harvest Restricted Native Plants**

- A. Salvage Assessed Native Plants.
  1. A permittee shall maintain a record of each protected native plant removed under an annual permit for two years from the date of each transaction and allow Department inspection of the records during normal business hours. The transaction record shall include the date salvage assessed protected native plants were removed, the location where the plants were taken from, the location where the plants were replanted, and the permit and tag numbers.
  2. A permittee shall maintain a record of written permission granted by a landowner for the collection of salvage assessed native plants.
  3. Annually, by January 31, a permittee shall submit to the Department a copy of each transaction record for the prior calendar year.
- B. Harvest Restricted Native Plants. A permittee shall submit to the Department by the tenth day of each month the transaction records for the previous month, or a written statement that no transactions were conducted for that month.

**Historical Note**

New Section recodified from R3-4-608 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1109. Repealed****Historical Note**

New Section recodified from R3-4-609 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Repealed by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1110. Permit Denial**

- A. A person that is found in violation of A.R.S. § 3-908 or the rules of this Article shall be denied a permit, tag, or seal applied for or issued, pursuant to this Article.
- B. Upon notice of denial of a permit, an applicant may request, in writing, that the Department provide an administrative hearing under A.R.S. Title 41, Chapter 6, Article 10, to appeal the denial.

**Historical Note**

New Section recodified from R3-4-610 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1). Amended by final rulemaking at 30 A.A.R. 3865 (December 27, 2024), effective February 2, 2025 (Supp. 24-4).

**R3-3-1111. Repealed****Historical Note**

New Section recodified from R3-4-611 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Repealed by final rulemaking at 14 A.A.R. 811, effective May 3, 2008 (Supp. 08-1).

**Appendix A. Protected Native Plants by Category**

- A. Highly safeguarded native plants as prescribed in A.R.S. § 3-903(B)(1), for which removal is not allowed except as provided in R3-3-1105:

*Amaryllidaceae Allium gooddingii* - Goodding's onion

*Apiaceae Eryngium sparganophyllum* - Arizona eryngo

*Apiaceae Lilaeopsis schaffneriana* ssp. *recurva* - Cienega false rush, Huachuca water umbel

*Apocynaceae Amsonia grandiflora* - Arizona bluestar

*Apocynaceae Amsonia kearneyana* - Kearney's bluestar

*Apocynaceae Asclepias welshii* - Welsh's milkweed

*Apocynaceae Cycladenia humilis* var. *jonesii* - Jones' waxy dogbane

*Apocynaceae Matelea tristiflora* - Talayote

*Asparagaceae Agave x arizonica* - Arizona agave

*Asparagaceae Agave delamateri* - Tonto Basin agave

*Asparagaceae Agave murpheyi* - Hohokam agave

*Asparagaceae Agave parviflora* - Santa Cruz striped agave

*Asparagaceae Agave phillipsiana* - Grand Canyon agave



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- Asparagaceae Agave sanpedroensis* - San Pedro agave
- Asparagaceae Agave schottii* var. *treleasei* - Trelease agave
- Asparagaceae Agave verdensis* - Sacred Mountain agave
- Asparagaceae Agave yavapaiensis* - Page Springs agave
- Asparagaceae Yucca kenabensis* - Kanab yucca
- Asteraceae Ericameria arizonica* - Arizona heath-goldenrod
- Asteraceae Erigeron lemmonii* - Lemmon fleabane
- Asteraceae Erigeron rhizomatus* - Zuni fleabane
- Asteraceae Packera franciscana* - San Francisco Peaks groundsel
- Asteraceae Pectis imberbis* - Beardless chinchweed
- Asteraceae Perityle* spp. (except *Perityle emoryi*) - Rockdaisy
- Asteraceae Senecio multidentatus* var. *huachuensis* - Huachuca groundsel
- Boraginaceae Oreocarya semiglabra* - Smooth cryptantha
- Boraginaceae Phacelia cronquistiana* - Cronquist's phacelia
- Cactaceae Carnegiea gigantea*, crested form - Saguaro, "crested" or "fan-top"
- Cactaceae Coryphantha recurvata* - Golden-chested beehive cactus
- Cactaceae Coryphantha robustispina* ssp. *robustispina* - Scheer's strong-spined cory cactus
- Cactaceae Coryphantha robustispina* ssp. *uncinata*
- Cactaceae Cylindropuntia abyssii* - Peach Springs cholla
- Cactaceae Cylindropuntia x campii* - Camp's cholla
- Cactaceae Echinocactus horizonthalonius* ssp. *nicholii* - Nichol's Turk's head cactus
- Cactaceae Echinocereus arizonicus* ssp. *arizonicus* - Arizona hedgehog cactus
- Cactaceae Echinomastus erectocentrus* ssp. *acunensis* - Acuna cactus
- Cactaceae Escobaria robbinsorum* - Cochise pincushion cactus
- Cactaceae Pediocactus bradyi* - Brady's pincushion cactus
- Cactaceae Pediocactus paradinei* - Paradine plains cactus
- Cactaceae Pediocactus peeblesianus* - Peebles' Navajo cactus, Navajo plains cactus
- Cactaceae Pediocactus sileri* - Siler pincushion cactus
- Cactaceae Sclerocactus sileri* - House Rock Fish-Hook Cactus
- Caryophyllaceae Silene rectiramea* - Grand Canyon campion
- Cyperaceae Carex specuicola* - Navajo sedge
- Fabaceae Astragalus cremnophylax* var. *cremnophylax* - Sentry milkvetch
- Fabaceae Astragalus endopterus* - Sandbar milkvetch
- Fabaceae Astragalus holmgreniorum* - Holmgren milkvetch
- Fabaceae Dalea tentaculoides* - Gentry indigo bush
- Fabaceae Acmispon mearnsii* var. *equisolenus*
- Lamiaceae Trichostema micranthum* - Small flower bluecurls
- Lennoaceae Pholisma arenarium* - Scaly-stemmed sand plant
- Lennoaceae Pholisma sonora* - Sandfood, sandroot
- Malvaceae Sphaeralcea gierischii* - Gierisch's globemallow
- Orchidaceae Cypripedium calceolus* var. *pubescens* - Yellow lady's slipper
- Orchidaceae Hexalectris parviflora*
- Orchidaceae Hexalectris warnockii* - Texas purple spike
- Orchidaceae Spiranthes delitescens* - Canelo Hills ladies'-tresses
- Orobanchaceae Castilleja mogollonica* - Mogollon Indian-paintbrush
- Papaveraceae Arctomecon californica* - Las Vegas bearclaw-poppy
- Plantaginaceae Penstemon discolor* - Variegated beardtongue
- Poaceae Puccinellia parishii* - Parish alkali grass
- Polemoniaceae Loeseliastrum franciscanum* - Wupatki calico
- Polygonaceae Eriogonum mortonianum* - Fredonia buckwheat
- Polygonaceae Rumex orthoneurus* - Chiricahua Mountain wild dock
- Psilotaceae Psilotum nudum* - Whisk Fern, Skeleton fork fern
- Ranunculaceae Cimicifuga arizonica* - Arizona bugbane
- Ranunculaceae Clematis hirsutissima* var. *arizonica* - Arizona leatherflower
- Rosaceae Potentilla arizonica* - Garland Prairie Cinquefoil
- Rosaceae Purshia x subintegra* - Arizona cliffrose, Burro Creek cliffrose
- Rosaceae Purshia pinkavae* - Pinkava cliffrose
- Salicaceae Salix arizonica* - Arizona willow
- Scrophulariaceae Buddleja sessiliflora* - Rio Grande butterfly bush
- B.** Salvage restricted native plants as prescribed in A.R.S. § 3-903(B)(2) that require a permit issued pursuant to this Article, for removal. In addition to the plants listed under Agavaceae, Cactaceae, Liliaceae, and Orchidaceae, all other species in these families are salvage restricted protected native plants:
- Amaranthaceae Atriplex hymenelytra* - Desert-holly
- Amaryllidaceae Allium* spp. that are not listed in subsection (A) - Wild onion
- Amaryllidaceae Habranthus longifolius* - Plains Rain Lily
- Amaryllidaceae Nothoscordum bivalve* - Crowpoison
- Anacardiaceae Rhus kearneyi* ssp. *kearneyi* - Kearney Sumac
- Apocynaceae Amsonia peeblesii* - Peeble's Bluestar
- Arecaceae Washingtonia filifera* - California fan palm
- Asparagaceae Agave* spp. that are not listed in subsection (A) - Agave, century plant
- Asparagaceae Androstephium breviflorum* - Funnel-lily
- Asparagaceae Dasylirion wheeleri* - Sotol, desert spoon

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- Asparagaceae Echeandia flavescens* - Amberlily  
*Asparagaceae Eremocrinum albomarginatum* - Lonely-lily  
*Asparagaceae Hesperocallis undulata* - Ajo-lily  
*Asparagaceae Hesperoyucca newberryi* - Newberry's-yucca  
*Asparagaceae Milla biflora* - Mexican star  
*Asparagaceae Nolina* spp. - Beargrass  
*Asparagaceae Polygonatum cobrense*  
*Asparagaceae Tritelia lemmoniae* - Oak Creek Triplet-lily  
*Asparagaceae Triteliopsis palmeri* - Palmer's Blue sand lily  
*Asparagaceae Yucca* spp. that are not listed in subsection (A) - Narrow-leaf yucca  
*Asteraceae Cirsium virginensis* - Virgin thistle  
*Asteraceae Erigeron anchana* - Sierra Ancha fleabane  
*Asteraceae Erigeron heliographis* - Heliograph Peak fleabane  
*Asteraceae Erigeron hodgsoniae* - Hodgson's fleabane  
*Asteraceae Erigeron piscaticus* - Fish Creek fleabane  
*Asteraceae Erigeron pringlei* - Pringle's fleabane  
*Asteraceae Hymenoxys ambigens* - Pinaleno Mountain Rub-berweed  
*Asteraceae Perityle* spp. except *emoryii* - Ajo rock daisy  
*Asteraceae Senecio quaerens* - Gila groundsel  
*Asteraceae Tetraneuris verdiensis* - Verde Valley four-nerved daisy  
*Boraginaceae Mertansia macdougalii* - Macdougal's bluebells  
*Boraginaceae Phacelia sonoitensis* - Sonoita Creek scorpion-weed  
*Brassicaceae Draba asprella* - Rough Whitlow-grass  
*Burseraceae Bursera microphylla* - Elephant tree, torote  
*Cactaceae Carnegiea gigantea* - Saguaro  
*Cactaceae Cochiemia* spp. - Biznagua  
*Cactaceae Cyllindropuntia* spp. except listed in subsection (A) - Cholla  
*Cactaceae Echinocereus* spp. *emoryii* - Hedgehogs, claret-cup hedgehogs  
*Cactaceae Echinomastus* spp. that are not listed in subsection (A) - Fishhook cactus  
*Cactaceae Epithelantha micromeris* - Pingpong ball cactus  
*Cactaceae Escobaria* spp. that are not listed in subsection (A) - Foxtail cactus  
*Cactaceae Ferocactus* spp. - Barrel cactus, biznaga  
*Cactaceae Grusonia* spp. - Devil-cholla  
*Cactaceae Homalocephala polycephala* - Many-headed barrel cactus  
*Cactaceae Lophocereus schottii* - Senita  
*Cactaceae Mammillaria heyderi* - Heyder's pincushion cactus  
*Cactaceae Opuntia* spp. - Prickly-pear  
*Cactaceae Pediocactus* spp. except listed in subsection (A) - Pincushion cactus, pediocactus  
*Cactaceae Peniocereus* spp. - Queen-of-the-night cactus  
*Cactaceae Sclerocactus* spp. except listed in subsection (A) - Fishhook cactus  
*Cactaceae Stenocereus thurberi* - Organpipe cactus  
*Campanulaceae Lobelia fenestralis* - Fringeleaf lobelia  
*Campanulaceae Lobelia laxiflora* - Sierra Madre lobelia  
*Caryophyllaceae Eremogone aberrans* - Mt. Dellenbaugh Matted Sandwort  
*Cochlospermaceae Cochlospermum* spp. - Saiya  
*Crassulaceae Dudleya* spp. - Live-forever, echeveria  
*Crassulaceae Graptopetalum* spp. - Leather-petals  
*Crassulaceae Sedum* spp. - Stonecrop  
*Crossosomataceae Apacheria chiricauhensis* - Apache-bush  
*Cucurbitaceae Tumamoca mcdougallii* - Tumamoc globeberry  
*Euphorbiaceae Euphorbia aaron-rossii* - Marble Canyon spurge  
*Euphorbiaceae Euphorbia plummerae* - Huachuca Mountain spurge  
*Euphorbiaceae Pleradenophora bilocularis* - Jumping Bean (es: hierba de la flecha)  
*Fabaceae Astragalus cobrensis* var. *maguirei* - Maguire's milkvetch  
*Fabaceae Astragalus cremnophylax* - Sentry milkvetch  
*Fabaceae Astragalus hypoxylus* - Huachuca Mountain milkvetch  
*Fabaceae Astragalus lentiginosus* var. *maricopae* - Maricopa milkvetch  
*Fabaceae Astragalus nutriosensis* - Apache milkvetch  
*Fabaceae Astragalus xiphoides* - Gladiator milkvetch  
*Fabaceae Cercis orbiculata* - California redbud  
*Fabaceae Dermatophyllum arizonicum* - Arizona Western mountain-laurel  
*Fabaceae Errazurizia rotundata* - Roundleaf dunebroom  
*Fabaceae Olneya tesota* - Ironwood, palo fierro  
*Fabaceae Pediomelum pauperitense*  
*Fabaceae Phaseolus supinus* - Supine bean  
*Fouquieriaceae Fouquieria splendens* - Ocotillo  
*Gentianaceae Gentianella wislizenii* - Chiricahua Mountain dwarf gentian  
*Lamiaceae Hedeoma diffusa* - Flagstaff mock pennyroyal  
*Lamiaceae Monardella arizonica* - Arizona monardella  
*Lamiaceae Salvia dorrii* ssp. *mearnsii* - Purple sage  
*Lamiaceae Scutellaria potosina* var. *occidentalis* - Kaibab skullcap  
*Liliaceae Calochortus* spp. - Mariposa-lily

## TITLE 3. AGRICULTURE

## CHAPTER 3. DEPARTMENT OF AGRICULTURE - ENVIRONMENTAL SERVICES DIVISION

*Liliaceae Fritillaria atropurpurea* - Spotted fritillary

*Liliaceae Lilium* spp. - Lemon lily

*Liliaceae Prosartes trachycarpa* - Roughfruit fairy-bells

*Liliaceae Streptopus amplexifolius* - Twisted stalk

*Loasaceae Mentzelia longiloba* - Blazing-star

*Malvaceae Abutilon parishii* - Tucson Indian-mallow

*Malvaceae Fremontodendron californicum* - Flannel bush

*Malvaceae Pseudabutilon thurberi* - Baboquivari Indian-mallow

*Malvaceae Sphaeralcea rusbyi* ssp. *gilensis* - Gila globe-mallow

*Malvaceae Sphaeralcea gierischii* - Gierisch's globe-mallow

*Nyctaginaceae Boerhavia megaptera* - Tucson Mountain spiderling

*Onagraceae Camissonia confertiflora* - Grand Canyon suncup

*Onagraceae Chylismia exilis* - Cottonwood Springs beeblossum

*Orchidaceae* all orchidaceae with exception of those that are listed in subsection (A)

*Papaveraceae Argemone arizonica* - Grand Canyon pricklepoppy

*Pinaceae Pinus aristata* - Bristlecone pine

*Plantaginaceae Mabrya acerifolia* - Brittle-stem

*Plantaginaceae Penstemon albomarginatus* - Whitemargin beardtongue

*Plantaginaceae Penstemon bicolor* spp. *roseus* - Pinto beardtongue

*Plantaginaceae Penstemon clutei* - Sunset Crater beardtongue

*Plantaginaceae Penstemon distans* - Mt. Trumbull beardtongue

*Plantaginaceae Penstemon linarioides* ssp. *maguirei* - Maguire's beardtongue

*Plantaginaceae Penstemon nudiflorus* - Flagstaff beardtongue

*Plantaginaceae Penstemon subulatus* - Hackberry beardtongue

*Poaceae Sporobolus interruptus* - Black dropseed

*Polemoniaceae Linanthus maricopensis* - Maricopa linanthus

*Polygalaceae Rhinotropis rusbyi* - Rusby's desert milkwort

*Polygonaceae Eriogonum heermannii* var. *apachense* - Apache buckwheat

*Polygonaceae Eriogonum capillare* - San Carlos buckwheat

*Polygonaceae Eriogonum ericifolium* - Yavapai County buckwheat

*Polygonaceae Eriogonum jonesii* - Jones' buckwheat

*Polygonaceae Eriogonum mortonianum* - Fredonia buckwheat

*Polygonaceae Eriogonum pulchrum* - Yavapai County buckwheat

*Polygonaceae Eriogonum ripleyi* - Frazier's Well buckwheat

*Polygonaceae Eriogonum terrenatum* - San Pedro River buckwheat

*Polygonaceae Eriogonum thompsonae* var. *atwoodii* - Atwood's buckwheat

*Portulacaceae Lewisia* spp. - Bitter-root

*Portulacaceae Phemeranthus* spp. - Flameflower

*Primulaceae Dodecatheon* spp. - Shooting-star

*Primulaceae Primula rusbyi* - Rusby's primrose

*Primulaceae Primula specuicola* - Cave-dwelling primrose

*Pteridaceae Astrolepis cochisensis* subsp. *arizonica* - Arizona scaly cloakfern

*Ranunculaceae Aquilegia* spp. - Columbines

*Rosaceae Potentilla albiflora* - Pinaleno cinquefoil

*Rosaceae Potentilla demotica* - Hualapai cinquefoil

*Rosaceae Potentilla rhyolitica* - Santa Rita cinquefoil

*Rosaceae Rosa stellata* ssp. *abyssa* - Desert rose

*Rosaceae Vauquelinia californica* - Arizona rosewood

*Rubiaceae Galium collomiae* - Fossil Hill Creek bedstraw

*Saxifragaceae Heuchera eastwoodiae* - Senator Mine allum-root

*Saxifragaceae Heuchera glomerulata* - Chiricahua Mountain allum-root

*Simaoubaceae Castela emoryi* - Crucifixion-thorn, corona de cristo

*Solanaceae Lycium* spp. - Wolfberry, tomatillo

*Solanaceae Capsicum annuum* var. *glabriusculum* - Chiltepin

- C. Salvage assessed native plants as prescribed in A.R.S. § 3-903(B)(3) that require a permit issued pursuant to this Article for removal:

*Bignoniaceae Chilopsis linearis* - Desert willow

*Fabaceae Parkinsonia florida* - Blue palo verde

*Fabaceae Parkinsonia microphylla* - Foothill palo verde

*Fabaceae Neltuma odorata* - Texas Honey Mesquite

*Fabaceae Strombocarpa pubescens* - Screwbean mesquite

*Fabaceae Neltuma velutina* - Velvet mesquite

*Fabaceae Psoralea spinosa* - Smoke tree

- D. Harvest restricted native plants as prescribed at A.R.S. § 3-903(B)(4) that require a permit issued pursuant to this Article, to cut or remove the plants for their by-products, fibers, or wood:

*Asparagaceae Nolina* spp. - Bear-grass

*Fabaceae Neltuma odorata* - Texas Honey Mesquite

*Fabaceae Neltuma velutina* - Velvet Mesquite

*Fabaceae Psoralea spinosa* - Smoketree

**Historical Note**

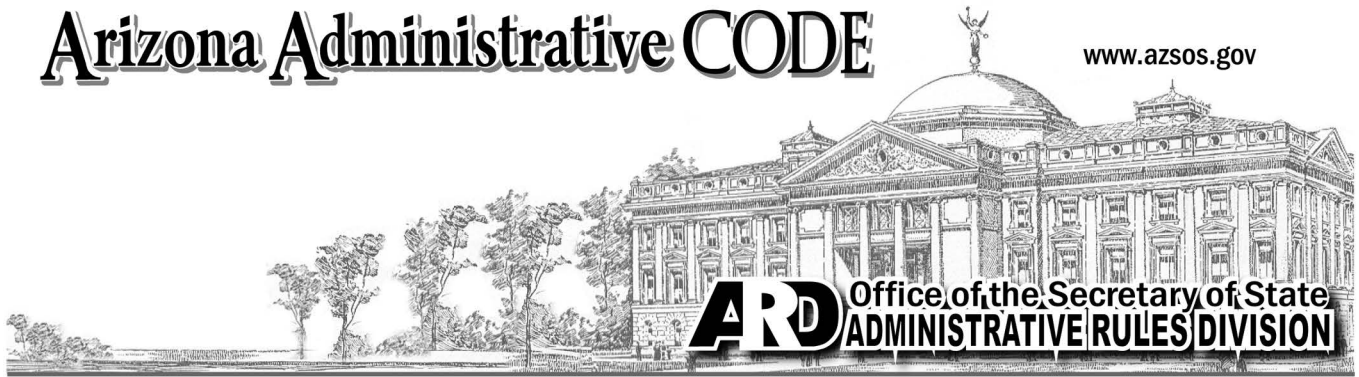
New Section recodified from 3 A.A.C. 4, Article 6 at 10 A.A.R. 726, effective February 6, 2004 (Supp. 04-1). Amended by final rulemaking at 14 A.A.R. 811, effective

TITLE 3. AGRICULTURE

CHAPTER 3. DEPARTMENT OF AGRICULTURE - ENVIRONMENTAL SERVICES DIVISION

May 3, 2008 (Supp. 08-1). Appendix A amended by final  
rulemaking at 30 A.A.R. 3865 (December 27, 2024),

effective February 2, 2025 (Supp. 24-4).



4 A.A.C. 17

Supp. 24-4

## TITLE 4. PROFESSIONS AND OCCUPATIONS

### CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

[R4-17-402.](#)     [Practicing Collaboratively with a Physician Assistant .....](#) [8](#)

#### Questions about these rules? Contact:

Board: Arizona Medical Board  
Address: 1740 W. Adams St., Suite 4000  
Phoenix, AZ 85007  
[Website:](#) [www.azmd.gov](http://www.azmd.gov)  
Name: Patricia McSorley, Executive Director  
Telephone: (480) 551-2700  
Fax: (480) 551-2704  
[Email:](#) [patricia.mcsorley@azmd.gov](mailto:patricia.mcsorley@azmd.gov)

**The release of this Chapter in Supp. 24-4 replaces Supp. 23-4, 1-9 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

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A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

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Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

Authority: A.R.S. § 32-2504

## Supp. 24-4

## CHAPTER TABLE OF CONTENTS

**Editor's Note:** The name of the Joint Board on the Regulation of Physician's [sic] Assistants was changed to the Arizona Regulatory Board of Physician Assistants by Laws 2002, Ch. 277, § 7, effective August 22, 2002 (Supp. 03-2).

Laws 1984, Ch. 102, changed the name of the Joint Board of Medical Examiners and Osteopathic Examiners in Medicine and Surgery to Joint Board on the Regulation of Physician's Assistants.

Chapter 17 consisting of Article 1, Section R4-17-101; Article 2, Sections R4-17-201 through R4-17-204; Article 3, Sections R4-17-301 through R4-17-304; Article 4, Sections R4-17-401 and R4-17-402 adopted effective July 8, 1986.

Former Chapter 17 consisting of Article 1, Section R4-17-01; Article 2, Sections R4-17-02 through R4-17-06; Article 3, Sections R4-17-07 through R4-17-12; Article 4, Sections R4-17-13 through R4-17-17; Article 5, Sections R4-17-18 through R4-17-22; and Article 6, Section R4-17-23 repealed effective July 8, 1985.

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

## ARTICLE 1. GENERAL PROVISIONS

**R4-17-101. Definitions**

For the purposes of A.R.S. Title 32, Chapter 25 and this Chapter:

1. "Ability to perform health care tasks authorized by A.R.S. § 32-2531" means:
  - a. The cognitive capacity to make clinical diagnoses and exercise medical judgments and to learn and keep abreast of medical developments through the completion of continuing medical education,
  - b. The ability to communicate medical judgments and medical information to patients and other professionals, and
  - c. The physical capability to perform the health care tasks authorized by A.R.S. § 32-2531.
2. "Applicant" means an individual seeking a regular license or renewal license.
3. "Category I" means a designation given to a continuing medical education activity provided by an institution or organization that has been accredited for continuing medical education by the:
  - a. Accreditation Council for Continuing Medical Education,
  - b. American Medical Association,
  - c. American Academy of Physician Assistants,
  - d. American Osteopathic Association,
  - e. Accreditation Council for Continuing Medical Education,
  - f. Accreditation Review Commission on Education for Physician Assistants, or
  - g. Commission on the Accreditation of Allied Health Education Programs.
4. "Controlled Substance" means the same as in A.R.S. § 32-1901.
5. "Dispense" means the same as in A.R.S. § 32-1901.
6. "Drug" means the same as in A.R.S. § 32-1901.
7. "Health care institution" means the same as in A.R.S. § 36-401.
8. "Health professional" means the same as in A.R.S. § 32-3201 or its equivalent in another state.
9. "Health profession regulatory authority" means a state or federal entity that issues and regulates health professional licenses.
10. "NCCPA" means the National Commission on the Certification of Physician Assistants.
11. "PANCE" means the Physician Assistant National Certifying Examination.
12. "PANRE" means the Physicians Assistants National Recertification Examination.
13. "Prescribe" means to issue:
  - a. A signed, written order to a pharmacist for drugs or medical devices; or
  - b. An order transmitted to a pharmacist by word of mouth, telephone, or other means of communication.
14. "Privileges" means the authority granted by a health care institution to a physician or physician assistant to practice medicine at the health care institution.
15. "Service" means personal delivery or mailing by certified mail to a physician assistant, supervising physician, or applicant affected by a decision of the Board at the physician assistant's, supervising physician's, or applicant's last known residence or place of business.
16. "State fiscal year" means from July 1 of one calendar year to June 30 of the next calendar year.

17. "Substance use disorder" means the maladaptive pattern of the use of a drug, alcohol, or chemical leading to effects that are detrimental to an individual's physical or mental health.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Amended effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**R4-17-102. Time-frames for Licenses and Approvals**

- A. The overall time-frame described in A.R.S. § 41-1072(2) for a regular license or renewal license is set forth in Table 1.
- B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for a regular license or renewal license is set forth in Table 1 and begins on the date the Board receives an application.
  1. If the application is not administratively complete, the Board shall send a deficiency notice to the applicant.
    - a. The deficiency notice shall state each deficiency and the information needed to complete the application.
    - b. Within the time provided in Table 1 for response to the deficiency notice, the applicant shall submit to the Board the missing information specified in the deficiency notice. The time-frame for the Board to finish the administrative completeness review is suspended from the date the Board mails the deficiency notice to the applicant until the date the Board receives the missing information.
    - c. If the applicant does not submit the missing information within the time to respond to the deficiency notice set forth in Table 1, the Board shall send a written notice to the applicant informing the applicant that the application is deemed withdrawn.
  2. If the application is administratively complete, the Board shall send a written notice of administrative completeness to the applicant.
- C. The substantive review time-frame described in A.R.S. § 41-1072(3) for a regular license or renewal license is set forth in Table 1 and begins on the date the Board sends written notice of administrative completeness to the applicant.
  1. During the substantive review time-frame, the Board may make one comprehensive written request for additional information. The applicant shall submit the additional information within the time provided in Table 1 for response to a comprehensive written request for additional information. The time-frame for the Board to finish the substantive review is suspended from the date the Board mails the request until the Board receives the information.
  2. The Board shall issue a written notice informing the applicant that the application is deemed withdrawn if the applicant does not submit the requested additional information within the time-frame in Table 1.
  3. The Board shall issue a written notice of denial of a license or license renewal if the Board determines that the applicant does not meet all of the substantive criteria required by statute or this Chapter for licensure or license renewal.
  4. If the applicant meets all of the substantive criteria required by statute and this Chapter for a license or license renewal, the Board shall issue the license or license renewal to the applicant.



## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

- D.** In computing any period of time prescribed in this Section, the day of the act, event, or default shall not be included. The last day of the period shall be included unless it is Saturday, Sunday, or a state holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or state holiday. The computation shall include intermediate Saturdays, Sundays, and holidays. The time period for an applicant to respond to a deficiency notice or request for additional information shall commence on the date of personal service or the date of mailing.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**Table 1. Time Frames (in days)**

Type of License	Overall Time Frame	Administrative Review Time Frame	Time to Respond to Deficiency Notice	Substantive Review Time Frame	Time to Respond to Request for Additional Information
Regular License including schedule II or schedule III controlled substances approval R4-17-203	120	30	365	90	90
License Renewal R4-17-206	75	30	60	45	60
Registration as an Out-of-state Health Care Provider of Telehealth Services A.R.S. § 36-3606(A)(3)	40	20	30	20	30

**Historical Note**

Adopted effective April 22, 1998 Amended by final exempt rulemaking at 27 A.A.R. 1647, with an immediate effective date of September 22, 2021 (Supp. 21-3). (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final exempt rulemaking at 27 A.A.R. 1647, with an immediate effective date of September 22, 2021 (Supp. 21-3).

**ARTICLE 2. PHYSICIAN ASSISTANT LICENSURE****R4-17-201. Repealed****Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-201 renumbered to R4-17-202; new Section adopted effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**R4-17-202. Examination**

An applicant for a regular license as a physician assistant shall pass the PANCE or PANRE and be certified by the NCCPA at the time of application for licensure.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section R4-17-202 renumbered from R4-17-201 and amended effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-203. Regular License Application**

- A.** An applicant for a regular license shall submit a completed application to the Board that includes:

1. The applicant's:
  - a. First, last, and middle name;
  - b. Every other name used by the applicant;
  - c. Social Security number;
  - d. Office, mailing, e-mail, and home addresses;
  - e. Office, mobile, and home telephone numbers; and
  - f. Birth date and state or country of birth;
2. The name and address of the approved physician assistant program completed by the applicant and the date of completion;

3. The name of each state or province in which the applicant has ever been certified, registered, or licensed as a physician assistant, including the certificate, registration, or license number, and current status;
4. Whether the applicant has practiced as a physician assistant for 10 continuous years before the date the application was submitted to the Board or since graduation from a physician assistant program and if not, an explanation;
5. A questionnaire that includes answers to the following:
  - a. Whether the applicant has had an application for a certificate, registration, or license refused or denied by any licensing authority, and if so, an explanation;
  - b. Whether the applicant has had the privilege of taking an examination for a professional license refused or denied by any entity, and if so, an explanation;
  - c. Whether the applicant has ever resigned or been requested to resign, been suspended or expelled from, been placed on probation, or been fined while enrolled in an approved physician assistant program or a postsecondary educational program, and if so, an explanation;
  - d. Whether, while attending an approved physician assistant program, the applicant has ever had any action taken against the applicant by the approved program, resigned, or been asked to leave the approved program for any amount of time, and if so, an explanation;
  - e. Whether the applicant has ever surrendered a health professional license, and if so, an explanation;
  - f. Whether the applicant has ever had a health professional license suspended or revoked, or whether any other disciplinary action has ever been taken against a health professional license held by the licensee, and if so, an explanation;
  - g. Whether the applicant is currently under investigation by any health profession regulatory authority,

## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 17. ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

- health care association, licensed health care institution, or there are any pending complaints or disciplinary actions against the applicant, and if so, an explanation;
- h. Whether the applicant has ever had any action taken against the applicant's privileges, including termination, resignation, or withdrawal by a health care institution or health profession regulatory authority, and if so, an explanation;
  - i. Whether the applicant has ever had a federal or state regulatory authority take any action against the applicant's authority to prescribe, dispense, or administer controlled substances including revocation, suspension, or denial, or whether the applicant ever surrendered the authority in lieu of any of these actions, and if so, an explanation;
  - j. Whether the applicant has ever been charged with, convicted of, pleaded guilty to, or entered into a plea of no contest to a felony or misdemeanor involving moral turpitude or has been pardoned or had a record expunged or vacated, and if so, an explanation;
  - k. Whether the applicant has ever been charged with or convicted of a violation of any federal or state drug statute, rule, or regulation, regardless of whether a sentence was or was not imposed, and if so, an explanation;
  - l. Whether the applicant has been named as a defendant in a malpractice matter currently pending or that resulted in a judgment or settlement entered against the applicant, and if so, an explanation;
  - m. Whether the applicant has ever been court-martialed or discharged other than honorably from any component of the uniformed services of the United States, and if so, an explanation;
  - n. Whether the applicant has ever been involuntarily terminated from a health professional position, resigned, or been asked to leave the health care position, and if so, an explanation;
  - o. Whether the applicant has ever been convicted of insurance fraud or received a sanction, including limitation, suspension, or removal from practice, imposed by any state or the federal government, and if so, an explanation; and
  - p. Whether the applicant, within the three years before the date of the application, has completed 45 hours in pharmacology or clinical management of drug therapy or is certified by a national commission on the certification of physician assistants or its successor;
6. A confidential questionnaire that includes answers to the following:
    - a. Whether the applicant currently has a medical condition that impairs the applicant's judgment or ability to practice medicine in a competent, ethical, and professional manner;
    - b. If the answer to subsection (A)(6)(a) is yes:
      - i. Provide an explanation of the medical condition; and
      - ii. If currently practicing under a monitoring agreement with a licensing board in another state, attach a copy of the monitoring agreement to the application; and
  7. Consistent with the Board's statutory authority, other information the Board may deem necessary to evaluate the applicant fully; and
  8. A sworn statement that complies with A.R.S. § 32-2522(C).
- B.** In addition to the requirements in subsection (A), an applicant shall submit the following to the Board:
    1. Documentation of citizenship or alien status that conforms to A.R.S. § 41-1080;
    2. Documentation of a legal name change if the applicant's legal name is different from that shown on the document submitted in accordance with subsection (B)(1);
    3. A form provided by the Board and completed by the applicant that lists all current or past employment with health professionals, health professions educational institutions, or health care institutions within five years before the date of application or since graduation from a physician assistant program, if less than five years, including each health professional's, health professions educational institution's, or health care institution's name, address, and dates of employment;
    4. Verification of any medical malpractice matter currently pending or resulting in a settlement or judgment against the applicant, including a copy of the complaint and either the agreed terms of settlement or the judgment and a narrative statement specifying the nature of the occurrence resulting in the medical malpractice action. An applicant who is unable to obtain a document required under this subsection may submit a written request for a waiver of the requirement. The applicant shall include the following information in a request for waiver:
      - a. The document for which waiver is requested;
      - b. Detailed description of efforts made by the applicant to provide the required document; and
      - c. Reason the applicant's inability to provide the required document is due to no fault of the applicant; and
    5. The fee required in R4-17-204.
  - C.** In addition to the requirements in subsections (A) and (B), an applicant shall have the following directly submitted to the Board:
    1. A copy of the applicant's certificate of successful completion of the PANCE or PANRE and the applicant's examination score provided by the NCCPA;
    2. An approved program form provided by the Board, completed and signed by the director or administrator of the approved program that granted the applicant a physician assistant degree, that includes the:
      - a. Applicant's full name,
      - b. Type of degree earned by the applicant,
      - c. Name of the physician assistant program completed by the applicant,
      - d. Starting and ending dates, and
      - e. Date the applicant's degree was granted.
  - D.** The Board's issuance of a regular license to an applicant certifies the applicant to issue, dispense, or administer schedule II or schedule III controlled substances, subject to the limits and requirements specified in A.R.S. § 32-2532. Additionally, beginning October 1, 2018, a physician assistant previously certified by the Board for 30-day prescription privileges for schedule II or schedule III controlled substances is certified for 90-day prescription privileges for schedule II or schedule III controlled substances that are not opioids or benzodiazepine.

**Historical Note**

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Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 25 A.A.R. 401, effective April 6, 2019 (Supp. 19-1). Amended by final rulemaking at 28 A.A.R. 1757 (July 22, 2022), effective September 4, 2022 (Supp. 22-3).

**R4-17-204. Fees and Charges**

- A.** As expressly authorized under A.R.S. § 32-2526(A)(1) through (4), the Board shall charge the following fees:
  - 1. License application - \$125.00;
  - 2. Regular license - \$370.00, prorated for each month remaining in the biennial period;
  - 3. Regular license renewal - \$370.00 if the renewal application is postmarked no later than the applicant's birthdate; and
  - 4. Penalty for late renewal - \$100.00.
- B.** Under the specific authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect the following fee to register as an out-of-state health care provider of telehealth services: \$200.
- C.** The fees specified in subsections (A) and (B) are nonrefundable unless A.R.S. §§ 32-2526(B) or 41-1077 applies.
- D.** As expressly authorized under A.R.S. § 32-2526(A)(5) through (9), the Board establishes the following charges for providing the services listed:
  - 1. Duplicate license - \$25.00;
  - 2. Copies of Board documents - \$1.00 for first three pages, \$.25 for each additional page;
  - 3. Medical Directory (CD-ROM) - \$30.00;
  - 4. Data Disk - \$100.00; and
  - 5. License verification - \$100.00.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section adopted effective April 22, 1998 (Supp. 98-2). Section repealed; new Section adopted by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final exempt rulemaking at 27 A.A.R. 1647, with an immediate effective date of September 22, 2021 (Supp. 21-3).

**R4-17-205. Continuing Medical Education; Request for Extension of Time**

- A.** Under A.R.S. § 32-2523(A), renewal of a license is conditioned on the licensee completing 40 hours of category I continuing medical education during each biennial license period.
- B.** During a licensee's first biennial license period, the licensee may complete a pro-rated number of continuing medical education hours established by the Board.
- C.** A licensee who is unable to complete the required hours of continuing medical education for any of the reasons in A.R.S. § 32-2523(E) may submit a written request to the Board for an extension no later than 30 days before expiration of the license that contains:
  - 1. The name, address, and telephone number of the licensee;
  - 2. The reason for the request;
  - 3. The number of continuing medical education hours completed during the biennial license period;
  - 4. The dates on which the remaining hours of continuing medical education are scheduled to be completed; and

- 5. The signature of the licensee.

- D.** The Board shall send a written notice of approval of the extension within seven days from the date of receipt of the request if the Board determines:

- 1. The extension is needed for a reason specified in A.R.S. § 32-2523(E),
- 2. The remaining hours of continuing medical education are scheduled to be completed within 30 days, and
- 3. The extension is in the best interest of the state.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-206. License Renewal**

- A.** To renew a license, a licensee shall submit a completed application to the Board that includes:
  - 1. An application form that contains the licensee's:
    - a. First, last, and middle names;
    - b. Arizona license number;
    - c. Office, mailing, e-mail, and home addresses;
    - d. Office, mobile, and home telephone numbers;
  - 2. A questionnaire that includes answers to the following since the last renewal date:
    - a. Whether the licensee has had an application for a certificate, registration, or license refused or denied by any licensing authority, and if so, an explanation;
    - b. Whether the licensee has had the privilege of taking an examination for a professional license refused or denied by any entity, and if so, an explanation;
    - c. Whether the licensee has voluntarily surrendered a health care professional license, and if so, an explanation;
    - d. Whether the licensee has had a health professional license suspended or revoked, or whether any other disciplinary action has been taken against a health professional license held by the licensee, and if so, an explanation;
    - e. Whether the licensee has had any action taken against the applicant's privileges, including termination, resignation, or withdrawal by a health care institution or health profession regulatory authority, and if so, an explanation;
    - f. Whether the licensee has had a federal or state regulatory authority take any action against the licensee's authority to prescribe, dispense, or administer controlled substances including revocation, suspension, or denial, or whether the applicant surrendered the authority in lieu of any of these actions, and if so, an explanation;
    - g. Whether the licensee has been charged with, convicted of, pleaded guilty to, or entered into a plea of no contest to a felony or misdemeanor involving moral turpitude or an alcohol- or drug-related offense in any state, or has been pardoned or had a record expunged or vacated, and if so, an explanation;
    - h. Whether the licensee has been court-martialed or discharged other than honorably from any component of the uniformed services of the United States, and if so, an explanation;
    - i. Whether the licensee has been involuntarily terminated from a health professional position with any

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city, county, state, or federal government, and if so, an explanation;

- j. Whether the licensee has been convicted of insurance fraud or a state or the federal government has sanctioned or taken any action against the licensee, such as suspension or removal from practice, and if so, an explanation;
- 3. Consistent with the Board's statutory authority, other information the Board may deem necessary to evaluate the licensee fully;
- 4. A dated and sworn statement by the licensee verifying that during the past biennial license period, the licensee completed at least 40 hours of Category I continuing medical education as required by A.R.S. § 32-2523;
- 5. The fee required in R4-17-204;
- 6. A confidential questionnaire that includes answers to the following:
  - a. Whether the licensee currently has a medical condition that impairs the licensee's judgment or ability to practice medicine in a competent, ethical, and professional manner;
  - b. If the answer to subsection (A)(6)(a) is yes:
    - i. Provide an explanation of the medical condition; and
    - ii. If currently practicing under a monitoring agreement with a licensing board in another state, attach a copy of the monitoring agreement to the application; and
- 7. If the document submitted under R4-17-203(B)(1) was a limited form of work authorization issued by the federal government, evidence that the licensee's presence in the U.S. continues to be authorized under federal law.

- B. Under A.R.S. §32-2523(A), the Board shall randomly select at least 10 percent of renewal applications submitted by licensees who are not currently certified by a national certification organization to verify compliance with the continuing medical education requirement specified in R4-17-205(A). If selected, a licensee shall submit to the Board documents that verify compliance with the continuing medical education requirement.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). Amended by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 1757 (July 22, 2022), effective September 4, 2022 (Supp. 22-3).

**R4-17-207. Denial of License or Extension to Complete Continuing Education**

An applicant for a license who is denied the license or a physician assistant who is denied an extension to complete continuing medical education may request a hearing to contest the matter by filing a written notice with the Board within 30 days of receipt of notice of the Board's action. A hearing shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 6 and Article 10.

**Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

**R4-17-208. Expired****Historical Note**

Adopted effective April 22, 1998 (Supp. 98-2). Section expired under A.R.S. § 41-1056(E) at 11 A.A.R. 1569, effective March 31, 2005 (Supp. 05-2).

**ARTICLE 3. DUTIES OF THE EXECUTIVE DIRECTOR****R4-17-301. Dismissal of Complaint**

- A. The executive director, with concurrence of the investigative staff, shall dismiss a complaint if review shows the complaint is without merit and dismissal is appropriate.
- B. The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of physician assistants about whom complaints were dismissed since the preceding Board meeting.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-301 renumbered to R4-17-302; new Section R4-17-301 adopted effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-302. Referral to Formal Hearing**

- A. The executive director may refer a case directly to a formal hearing if the investigative staff, medical consultant, and lead Board member concur after review of the case that a formal hearing is appropriate.
- B. The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of the physician assistants whose cases were referred to formal hearing since the preceding Board meeting and indicate whether each case was referred because it involves revocation, suspension, out-of-state disciplinary action, or complexity.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section repealed; new Section renumbered from R4-17-301 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-303. Non-disciplinary Consent Agreement**

The executive director may enter into a consent agreement under A.R.S. § 32-2505(C)(23) with a physician assistant to limit the physician assistant's practice or rehabilitate the physician assistant if there is evidence the physician assistant is mentally or physically unable to engage in the practice of medicine safely and the investigative staff, medical consultant, and lead Board member concur after review of the case that a consent agreement is appropriate.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section renumbered to R4-17-304; new Section R4-17-303 adopted effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-304. Request for Inactive Status and License Cancellation**

- A. If a physician assistant requests inactive status or license cancellation, meets the requirements of A.R.S. §§ 32-2525 or 32-2528, and is not participating in the program defined under

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A.R.S. § 32-2552(E), the executive director shall grant the request.

- B.** The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of the individuals granted inactive or cancelled license status since the preceding Board meeting.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-304 renumbered to R4-17-305; new Section R4-17-304 renumbered from R4-17-303 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-305. Referral to Formal Interview**

The executive director shall refer a case to a formal interview on a future Board meeting agenda if the investigative staff, lead Board member, and in cases involving quality of care, the medical consultant, concur after review of the case that a formal interview is appropriate.

**Historical Note**

New Section R4-17-305 renumbered from R4-17-304 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-306. Denial of License**

- A.** The executive director shall deny a license to an applicant if the executive director, in consultation with the investigative staff and medical consultant concur after review of the application, that the applicant does not meet the statutory requirements for licensure.
- B.** The executive director shall provide to the Board, at each regularly scheduled Board meeting, a list of the physician assistants whose applications were denied since the preceding Board meeting.

**Historical Note**

New Section made by final rulemaking at 22 A.A.R. 3700, effective February 6, 2017 (Supp. 16-4).

**R4-17-307. Appealing Executive Director Actions**

- A.** Any person aggrieved by an action taken by the executive director under the authority delegated in this Article may appeal that action to the Board. The aggrieved person shall file a written request with the Board no later than:
1. Thirty days after notification of the action, if personally served; or
  2. Thirty-five days after the date on the notification, if mailed.
- B.** The aggrieved person shall provide, in the written request, evidence showing:
1. An irregularity in the investigative process or the executive director's review deprived the party of a fair decision;
  2. Misconduct by Board staff, a Board consultant, or the executive director that deprived the party of a fair decision; or
  3. Material evidence newly discovered that could have a bearing on the decision and that, with reasonable diligence, could not have been discovered and produced earlier.

- C.** The fact that the aggrieved party does not agree with the executive director's action is not grounds for a review by the Board.
- D.** If an aggrieved person fails to submit a written request within the time specified in subsection (A), the Board is relieved of the requirement to review actions taken by the executive director. The executive director may, however, evaluate newly provided information that is material or substantial in content to determine whether the Board should review the case.
- E.** If a written request is submitted that meets the requirements of subsection (B):
1. The Board shall consider the written request at its next regularly scheduled meeting.
  2. If the written request provides new material or substantial evidence that requires additional investigation, the investigation shall be conducted as expeditiously as possible and the case shall be forwarded to the Board at the first possible regularly scheduled meeting.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1757 (July 22, 2022), effective September 4, 2022 (Supp. 22-3).

**ARTICLE 4. COLLABORATIVE PRACTICE; REGULATION****R4-17-401. Application for Certification of Clinical Practice Hours; Waiver of Documentation**

- A.** As required under A.R.S. § 32-2536(A), a physician assistant who is licensed by the Board and in good standing may apply to the Board for certification of the clinical practice hours required to practice collaboratively with a physician or entity. A physician assistant is in good standing if the physician assistant is not:
1. Under investigation by a regulatory authority, or
  2. Subject to a public or confidential probation order.
- B.** To be eligible to practice collaboratively with a physician or entity, a physician assistant shall have at least 8,000 hours of clinical practice, as described in subsection (E), obtained:
1. In the five years before the date of the application submitted under subsection (C), or
  2. In the 10 years before the date of the application submitted under subsection (C) if:
    - a. At least 2,000 hours of clinical practice were obtained in the three years before the date of application submitted under subsection (C); and
    - b. The physician assistant is currently certified by the National Commission on Certification of Physician Assistants.
- C.** To apply for certification of clinical practice hours, a physician assistant shall submit to the Board an application form, which is available on the Board's website.
- D.** In addition to complying with subsection (C), a physician assistant applying for certification of clinical practice hours shall have submitted directly to the Board by the document custodian or an individual with direct knowledge, documentation of hours of clinical practice performed by the physician assistant. Documentation may be submitted by multiple persons.
- E.** Clinical practice includes:
1. Performing medical services related directly to patient care;
  2. Providing instruction to physician assistants at an institution accredited by the Accreditation Review Commission on Education for the Physician Assistant. Time spent preparing to provide instruction or performing administrative

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tive tasks related to providing instruction is not clinical practice.

- F. The Board may waive the documentation requirement specified under subsection (D). To obtain a waiver of the documentation requirement, the physician assistant shall submit to the Board a written request that includes the following information:
1. The physician assistant's name and license number;
  2. Date on the request for waiver;
  3. Identification and an estimate of the number of clinical hours for which documentation has not been submitted under subsection (D);
  4. Description of the physician assistant's efforts to have the documentation submitted as required under subsection (D);
  5. Explanation of why the documentation cannot be submitted;
  6. If applicable, evidence that supports the request for waiver; and
  7. The physician assistant's affirmation that the physician assistant has performed the required hours of clinical practice even though documentation has not been submitted.
- G. The Board shall waive the documentation requirement if the Board determines the documentation is unavailable for a reason beyond the control of the physician assistant requesting the waiver. In making this determination, the Board shall consider:
1. The sufficiency of the physician assistant's effort to have the documentation submitted;
  2. Evidence it is not possible to have the documentation submitted because:
    - a. The required document does not exist;
    - b. The individual or entity responsible for maintaining and submitting the documentation is unable to do so; or
    - c. Another reason beyond the control of the physician assistant; and
  3. Whether the Board is able to obtain the required documentation from another source.
- H. The Board shall document the Board's decision regarding a request for waiver submitted under subsection (F) in the official record regarding the application submitted under subsection (C). The Board's decision regarding a request for waiver is not subject to review or appeal.
- I. The Board shall maintain on the Board's website a list of physician assistants who have at least 8,000 hours of clinical practice certified by the Board and are eligible to practice in collaboration with a physician, physician group practice, or health care institution.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-401 renumbered to R4-17-402; new Section R4-17-401 adopted effective April 22, 1998 (Supp. 98-2). Section expired under A.R.S. § 41-1056(E) at 11 A.A.R. 1569, effective March 31, 2005 (Supp. 05-2). New Section made by final exempt rulemaking at 30 A.A.R. 63 (January 12, 2024), effective December 31, 2023 (Supp. 23-4).

**R4-17-402. Practicing Collaboratively with a Physician Assistant**

- A. Before practicing collaboratively with a physician assistant, the collaborating physician or entity shall verify that the physi-

cian assistant is qualified under A.R.S. § 32-2536 and R4-17-401 to practice collaboratively. The collaborating physician or entity shall maintain evidence of the verification as long as the physician assistant is employed by the collaborating physician or entity.

- B. A collaborating physician or entity shall designate one or more physicians by name or position as responsible for the oversight of the physician assistant. When requested by the Board, the collaborating physician or entity shall notify the Board of the identity of the physician designated as responsible for oversight of the physician assistant.
- C. The collaborating physician or entity shall ensure the physician assistant is competent to practice in any new area that is not substantially similar to the practice area in which the physician assistant previously practiced collaboratively. If the collaborating physician or entity determines the physician assistant needs additional education, training, and oversight, the collaborating physician or entity shall ensure additional education, training, and oversight is provided until the physician assistant acquires the necessary competence.
1. If the collaborating physician or entity determines a supervision agreement is warranted, the collaborating physician or entity shall require the physician assistant to enter a supervision agreement, as defined at A.R.S. § 32-2501, until the physician assistant acquires the education, experience, and competence necessary to practice in the practice setting or specialty in which the physician assistant has not previously practiced.
  2. The collaborating physician or entity shall document all actions taken under this subsection, including any additional education, training, and oversight or the initiation or termination of a supervision agreement, to ensure the actions are recorded in the employment file of the physician assistant. When requested by the Board, the collaborating physician or entity shall provide a copy of the information required under this subsection to the Board.
- D. The collaborating physician or entity shall make a determination required under subsection (C) in collaboration with the physician assistant.
- E. When certified under A.R.S. § 32-2536 to practice collaboratively, a physician assistant shall continue to collaborate or consult with or refer to the appropriate health care professional according to the policies of the practice setting at which the physician assistant is employed.

**Historical Note**

Adopted effective July 8, 1986 (Supp. 86-4). Section R4-17-402 renumbered to R4-17-403; new Section R4-17-402 renumbered from R4-17-401 and amended effective April 22, 1998 (Supp. 98-2). Section repealed by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3). New Section made by final exempt rulemaking at 30 A.A.R. 63 (January 12, 2024), effective December 31, 2023 (Supp. 23-4). The Governor's Regulatory Review Council determined subsections (B) through (G) exceeded the agency's statutory authority, were not authorized by statute, and therefore void under A.R.S. § 41-1033(K) at 30 A.A.R. 2665 (August 23, 2024), effective July 30, 2024; in consultation with the Arizona State Association of Physician Assistants the Board amended the voided provisions in a Notice of Final Exempt Rulemaking at 31 A.A.R. 129 (January 10, 2025), effective December 17, 2024 (Supp. 24-4).

**R4-17-403. Rehearing or Review**

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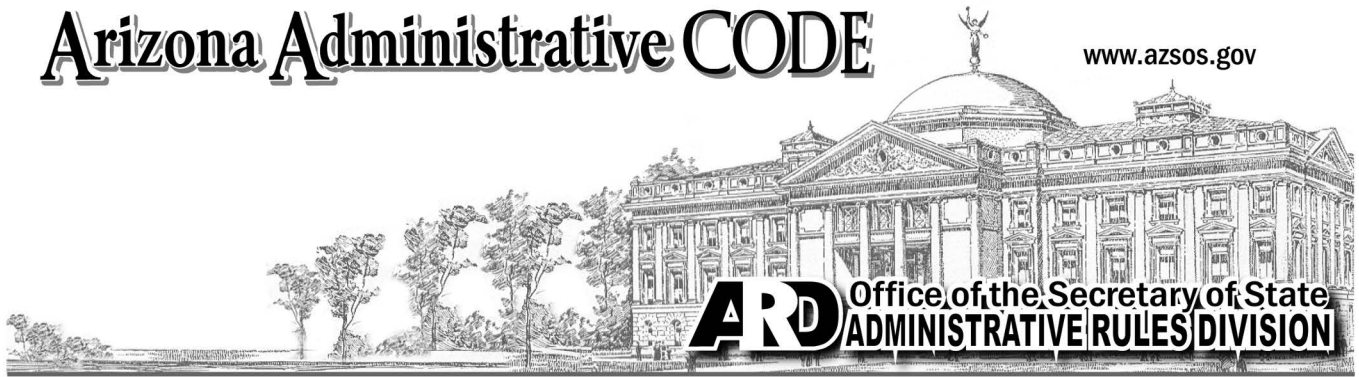
- A. Except as provided in subsection (B), a party who is aggrieved by a decision issued by the Board may file with the Board, no later than 30 days after service of the decision, a written request for rehearing or review of the decision, specifying the grounds for rehearing or review. For purposes of this Section, a decision is considered to have been served when personally delivered to the party's last known home or business address or five days after the decision is mailed by certified mail to the party or the party's attorney.
- B. If the Board makes specific findings that the immediate effectiveness of the decision is necessary for the preservation of the public health and safety and determines that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the Board may issue the decision as a final decision without an opportunity for rehearing or review. If the Board issues the decision as a final decision, without an opportunity for a rehearing or review, the aggrieved party may make an application for judicial review within the time limits permitted for an application for judicial review of the Board's final decision under A.R.S. § 12-904.
- C. A party filing a request for rehearing or review may amend the request at any time before it is ruled upon by the Board. Another party may file a response within 15 days after the date the request or amended request for rehearing is filed. The Board may require a party to file supplemental memoranda explaining the issues raised in the request or response and may permit oral argument.
- D. The Board may grant a rehearing or review of a decision for any of the following causes materially affecting the requesting party's rights:
1. Irregularity in the Board's or administrative law judge's administrative proceedings or any order or abuse of discretion that deprived the party of a fair hearing;
  2. Misconduct of the Board, administrative law judge, or the prevailing party;
  3. Accident or surprise that could not have been prevented by ordinary prudence;
  4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the original hearing;
  5. Excessive or insufficient penalties;
  6. Error in the admission or rejection of evidence, or other errors of law that occurred at the hearing;
  7. The decision is the result of passion or prejudice; or
  8. The decision or findings of fact are not justified by the evidence or are contrary to law.
- E. The Board may affirm or modify a decision or grant rehearing or review on all or part of the issues for any of the reasons set forth in subsection (D). An order granting a rehearing or review shall specify each ground for the rehearing or review.
- F. No later than 30 days after a decision is issued by the Board, the Board on its own initiative may order a rehearing or review for any reason in subsection (D).
- G. When a request for rehearing or review is based on affidavits, a party shall serve the affidavits with the request. The opposing party may, within 10 days after service, serve opposing affidavits. The Board may extend the time for serving opposing affidavits for no more than 20 days for good cause shown or by written stipulation by the parties. The Board may permit reply affidavits.

**Historical Note**

New Section R4-17-403 renumbered from R4-17-402 and amended effective April 22, 1998 (Supp. 98-2). Amended by final rulemaking at 18 A.A.R. 2123, effective October 7, 2012 (Supp. 12-3).

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### CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

<a href="#">R4-18-101.</a>	<a href="#">Definitions .....</a>	<a href="#">3</a>	<a href="#">R4-18-110.</a>	<a href="#">Display of Licenses and Certificates; Notice of</a>	
<a href="#">R4-18-106.</a>	<a href="#">Rehearing or Review of Decision .....</a>	<a href="#">4</a>		<a href="#">Change of Status; Student Identification .....</a>	<a href="#">5</a>
<a href="#">R4-18-108.</a>	<a href="#">Titles, Use of Abbreviations .....</a>	<a href="#">5</a>	<a href="#">R4-18-111.</a>	<a href="#">Notice of Civil and Criminal Actions .....</a>	<a href="#">5</a>

#### Questions about these rules? Contact:

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**The release of this Chapter in Supp. 24-4 replaces Supp. 24-1, 1-19 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

Authority: A.R.S. § 32-1501 et seq.

## Supp. 24-4

*Editor's Note: Laws 2008, 2nd Regular Session, Ch. 16 provided for a name change of the Naturopathic Physicians Board of Medical Examiners to Naturopathic Physicians Medical Board (Supp. 12-2).*

*Editor's Note: The Office of the Secretary of State publishes all Code Chapters on white paper (Supp. 02-3).*

*Editor's Note: This Chapter contains rules which were adopted under exemptions from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 41-1005(25). Exemption from A.R.S. Title 41, Chapter 6 means that the Naturopathic Physicians Board of Medical Examiners did not submit these rules to the Governor's Regulatory Review Council for review; the Board did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Board was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.*

*Editor's Note: This Chapter has been reprinted due to an error in publishing text that was thought to be adopted and certified but in fact was rejected by the Attorney General on December 29, 1995 (Supp. 95-4). Text removed includes amendments made to R4-18-101 and adoption of Article 2, consisting of Sections R4-18-201 through R4-18-205. Removal of this text reflects the latest effective rules on file with the Office of the Secretary of State last modified Supp. 88-4 (reprinted Supp. 96-4).*

*Laws 1982, 6th S.S., Chs. 1 and 4 provided for a name change of the Naturopathic Board of Examiners to Naturopathic Physicians Board of Examiners.*

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*Article 2 consisting of Sections R4-18-201 through R4-18-205 has been deleted due to an error in publishing text that was thought*

*to be adopted and certified but in fact was rejected by the Attorney General on December 29, 1995 (Supp. 95-4). Removal of this text reflects the latest effective rules on file with the Office of the Secretary of State last modified Supp. 88-4 (reprinted Supp. 96-4).*

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

## ARTICLE 1. GENERAL PROVISIONS

**R4-18-101. Definitions**

In addition to the definitions in A.R.S. §§ 32-1501 through 32-1581, the following definitions apply to this Chapter unless otherwise specified:

1. “Administrative completeness review” means the Board’s process for determining that an applicant has provided, or caused to be provided, all of the application packet information and documentation required by statute or rule for an application for a license or a certificate.
2. “Applicant” means a person requesting from the Board an initial, temporary, or renewal license or certificate.
3. “Approved Specialty College or Program” means a post-doctoral training program that awards a medical specialist certificate, and is certified by a Specialty Board of Examiners, The American Association of Naturopathic Physicians (“AANP”) or another professional association or, another state’s licensing agency, and which is recognized by the Board.
4. “Chief medical officer” means a physician who is responsible for a clinical, preceptorship, internship, or postdoctoral training program’s compliance with state and federal laws, rules, and regulations.
5. “Continuing medical education” or “CME” means courses, seminars, lectures, programs, conferences, and workshops related to subjects listed in A.R.S. § 32-1525(B), that are offered or sanctioned by one of the organizations referenced in R4-18-205(B).
6. “Endorsement” means the procedure for granting a license in this state to an applicant who is currently licensed to practice naturopathic medicine by another state, district, or territory of the United States or by a foreign country that requires a written examination substantially equivalent to the written examination provided for in A.R.S. § 32-1525.
7. “Facility” means a health care institution as defined in A.R.S. § 36-401, office or clinic maintained by a health care institution or by an individual licensed under A.R.S. Title 32, Chapter 13, 14, 17, or 29, office or public health clinic maintained by a state or county, office or clinic operated by a qualifying community health center under A.R.S. § 36-2907.06, or an office or clinic operated by a corporation, association, partnership, or company authorized to do business in Arizona under A.R.S. Title 10.
8. “Informed consent” means a document, signed by a patient or the patient’s legal guardian, which contains the information in R4-18-802(A)(1), (A)(2), and (A)(3).
9. “Institutional review board” means a group of persons that is approved according to guidelines of the United States Department of Health and Human Services, Office for Human Research Protection, which reviews investigational or experimental protocols and approves their use on animals or humans for the purposes of protecting the subjects of the investigational or experimental protocol from undue harm and assures that the research and its review is carried out according to guidelines of the United States Department of Health and Human Services, Office for Human Research Protection.
10. “Internship” means clinical and didactic training by a doctor of naturopathic medicine certified by the Board according to A.R.S. § 32-1561.
11. “License” means a document issued by the Board that authorizes the individual to whom it is issued to practice naturopathic medicine.
12. “Medication” means the same as drug defined in A.R.S. § 32-1501(15) or natural substance defined in A.R.S. § 32-1501(23).
13. “National board” means any of the following:
  - a. The Federation of State Medical Licensing Boards,
  - b. The National Board of Chiropractic Examiners,
  - c. The National Board of Medical Examiners,
  - d. The National Board of Osteopathic Examiners, or
  - e. The North American Board of Naturopathic Examiners.
14. “Procedure” means an activity directed at or performed on an individual for improving health, treating disease or injury, or making a diagnosis.
15. “Protocol” means an explicit detailed plan of an experimental medical procedure or test that is approved by an institutional review board.
16. “Resident physician in training” means a person who holds a degree of doctor of naturopathic medicine and is certified by the Board to diagnose and treat patients under supervision in an internship, preceptorship, or a post doctoral training program.
17. “Substantive review” means the Board’s process for determining whether an applicant for licensure, certification, or approval meets the requirements of A.R.S. Title 32, Chapter 14 and this Chapter.
18. “Verified” means a notarized form dated, and signed by the applicant, affirming the information provided in the application, including any accompanying documents submitted by or on behalf of the applicant, is true and complete.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6).

Amended effective December 29, 1995 (Supp. 95-4).

Amended Section corrected Supp. 96-4 to reflect adopted Section on file with the Office of the Secretary of State effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3). Amended by final rulemaking at 30 A.A.R. 3091 (October 25, 2024), effective December 1, 2024 (Supp. 24-4).

**R4-18-102. Board Meetings; Elections; Officers**

- A. The Board shall hold a regular meeting in January and July of each year. The officers shall be elected at the January meeting of the Board by majority vote of the Board members present at that meeting. The Board chairman shall preside at all Board meetings. If the chairman is disqualified or unable to attend, the Board vice-chairman shall preside at the meeting. If the Board vice-chairman is disqualified or unable to attend, the Board secretary-treasurer shall preside at the meeting.
- B. If an officer’s position becomes vacant, the Board shall elect a member of the Board to complete the term of office that is vacant.
- C. A Board member shall attend meetings scheduled by the Board. The Board may recommend to the Governor that a Board member who fails to attend three consecutive Board meetings be removed from the Board.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6).

Amended by final rulemaking at 8 A.A.R. 3702, effective

## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

August 9, 2002 (Supp. 02-3).

**R4-18-103. Duties of Board Committees**

A committee appointed by the Board chairman shall make a report to the Board based on the findings or investigations of the committee and may make recommendations for further action by the Board.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-104. Repealed****Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Amended by adding a new subsection (H) effective June 18, 1987 (Supp. 87-2). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-105. Reserved****R4-18-106. Rehearing or Review of Decision**

- A. Except as provided in subsection (G), any party under the jurisdiction of the Board who is aggrieved by a decision issued by the Board regarding an appealable agency action, may file with the Board not later than 30 days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds for the rehearing or review. For purposes of this Section, a decision is considered served when personally delivered or five days after mailing by certified mail to the party at the party's last known residence or place of business.
- B. A motion for rehearing or review under this Section may be amended at any time before it is ruled upon by the Board. A response may be filed within 15 days after service of the motion or amended motion by any other party. The Board may require the filing of written briefs upon the issue raised in the motion and may provide for oral argument.
- C. A rehearing or review of a decision may be granted by the Board for any of the following reasons materially affecting the party's rights:
  1. Irregularity in the proceedings of the Board, administrative law judge, or any abuse of discretion that deprives the moving party of a fair hearing;
  2. Misconduct of the Board or an administrative law judge;
  3. Accident or surprise that could not have been prevented by ordinary prudence;
  4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
  5. Excessive or insufficient penalties;
  6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing; or
  7. That the findings of fact or decision is not justified by the evidence, or is contrary to law.
- D. The Board may affirm or modify its decision or grant a rehearing or review, to all or any of the parties on all or part of the issues for the reasons specified in subsection (C). An order modifying a decision or granting a rehearing or review shall specify with particularity the grounds on which the rehearing or review is granted, and the rehearing or review shall cover only those matters specified.
- E. Not later than 35 days after the date a decision is rendered, the Board may, on its own initiative order a rehearing or review of its decision for any reason for which it might have granted a

rehearing or review on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion. In either case, the order shall specify the grounds for rehearing and review.

- F. When a motion for rehearing is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. The Board may extend this period for good cause.
- G. If the Board makes specific findings that the immediate effectiveness of the decision is necessary for the preservation of the public health and safety and determines that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review. If a decision is issued as a final decision without an opportunity for rehearing or review, any application for judicial review of the decision shall be made within the time limits permitted for applications for judicial review of the Board's final decisions under A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed; new Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 30 A.A.R. 3091 (October 25, 2024), effective December 1, 2024 (Supp. 24-4).

*Editor's Note: The following Section was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 41-1005(25). Exemption from A.R.S. Title 41, Chapter 6 means the Board did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Board did not submit the rules to the Governor's Regulatory Review Council for review; and the Board was not required to hold public hearings on this Section (Supp. 99-3).*

**R4-18-107. Fees**

- A. Application fees are as follows:
  1. Medical license, \$225
  2. Certificate to dispense, \$225
  3. Medical assistant certificate, \$100
  4. Clinical training certificate, \$0.00
  5. Preceptorship certificate, \$100
  6. Specialty certificate, \$225
- B. Arizona naturopathic jurisprudence examination, \$30
- C. Annual renewal fees are as follows:
  1. Medical license, \$165
  2. Certificate to Dispense, \$225
  3. Medical assistant certificate, \$150
  4. Clinical training certificate, \$0.00
  5. Preceptorship certificate, \$225
  6. Renewal of Specialty certificate, \$225
- D. Late renewal fees are as follows:
  1. Medical license \$83
  2. Certificate to dispense, \$113
  3. Medical assistant certificate, \$75
  4. Clinical training certificate, \$0.00
  5. Preceptorship certificate, \$113
  6. Specialty certificate, \$113
- E. Other fees are as follows:
  1. For a duplicate license or certificate, \$20

## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

2. For photocopying Board records, documents, letters, applications, or files, \$5 or \$0.25 per page, whichever is greater.
3. For each audio tape or computer disk containing information requested, \$25
4. For written verification of a license or certificate, \$5
5. For the costs in locating a person who is licensed or certified, Actual cost incurred by the Board.
6. For each insufficient fund check, \$25.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Amended as an emergency effective December 31, 1986, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 86-6). Emergency expired. Amended and adopted as a permanent rule effective June 18, 1987 (Supp. 87-2). Amended paragraph (3) effective November 10, 1988 (Supp. 88-4). Section repealed; new Section adopted by exempt rulemaking at 5 A.A.R. 2874, effective July 28, 1999 (Supp. 99-3). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by exempt rulemaking at 18 A.A.R. 1499, effective June 6, 2012 (Supp. 12-2). Amended by exempt rulemaking at 19 A.A.R. 1986, effective September 16, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3). Amended by exempt rulemaking at 28 A.A.R. 2643 (October 7, 2022), effective November 13, 2022 (Supp. 22-3).

**R4-18-108. Titles, Use of Abbreviations**

- A. A physician issued a license by the Board may use any of the following titles or abbreviations:
  1. Doctor of Naturopathic Medicine,
  2. N.M.D.,
  3. Doctor of Naturopathy,
  4. N.D.,
  5. Naturopath,
  6. Naturopathic Physician, or
  7. Naturopathic Medical Doctor.
- B. A physician issued a license, or a graduate of a school approved by the Board, shall not use any of the following titles or abbreviations:
  1. Doctor of medicine (naturopathic),
  2. M.D.(N.), or
  3. M.D. (naturopathic).
- C. An unlicensed graduate of an approved school of naturopathic medicine as defined in A.R.S. § 32-1501(8)(a) and (b), who is certified by the Board to engage in preceptorship training shall use the designation “(Preceptee)” after any of the designations in subsection (A). The preceptee shall also ensure that any patient treated by the preceptee signs an informed consent treatment form stating clearly that the preceptee is undergoing training, is not licensed, and identifying the name of the supervising physician.
- D. An unlicensed graduate of an approved school of naturopathic medicine as defined in A.R.S. § 32-1501(8)(a) and (b), who is certified by the Board to engage in internship training shall use the designation “(Intern)” after any of the designations in subsection (A). The intern shall ensure that any patient treated by the intern signs an informed consent treatment form stating clearly that the intern is undergoing training, is not licensed and identifying the name of the supervising physician.
- E. A person who is retired from the practice of naturopathic medicine under A.R.S. § 32-1528 may use any of the designations

listed in subsection (A) if that person also uses the designation “(Retired)” after each designation.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 30 A.A.R. 3091 (October 25, 2024), effective December 1, 2024 (Supp. 24-4).

**R4-18-109. Repealed****Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-110. Display of Licenses and Certificates; Notice of Change of Status; Student Identification**

- A. Each person licensed by the Board shall display that license, or a Board issued duplicate in a conspicuous place in each location in which the person conducts regular and ongoing patient care activity.
- B. A person regulated by the Board shall notify the Board of any change in the information provided to the Board concerning a license or certificate application or its renewal, including changes in name, address, place of practice, or actions taken against the licensee, for any reason, in any court or by any governmental regulatory body.
- C. Each person certified by the Board to engage in clinical training shall wear an identification card issued by the approved naturopathic medical school conducting the training that clearly identifies the person as a student, at all times that the person is involved in clinical training. An approved school may keep all certificates to engage in clinical training issued by the Board at a central location of the primary training facility, if it is easily available for public viewing.
- D. Each person, that is issued a certificate by the Board shall display that certificate or a Board issued duplicate, in a conspicuous place at each location in which the person, business, or institution conducts regular and ongoing business activity.
- E. All notice requirements under this Section shall be in writing and made within 30 days of change of status.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 30 A.A.R. 3091 (October 25, 2024), effective December 1, 2024 (Supp. 24-4).

**R4-18-111. Notice of Civil and Criminal Actions**

- A. As required under A.R.S. § 32-3208, a person licensed or certified by the Board shall, within 10 days of receipt, notify the Board of any notice, subpoena, summons, or receipt of complaint, whether civil or criminal, arising directly or indirectly out of the person’s conduct of the person’s professional activities.
- B. To provide notice to the Board a person licensed or certified by the Board shall provide a copy of the notice or other service or a letter advising the Board of the nature of the cause of action allegations made, and the date, time, and place where appearance is required.

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Amended by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking



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ing at 30 A.A.R. 3091 (October 25, 2024), effective December 1, 2024 (Supp. 24-4).

**R4-18-112. Reserved**

**R4-18-113. Reserved**

**R4-18-114. Reserved**

**R4-18-115. Reserved**

**R4-18-116. Repealed**

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-117. Repealed**

**Historical Note**

Adopted effective December 31, 1984 (Supp. 84-6). Section repealed by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**ARTICLE 2. LICENSES; SPECIALIST CERTIFICATES; CONTINUING MEDICAL EDUCATION; RENEWAL**

**R4-18-201. Jurisprudence Examination**

In addition to the requirements of R4-18-202 or R4-18-203, every applicant for licensure shall take and pass the Arizona Naturopathic Jurisprudence Examination, administered by the Board, with a minimum score of 75%. The examination shall consist of multiple-choice and true-false questions. If an applicant passes the jurisprudence examination to obtain a clinical training certificate under R4-18-501 and is under the continuous regulation of the Board after obtaining the clinical training certificate, the applicant is not required to take the examination again.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-202. License by Examination**

In addition to the requirements of R4-18-201, an applicant for licensure by examination shall meet the requirements of A.R.S. Title 32, Chapter 14 and provide the Board:

1. A completed application form, provided by the Board that is signed, dated, and verified; and shall include the following information;
  - a. Applicant's full name and any former names used by the applicant;
  - b. Applicant's place and date of birth;
  - c. Applicant's Social Security number;
  - d. Applicant's home, business, and e-mail addresses;
  - e. Applicant's home, business, and cell phone numbers;
  - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
  - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
  - h. The date applicant took and passed the required NPLEX examinations of Part I; Biomedical examination, Part II; Clinical Science examination, Part II; Core Clinical Science Examination, and the Clinical Elective examinations in acupuncture, and minor surgery. The date applicant took and passed the examination in Arizona naturopathic jurispru-

dence that is administered by the Board. Applicant must have taken and passed all the required examinations within a five-year period immediately preceding the date of application submission to the Board;

- i. A list of all license or certificates issued or denied by any agency. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status, and whether or not any disciplinary actions are pending or have ever been taken;
- j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
- k. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency;
- l. Whether applicant has ever been disciplined by any agency for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
- m. Whether applicant, in lieu of disciplinary action, has entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
- n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
- o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, in any state, district or territory of the United States or country;
- p. Whether applicant has ever been found medically incompetent;
- q. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
- r. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
- s. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
2. A copy of the applicant's complete NPLEX examination record, to be sent directly to the Board by the North American Board of Naturopathic Examiners ("NABNE") or its successor;
3. A complete transcript sent directly to the Board from the approved school of naturopathic medicine from which the applicant graduated. The transcript shall include the date of graduation and the date of completion of clinical training;
4. A complete and legible fingerprint card, including the DPS processing fee as specified on the application form;
5. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, and;
6. The fees specified in R4-18-107.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702,



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effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-203. License by Endorsement**

In addition to the requirements of R4-18-201, an applicant for licensure by endorsement shall meet the requirements of A.R.S. Title 32, Chapter 14, and provide the Board:

1. A completed application form, provided by the Board that is signed, dated, and verified, which shall include the following information;
  - a. Applicant's full name and any former names used by the applicant;
  - b. Place and date of birth;
  - c. Social Security number;
  - d. Home, business, and e-mail addresses;
  - e. Home, business, and cell phone numbers;
  - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
  - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
  - h. The date applicant took and passed the examination in Arizona naturopathic jurisprudence that is administered by the Board, and the required NPLEX examinations of Part I; Biomedical examination, Part II; Clinical Science examination, Part II; Core Clinical Science Examination, the Clinical Elective examination in acupuncture, and the Clinical Elective examination in minor surgery;
  - i. A list of all license or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status, and whether or not any disciplinary actions are pending or have ever been taken;
  - j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
  - k. Whether applicant has ever had a naturopathic medical license or certification, or any other profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
  - l. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
  - m. Whether applicant, in lieu of disciplinary action, has entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
  - n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
  - o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law; in any state, district or territory of the United States or another country;
2. A document submitted directly to the Board by the agency by whom the applicant is licensed as a naturopathic physician that is signed and dated by an official of the agency and that contains:
  - a. The applicant's name;
  - b. The date of issuance of the license;
  - c. The current status of the license;
  - d. A statement of whether the applicant has ever been denied a license by the agency, and;
  - e. A statement of whether any disciplinary action is pending or has ever been taken against the applicant;
3. A copy of the applicant's complete NPLEX examination record, to be sent directly to the Board by the North American Board of Naturopathic Examiners "NABNE") or its successor;
4. A complete transcript sent directly to the board from the approved school of naturopathic medicine from which the applicant graduated. The transcript shall include the date of graduation and the date of completion of clinical training.
5. Applicant must provide evidence of being actively engaged, for at least three years immediately preceding the application, in one or more of the following:
  - a. The active practice as a licensed doctor of naturopathic medicine;
  - b. Participation in an approved internship, preceptorship or clinical training program in naturopathic medicine, as defined in A.R.S. § 32-1501(4), (5), (7);
  - c. Participation in an approved postdoctoral training program in naturopathic medicine, as defined in A.R.S. § 32-1501(6);
  - d. Active in the resident study of naturopathic medicine at an approved school of naturopathic medicine, as defined in A.R.S. § 32-1501(8)(a) and (b);
6. A complete and legible fingerprint card, including the DPS processing fee, as specified on the application form;
7. A passport size photograph taken within 60 days prior to application submission, that is signed on the back by the applicant;
8. The fees specified in R4-18-107;
9. Applicants who were licensed in another state or a Canadian province before January 1, 2005, shall include evidence of completion of additional 60 hours of continuing medical education ("CME") in the subject of pharmacotherapeutics. The CME must be offered, sanctioned, or accredited by one of the organizations referenced in R4-18-205(B)(1), (2)(a), (b), (c) or (4)(a), (b), (c), and include an examination. In the event the applicant cannot provide satisfactory evidence of completion of the required pharmacotherapeutics, or the required examinations, pursuant to A.R.S. § 32-1524(E), and (G)(3), the applicant will have an additional 365 days from the date

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the board notifies the applicant of the deficiency, to supply satisfactory evidence of completion.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3). Duplicate word "has" removed under subsection (1)(m) (Supp. 22-3).

**R4-18-204. Specialists Certificate**

To obtain a specialist certificate, a physician shall meet the requirements of A.R.S. Title 32, Chapter 14 and provide the Board:

1. A completed application form, provided by the Board that is signed, dated, and verified, which shall include the following information;
  - a. Applicant's full name;
  - b. Current State of Arizona Naturopathic Physicians Medical License number;
  - c. Email address, phone number, and mailing address;
  - d. Name and address of the approved specialty college or program from which applicant completed post-doctoral specialty training;
  - e. The specialty applicant received training in, and a copy of the certificate of completion received in the specialty;
  - f. Who the specialty program was approved by;
  - g. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine;
  - h. Whether applicant has ever been disciplined by any agency in any state or territory of the United States, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
  - i. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state or territory of the United States, and;
  - j. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
2. The fees specified in R4-18-107 and;
3. A letter from the specialty board that conducted the specialty examination verifying that the licensee is certified as a specialists in the specialty for which application is made;
4. A certificate issued to a physician pursuant to A.R.S. § 32-1529(C.), shall be concurrently renewed, suspended or revoked, with that physician's license to practice naturopathic medicine.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-205. Continuing Medical Education Requirements**

- A. Every calendar year, a physician shall complete 30 credit hours of approved continuing medical education activities. Ten credit hours shall be in pharmacology as it relates to the diagnosis, treatment, or prevention of disease. Eight credit hours shall be from programs approved by one or more of the organizations listed in subsection (B)(2). One hour of credit is allowed for every 50 minutes of participation in an approved

continuing medical education activity unless otherwise noted in R4-18-205(B).

- B. The following are approved continuing medical education activities:

1. Education certified as Category I by an organization accredited by the Accreditation Council on Continuing Medical Education;
2. Continuing medical educational programs in the clinical application of naturopathic medical philosophy that are approved by;
  - a. The American Association of Naturopathic Physicians or any of its constituent organizations,
  - b. The Arizona Naturopathic Medical Association, or
  - c. Any naturopathic licensing authority in the United States or Canada.
3. One credit hour may be claimed for each eight hour day of training in an internship training program, a preceptorship training program, or a postdoctoral training program approved by the Board. A maximum of eight hours per year may be claimed in this manner.
4. One credit hour, not to exceed eight credit hours, may be claimed for each eight hour day of research in subjects listed in A.R.S. § 32-1525(B), if the research is conducted by or sponsored by a school of naturopathic medicine that is accredited or a candidate for accreditation by:
  - a. The Council on Naturopathic Medical Education,
  - b. The Council for Higher Education Accreditation, or
  - c. An accrediting agency recognized by the United States Department of Education.
5. One credit hour may be claimed for each hour serving as an instructor of naturopathic medical students or other physicians in a program approved by one of the organizations listed in subsection (B)(2), or a school approved by the Board. A maximum of eight hours may be claimed in this manner.
6. A maximum of four credit hours may be claimed for preparing or writing for presentation or publication, a medically related paper, report, or book that is presented or published addressing current developments, skills, procedures, or treatment in the practice of naturopathic medicine. Credit may be claimed only for materials presented or published. Credit may be claimed once as of the date of publication or presentation.
7. A maximum of eight credit hours may be earned for the following activities that provide necessary understanding of current developments, skills, procedures, or treatment related to the practice of naturopathic medicine if the physician maintains a record for at least three years that includes the name of the activity, the date of the activity, and the amount of time to complete the activity:
  - a. Self-instruction that utilizes videotapes, audiotapes, films, filmstrips, slides, radio broadcasts, or computers;
  - b. Independent reading of scientific journals and books;
  - c. Preparation for specialty board certification or recertification examinations; or
  - d. Participation on a staff committee or quality of care or utilization review committee in a facility or government agency.

- C. The Board shall grant an extension of time to complete continuing medical education required in subsection (A) upon written application by a licensee if the licensee fails to meet the requirements due to illness, military service, medical or religious missionary activity, residence in a foreign country, or

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other extenuating circumstance. An extension, other than for military service, shall not exceed 90 days.

- D. An applicant for renewal of a license shall certify on the application for renewal, under penalty of perjury, that the applicant has met or will meet, before January 1, the continuing medical education requirements for the calendar year.
- E. Board staff shall annually select a minimum of ten percent of the active licensees for an audit of required continuing medical education. Failure to complete the required continuing medical education is considered unprofessional conduct.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-206. Renewal of a License**

To renew a license to practice naturopathic medicine, on or before January 1 of each year, a licensee shall submit a complete license application renewal form, that allows the Board to determine whether the applicant continues to meet the requirements of A.R.S. Title 32, Chapter 14. If an applicant makes a timely and complete application for renewal of the applicant's license, the physician may continue to practice until the application is approved or denied by the Board.

1. A completed application form, provided by the Board that is signed, dated, and verified, which shall include the following information;
  - a. Applicant's full name;
  - b. Applicant's State of Arizona Naturopathic Physicians Medical License number and initial issuance date of the license;
  - c. Applicant's home, business, and choice of e-mail addresses, and choice of mailing address;
  - d. Applicant's home, business, and cell phone numbers;
  - e. Applicant's attestation of completion of the Continuing Medical Education credit hours required to renew the medical license;
  - f. A statement indicating whether, during the last 12 months, applicant was arrested, charged with, convicted of, or entered into a plea of no contest to any criminal act;
  - g. A statement indicating whether, during the last 12 months, applicant had any licensing agency or board, in any state, district or territory of the United States or another country, initiate or take any action against any license or certificate that is or was held;
  - h. A statement indicating whether, during the last 12 months, applicant entered into a consent agreement or stipulation with any agency in lieu of disciplinary action in any state, district or territory of the United States or another country;
  - i. A statement of whether during the last 12 months applicant was named in a malpractice suit;
  - j. A statement of whether applicant has a complaint currently pending before any agency, or court of law; in any state, district or territory of the United States or another country;
  - k. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background; and
2. The fee specified in R4-18-107.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final

rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-207. Reinstatement of an Expired License or Certificate**

- A. In order to reinstate an expired license, an applicant must meet the requirements in A.R.S. § 32-1526, and pay a renewal and penalty fee for each year the license has been expired. In addition, the applicant must demonstrate completion of 30 hours of continuing medical education for each year the license has been expired. The CME must cover clinical application of naturopathic medical philosophy, pharmacology, and be accredited by the Accreditation Council on Continuing Medical Education or approved by any of the programs listed in R4-18-201(B)(2).
- B. The applicant must provide the Board with:
  1. A completed application form, provided by the Board that is signed, dated, and verified; which shall include the following information;
    - a. Applicant's full name and any former names used by the applicant;
    - b. Applicant's place and date of birth;
    - c. Applicant's Social Security number;
    - d. Applicant's home, business, and e-mail addresses;
    - e. Applicant's home, business, and cell phone numbers;
    - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
    - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
    - h. A list of all license or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status and whether or not any disciplinary actions are pending or have ever been taken;
    - i. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
    - j. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
    - k. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
    - l. Whether in lieu of disciplinary action, has applicant ever entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
    - m. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
    - n. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency

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- or court of law in any state, district or territory of the United States or another country;
- o. Whether applicant has ever been found medically incompetent;
- p. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
- q. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
- r. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
- 2. A complete and legible fingerprint card, including the DPS processing fee as specified on the application form;
- 3. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant;
- C. An applicant for reinstatement of an expired certificate to dispense must complete the renewal application form and pay the renewal and late fees for each year the certificate has been expired;
- D. An applicant for reinstatement of a certificate to dispense must complete the initial application form for the certificate. Pursuant to A.R.S. § 32-1526(H), an applicant for reinstatement of an expired certificate shall pay all renewal and penalty fees;
- E. A applicant who held a specialty certificate that expired with the license, may request reinstatement of the certificate on the application for reinstatement of the medical license.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R.  
2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-208. Reinstatement of a Retired License**

- A. A person may apply to reinstate a retired license to active practice, upon payment of the renewal fee. As a condition of reinstatement of a retired license, pursuant to A.R.S. § 32-1528, each applicant shall provide proof of completion of 30 hours of continuing medical education, and provide the Board with:
  - 1. A completed application form, provided by the Board that is signed, dated, and verified; which shall include the following information:
    - a. Applicant's full name and any former names used by the applicant;
    - b. Applicant's place and date of birth;
    - c. Applicant's Social Security number;
    - d. Applicant's home, business, and e-mail addresses;
    - e. Applicant's home, business, and cell phone numbers;
    - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
    - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
    - h. The dates applicant retired the license;
    - i. A list of all licenses or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status and whether or not any disciplinary actions are pending or have ever been taken;

- j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
- k. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
- l. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
- m. Whether in lieu of disciplinary action, has applicant ever entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
- n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
- o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law in any state, district or territory of the United States or another country;
- p. Whether applicant has ever been found medically incompetent;
- q. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
- r. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
- s. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background.
- 2. A complete and legible fingerprint card, including the DPS processing fee as specified on the form;
- 3. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant;
- 4. The fees specified in R4-18-107; and
- 5. Provide proof of completion of 30 hours of CME taken, within the last 12 months prior to application submission. The CME is in addition to the 30 hours required each year for license renewal, must cover clinical application of naturopathic medical philosophy, pharmacology, and be accredited by the Accreditation Council on Continuing Education, or approved by any of the programs listed in R4-18-201(B)(2).
- B. An applicant for reinstatement of a retired certificate to dispense must complete the renewal application form for the certificate, and pay the fee specified in R4-18-107.
- C. An applicant who held a specialty certificate that retired with the license, may request reinstatement of the certificate on the application for reinstatement of the medical license.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R.  
2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-209. Reinstatement of a Suspended, Revoked, or Surrendered License or Certificate**

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- A.** A person may apply to the board for the termination of the suspension or reissuance of a revoked license. Pursuant to A.R.S. § 32-1551, the board shall make its determination on each application as it deems consistent with the public health, safety and just in the circumstances. The applicant must provide the Board with;
1. A completed application form, provided by the Board that is signed, dated, and verified; which shall include the following information;
    - a. Applicant's full name and any former names used by the applicant;
    - b. Applicant's place and date of birth;
    - c. Applicant's Social Security number;
    - d. Applicant's home, business, and e-mail addresses;
    - e. Applicant's home, business, and cell phone numbers;
    - f. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
    - g. The name of the approved naturopathic college applicant graduated from, date of graduation, and date of clinical training completion;
    - h. Documentation showing that the basis for the suspension or revocation has been removed, and that suspension termination or reinstatement of the license or certificate, does not constitute a threat to the public health or safety;
    - i. A list of all license or certificates issued or denied by any agency in any state, district or territory of the United States or another country. Applicant must cause to have a document submitted directly to the Board from each agency listed, containing the applicant's name, date of issuance or denial, current status and whether or not any disciplinary actions are pending or have ever been taken;
    - j. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
    - k. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
    - l. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
    - m. Whether in lieu of disciplinary action, has applicant ever entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
    - n. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
    - o. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law in any state, district or territory of the United States or another country;
    - p. Whether applicant has ever been found medically incompetent;
    - q. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
    - r. Whether applicant has a medical condition that in any way impairs or limits applicant's ability to practice medicine, and;
    - s. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
  2. A complete and legible fingerprint card, including the DPS processing fee as specified on the application form;
  3. A passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, and;
  4. The fees specified in R4-18-107;
  5. Proof of completion of 30 hours of CME for each year the license has been suspended or revoked. The CME is in addition to the 30 hours required each year for license renewal, must cover clinical application of naturopathic medical philosophy and pharmacology, and, be accredited by the Accreditation Council on Continuing Education, or approved by any of the programs listed in R4-18-205(B)(2);
- B.** An applicant for reinstatement of a suspended or revoked certificate to dispense shall submit a complete renewal form, along with the fee specified in R4-18-107;
- C.** An applicant who held a specialty certificate that was suspended or revoked with the license, may request reinstatement of the certificate on the application for reinstatement of the medical license.
- D.** An applicant seeking licensure after the surrendered of a license or certificate must apply and meet the requirements as a new applicant.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**ARTICLE 3. RESERVED****ARTICLE 4. APPROVAL OF SCHOOLS OF NATUROPATHIC MEDICINE****R4-18-401. Approval of a School of Naturopathic Medicine**

The Board shall approve a school of naturopathic medicine if, in addition to the requirements of A.R.S. § 32-1501(8):

1. It is accredited or a candidate for accreditation by the Council on Naturopathic Medical Education, or its successor agency, and
2. It has complied with the requirements of the Arizona State Board of Private Post Secondary Education in A.R.S. Title 32, Chapter 30 and A.A.C. 4-39-101 through 4-39-603.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-402. Annual Renewal of an Approved School of Naturopathic Medicine**

An approved school of naturopathic medicine shall be renewed by submitting on or before January 1 of each year, the information required by the Board that allows the Board to determine if the applicant continues to meet the requirements of A.R.S. § 32-1501(8) and of R4-18-401.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702,

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effective August 9, 2002 (Supp. 02-3).

# **ARTICLE 5. NATUROPATHIC CLINICAL TRAINING AND PRECEPTORSHIP TRAINING PROGRAM REQUIREMENTS**

## **R4-18-501. Certificate to Engage in Clinical or Preceptorship Training**

- A.** To obtain a certificate to engage in clinical or preceptorship training, an applicant shall submit to the Board a complete application form provided by the Board, that allows the Board to determine if the applicant meets the requirements of A.R.S. § 32-1524. The application shall be verified, and include the fee listed in R4-18-107;
- B.** In addition to the requirements in subsection (A) a naturopathic medical student who applies for a certificate to engage in clinical training shall comply with the requirements of A.R.S. § 32-1560, and, be attending an approved naturopathic medical school. Applicant must arrange to have submitted directly to the Board, a letter from the chief medical officer of the medical school verifying that the applicant will be entering clinical training, and the anticipated starting and completion dates. The Board may deny an application for any reason set forth in A.R.S. § 32-1501(31) and A.R.S. § 32-1522(A)(3) through (6);
- C.** Applicant must take and pass the examination in Arizona naturopathic jurisprudence that is administered by the Board, with a minimum score of 75%, include with the application a passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, provide a legible fingerprint card, including the DPS processing fee as specified on the application form;
- D.** The application form for clinical training entry shall include:
  1. Applicant's full name and any former names used by applicant;
  2. Applicant's place and date of birth;
  3. Applicant's Social Security number;
  4. Applicant's home and email address;
  5. Applicant's home and cell phone numbers;
  6. The name and address of the approved naturopathic college applicant is attending; name and address of clinical training program, the date of clinical entry and the date of completion of clinical entry;
  7. The name of the Supervising Physician and the name of the Chief Medical Officer of the Clinical Training program;
  8. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
  9. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any agency in any state, district or territory of the United States or another country;
  10. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
  11. Whether applicant, in lieu of disciplinary action, has entered into a consent agreement or stipulation with a licensing agency in any state, district or territory of the United States or another country;
  12. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court of law, in any state, district or territory of the United States or another country;
13. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, in any state, district or territory of the United States or another country;
14. Whether applicant has ever been found medically incompetent;
15. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
16. Whether applicant has a medical condition, that in any way, impairs or limits applicant's ability to practice medicine;
17. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background, and;
18. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence;
- E.** In addition to the requirements in subsection (A), an applicant for a certificate to engage in a preceptorship training program shall comply with the requirements of A.R.S. § 32-1561 and arrange to have submitted directly to the Board, an official transcript from the approved naturopathic medical school from which the applicant graduated;
- F.** Applicant must take and pass the examination in Arizona naturopathic jurisprudence that is administered by the Board with a minimum score of 75%, include with the application, a passport size photograph taken within 60 days prior to application submission that is signed on the back by the applicant, provide a legible fingerprint card, including the DPS processing fee as specified on the application form;
- G.** The application form for preceptorship training shall include:
  1. Applicant's full name and any former names used by applicant;
  2. Applicant's place and date of birth;
  3. Applicant's Social Security number;
  4. Applicant's home and email address;
  5. Applicant's home and cell phone numbers;
  6. The name, address, and medical license number of the Supervising Physician, designated Supervising Physician, if any, and Chief Medical Officer;
  7. Attestation signed by the Supervising Physician declaring they have read and understand A.R.S. § 32-1561 and R4-18-108, and agree to be the Supervising physician of record;
  8. Whether applicant has ever been arrested, charged with, convicted of, or entered into a plea of no contest to a felony or a misdemeanor;
  9. Whether applicant has ever had a naturopathic medical license or certification, or any other health profession license or certification denied, suspended, rejected or revoked by any state, district or territory or the United States or another country;
  10. Whether applicant has ever been disciplined by any agency in any state, district or territory of the United States or another country, for any act of unprofessional conduct as defined in A.R.S. § 32-1501;
  11. Whether applicant, in lieu of disciplinary action by any agency, in any state, district or territory of the United States or another country, has entered into a consent agreement or stipulation with a licensing agency;
  12. Whether applicant currently has an open complaint or is involved in any open investigation in any agency or court

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of law, in any state, district or territory of the United States or another country;

13. Whether applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, in any state, district or territory of the United States, or another country;
14. Whether applicant has ever been found medically incompetent;
15. Whether applicant has ever been a defendant in any malpractice matter that resulted in a settlement or judgment;
16. Whether applicant has a medical condition, that in any way, impairs or limits applicant's ability to practice medicine;
17. A detailed explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background; and
18. A completed Arizona Statement of Citizenship and Alien Status for State Public Benefits, and copy of evidence.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-502. Annual Renewal of a Certificate to Engage in Clinical or Preceptorship Training**

A holder of a certificate to engage in clinical training shall renew the certification by submitting before the expiration date of the certificate a completed clinical training renewal form. A holder of a certificate to engage in preceptorship training shall renew the certification on or before July 1, by submitting a completed preceptorship renewal form.

1. Applicant must submit a completed application form provided by the Board for renewal of certification that allows the Board to determine whether the holder of the certificate continues to meet the requirements of A.R.S. Title 32 Chapter 14. The form must be signed, dated, and shall include:
  - a. Applicant's full name and any former names used by applicant;
  - b. Applicant's certificate number, and original issue date;
2. The fees specified in R4-18-107.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**R4-18-503. Application for a Certificate to Conduct a Clinical or Preceptorship Training Program**

A chief medical officer applying on behalf of a school of naturopathic medicine for a certificate to conduct clinical training, or on behalf of a preceptorship training program, shall submit to the Board the fee indicated in R4-18-107 and an application form provided by the Board, signed and dated by the chief medical officer, that contains:

1. The chief medical officer's name, mailing address, and telephone number;
2. The name and address of the training program and of each facility where training will be conducted;

3. The name, professional degree, license number, and licensing agency for each physician who will be providing supervision in the training program; and
4. A mission statement outlining the goals of the training program.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**R4-18-504. Annual Renewal of Certificate to Conduct a Clinical or Preceptorship Training Program**

A certificate to conduct clinical or preceptorship training shall be renewed before the anniversary date, by submitting the appropriate fee listed in R4-18-107 and a completed form.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**ARTICLE 6. NATUROPATHIC MEDICAL ASSISTANTS****R4-18-601. Definitions**

In addition to the definitions in A.R.S. § 32-1501 and R4-18-101, the following definitions apply to this Article:

1. "Approved medical assistant training program" means a course of study for medical assistants that is provided:
  - a. At an institution that is accredited by:
    - i. The Commission on Accreditation of Allied Health Education Programs,
    - ii. The Commission for the Accrediting Bureau of Health Education Schools, or
    - iii. An accrediting agency recognized by the United States Department of Education or the Armed Forces of the United States, or
  - b. By an organization recognized by the American Association of Naturopathic Physicians.
2. "Employ" means to compensate by money or other consideration for work performed.
3. "Medical history" means an account of an individual's past and present physical and mental health including the individual's illness, injury, or disease.
4. "Medication" means a drug as defined in A.R.S. § 32-1501 or a natural substance as defined in A.R.S. § 32-1581.
5. "Naturopathic practice" means a place where the practice of naturopathic medicine as defined in A.R.S. § 32-1501 takes place.
6. "Training" means classroom and clinical instruction completed by an individual as part of an approved medical assistant training program, or training designed and offered by a licensed naturopathic physician, that meets or exceeds the standards of one of the approved medical assistant training programs listed in subsection (1)(a) through (b).
7. "Treatment" means any of the acts included in the practice of naturopathic medicine as defined in A.R.S. § 32-1501.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2). Amended by final rulemaking at 30 A.A.R. 346 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-602. Medical Assistant Qualification and Training Requirements**

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A licensed Naturopathic Physician who provides direct supervision to a medical assistant, shall ensure that the medical assistant satisfies one of the following training requirements before the medical assistant is employed:

1. Completes an approved medical assistant training program;
2. Completes a medical assistant training program designed and offered by a licensed Naturopathic Physician that meets the requirements outlined in A.R.S. § 32-1559(D)(1) through (4), and passes a medical assistant examination administered by either the American Association of Medical Assistants or the American Medical Technologists; or
3. Completes a medical services training program of The Armed Forces of the United States;
4. A licensed Naturopathic Physician must obtain approval of the medical assistant training program prior to providing the training, by submitting the required application to the Board.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2). Amended by final rulemaking at 30 A.A.R. 346 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-603. Application for Medical Assistant Certification**

An applicant for a medical assistant certificate shall submit an application packet to the Board that contains the following:

1. An application form provided by the Board, signed and dated by the applicant that contains:
  - a. The applicant's legal name, mailing address, telephone number, and Social Security number;
  - b. The applicant's date and place of birth;
  - c. The applicant's height, weight, and eye and hair color;
  - d. The name, address, and telephone number of the applicant's employer, if applicable;
  - e. The name of the licensed naturopathic physician who will supervise the applicant;
  - f. The name and address of the institution where the applicant completed an approved medical assistant training program; or
  - g. If the training was completed in a program provided by a licensed naturopathic physician, the following must be submitted:
    - i. A letter outlining the training provided and signed by the naturopathic physician who provided the training;
    - ii. Proof of passing the required medical assistant examination administered by either The American Association of Medical Assistants or The American Medical Technologists; or
    - iii. Proof of completion of a medical services training program of The Armed Forces of the United States.
2. A copy of a certificate of completion from an approved medical assistant training program or a letter of completion from an approved medical assistant training program signed by the person in charge of the approved medical assistant training program;
3. A completed and legible fingerprint card; and
4. The fees required by the Board under A.R.S. § 32-1527.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R.

1547, effective June 4, 2005 (Supp. 05-2). Amended by final rulemaking at 30 A.A.R. 346 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-604. Renewal of Medical Assistant Certificate**

An applicant for a renewal certificate shall submit to the Board:

1. A renewal form, provided by the Board, that is signed and dated by the applicant and contains the applicant's:
  - a. Name,
  - b. Social Security number,
  - c. Residence and naturopathic practice addresses, and
  - d. Telephone number; and
2. The fee required by the Board under A.R.S. § 32-1527.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2).

**R4-18-605. Authorized Procedures for Medical Assistants**

A. A medical assistant may perform the following under the direct supervision of a physician:

1. Obtain a patient's medical history;
2. Obtain a patient's vital signs;
3. Assist a physician in performing a physical examination, surgical procedure, or treatment;
4. Perform a diagnostic test ordered by a physician including:
  - a. An electrocardiogram;
  - b. A peripheral vein puncture;
  - c. A capillary puncture;
  - d. Urine analysis;
  - e. A hematology test; or
  - f. Respiratory function testing;
5. Administer a medication:
  - a. By mouth; or
  - b. By subcutaneous or intra-muscular injection if the medical assistant received training on performing this type of administration from an approved medical assistant training program;
6. Monitor and remove an intravenous administration of a medication established by a supervising physician if the medical assistant received training on monitoring and removing an intravenous administration from an approved medical assistant training program.
7. Perform physiotherapy, which includes the following:
  - a. Whirlpool treatment,
  - b. Diathermy treatment,
  - c. Electronic stimulation treatment,
  - d. Ultrasound therapy,
  - e. Massage therapy,
  - f. Traction,
  - g. Transcutaneous nerve stimulation,
  - h. Colon hydrotherapy, or
  - i. Hot and cold pack treatment.

B. A medical assistant shall not:

1. Diagnose a medical condition;
2. Design or modify a treatment program;
3. Prescribe a medication or natural substance;
4. Provide a patient with a prognosis;
5. Unless authorized by law, perform:
  - a. An ionizing radiographic procedure,
  - b. A surgical procedure,
  - c. A central venous catheterization,
  - d. An acupuncture needle insertion, or
  - e. Manipulative therapy;
6. Administer or establish an intravenous medication;



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7. Perform any procedure that requires precise placement of a needle into a patient by single or multiple injections including:
  - a. Sclerotherapy,
  - b. Prolotherapy,
  - c. Mesotherapy, or
  - d. Neurotherapy; or
8. Employ the medical assistant's supervising physician or have any financial interest in a naturopathic practice where the supervising physician is employed.
- C. While assisting a naturopathic physician or performing a procedure delegated to the medical assistant, the medical assistant shall wear a clearly visible tag that states the individual is a medical assistant.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1547, effective June 4, 2005 (Supp. 05-2).

**ARTICLE 7. TIME-FRAMES FOR BOARD DECISIONS**

**R4-18-701. Time-frames for Board Decisions**

- A. The overall time-frame described in A.R.S. § 41-1072(2) for each type of license, certification, or approval granted by the Board is listed in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend a substantive review and overall time-frame by no more than 25 percent of the overall time-frame listed in Table 1.
- B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of license, certification, and approval granted by the Board is listed in Table 1.
  1. The administrative completeness review time-frame begins on the day the Board receives the application form and the appropriate fee.
  2. If the application packet is incomplete, the Board shall send to the applicant a written notice specifying the missing document or incomplete information.
  3. The administrative completeness review time-frame and the overall time-frame are suspended from the date on the

- Board's notice until the date the Board office receives all missing information.
- C. The substantive review time-frame described in A.R.S. § 41-1072(3) for each type of license, certification, and approval granted by the Board is listed in Table 1.
  1. The substantive review time-frame begins on the date of the Board's notice of administrative completeness.
  2. If the Board determines that additional information or documentation is required, the Board shall send to the applicant a written request for that additional information or documentation.
  3. The time-frame for the substantive review is suspended from the date the request for additional information or documentation is sent to the applicant, until the date on which all of the requested information is received.
  4. The Board shall notify the applicant of the dates of all Board meetings at which the application will be considered.
  5. The Board shall send a written notice of approval or denial to applicants within ten working days of the Board meeting at which the decision is made. An applicant may request a hearing on the decision within 30 days of the Board's action.
- D. The Board shall consider an application withdrawn if within 360 days from the date of application the applicant fails to:
  1. Supply the missing information requested under subsection (B)(2) or (C)(2); or
  2. If applicable, take and obtain a minimum score of 75% on the Arizona Naturopathic Jurisprudence Examination.
- E. During the administrative review period, an applicant may withdraw an application by requesting withdrawal in writing. During the substantive review period, the Board shall decide whether to grant a request to withdraw.
- F. An applicant shall send written notice to the Board within 10 days from the date of any change of applicant's address.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**Table 1. Time-frames**

Type of Approval	Statutory Authority	Administrative Completeness Time-frame	Substantive Review Time-frame	Overall Time-frame
License by Examination (R4-18-202)	A.R.S. §§ 32-1504(A), 32-1522, 32-1523, 32-1523.01, 32-1524	90 days	90 days	180 days
License by Endorsement (R4-18-203)	A.R.S. §§ 32-1504(A), 32-1523	60 days	60 days	120 days
Specialist Certificate (R4-18-204)	A.R.S. §§ 32-1504(B)(3), 32-1529	60 days	60 days	120 days
Annual Renewal of License (R4-18-206)	A.R.S. §§ 32-1504(A), 32-1526	30 days	60 days	90 days
Certificate to Dispense	A.R.S. §§ 32-1504(A), 32-1581	30 days	60 days	90 days
Annual Renewal of Certificate to Dispense	A.R.S. §§ 32-1504(A), 32-1581	30 days	60 days	90 days
Certificate to Engage in a Clinical, Preceptorship, Internship, or Postdoctoral Training Program (R4-18-501)	A.R.S. §§ 32-1504(A), 32-1560, 32-1561	30 days	60 days	90 days
Annual Renewal of Certificate to Engage in a Clinical, Preceptorship, Internship, or Postdoctoral Training Program (R4-18-502)	A.R.S. §§ 32-1504(A), 32-1560, 32-1561	30 days	60 days	90 days
Certificate to Conduct a Clinical, Preceptorship, Internship, or Postdoctoral Training Program (R4-18-503)	A.R.S. §§ 32-1501, 32-1504(A)	30 days	60 days	90 days

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Annual Renewal of Certificate to Conduct a Clinical, Preceptorship, Internship, or Postdoctoral Training Program (R4-18-504)	A.R.S. § 32-1504(A)	30 days	60 days	90 days
Medical Assistant Certificate	A.R.S. §§ 32-1504(A), 32-1559	30 days	60 days	90 days
Annual Renewal of Medical Assistant Certificate	A.R.S. §§ 32-1504(A), 32-1559	30 days	60 days	90 days

**Historical Note**

New Table made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3).

**ARTICLE 8. EXPERIMENTAL MEDICINE****R4-18-801. Experimental Medicine**

A procedure, medication, or device is experimental if:

1. An Institutional review board exists for a particular procedure, medication, or device;
2. The procedure, medication, or device is not generally considered to be within the accepted practice standards for the naturopathic profession; and
3. The procedure, medication, or device is not part of the curriculum at an approved school of naturopathic medicine or approved postdoctoral training.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

**R4-18-802. Informed Consent and Duty to Follow Protocols**

A. A physician, medical student engaged in an approved clinical training program, preceptee, or intern who conducts research involving an experimental procedure, medication, or device, shall ensure that all research subjects give informed consent to participate, which states:

1. Whether a physician, preceptee, or an intern is treating the patient;
2. That the patient or legal guardian of the patient understands:
  - a. The type of treatment the patient is to receive;
  - b. Each procedure that will be provided to the patient;
  - c. The risks and benefits of each procedure, medication, or device to be provided;
  - d. That the patient can withdraw at any time; and
  - e. That the patient is voluntarily participating; and
3. The physician, medical student engaged in the approved clinical training program, preceptee, or intern has established a protocol as required by subsection (B) that meets the requirements of the institutional review board that approved the protocol.

B. A physician, medical student engaged in an approved clinical training program, preceptee, or intern, who conducts research on humans involving an experimental procedure, medication, or device shall have a protocol for that research approved by an institutional review board.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3702, effective August 9, 2002 (Supp. 02-3). Amended by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

**ARTICLE 9. CERTIFICATE TO DISPENSE****R4-18-901. Definitions**

The following definitions apply in this Article:

1. "Applicant" means:

- a. An individual applying for a license and a certificate to dispense; or
  - b. A licensee requesting a certificate to dispense only.
2. "Auscultation" means the act of listening to sounds within the human body either directly or through the use of a stethoscope or other means.
  3. "Certificate to dispense" means an approval granted by the Board to dispense a natural substance, drug, or device.
  4. "Dispense" means the same as in A.R.S. § 32-1581(H).
  5. "Drug" means the same as in A.R.S. § 32-1501(15).
  6. "Hour" means 50 to 60 minutes of participation.
  7. "Medical record" means the same as in A.R.S. § 12-2291.
  8. "Nutrient" means the same as in A.R.S. § 32-1501(15)(a)(iii).
  9. "Physical examination" means an evaluation of the health of an individual's body using inspection, palpation, percussion, and auscultation to determine cause of illness or disease.

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2).

**R4-18-902. Qualifications for a Certificate to Dispense**

- A. To qualify for a certificate to dispense, an applicant shall have completed before the submission date of the application, Board approved training in the safe administration of natural substances, drugs, or devices.
- B. The Board approves documentation of the following as evidence of completion of Board approved training in the safe administration of natural substances, drugs, or devices:
  1. Graduation from an approved school of naturopathic medicine after January 1, 2005 as referenced in A.R.S. § 32-1525(B)(4); or
  2. Completion of a 60 hour or more pharmacological course on natural substances, drugs, or devices that is offered, approved, or recognized by one of the organizations in R4-18-205(B)(1) or (B)(2), or by passing of The North American Board of Naturopathic Examiners (NABNE) add on Parenteral Medicine Examination.
- C. If an applicant intends to administer a natural substance or drug intravenously, the Board approved training completed by the applicant shall include administration of a natural substance or drug by intravenous means.

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 30 A.A.R. 348 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-903. Application for a Certificate to Dispense; Renewal**

- A. An applicant for a certificate to dispense shall submit:
  1. An application to the Board that contains:
    - a. The applicant's:

## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 18. NATUROPATHIC PHYSICIANS MEDICAL BOARD

- i. Full legal name;
    - ii. Naturopathic license number, if known; and
    - iii. Social Security number;
  - b. If a corporation, a statement of whether the corporation holds tax exempt status;
  - c. A statement of whether the applicant holds a drug enforcement number issued by the United States Drug Enforcement Administration, and if so, the drug enforcement number;
  - d. A statement of whether the applicant has ever had the authority to prescribe, dispense, or administer a natural substance, drug, or device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, and if so, an explanation that includes:
    - i. The name and address of the federal or state agency or court having jurisdiction over the matter, and
    - ii. The disposition of the matter;
  - e. A statement, signed by the applicant, that the applicant agrees to conform to all federal and state statutes, regulations, and rules; and
  - f. The date the application is submitted; and
2. Unless exempted by A.R.S. § 32-1530, the fee required by the Board.
- B.** A certificate holder shall renew a certificate to dispense on or before July 1 of each year by submitting:
- 1. An application to the Board that contains:
    - a. The applicant's full legal name;
    - b. If a corporation, a statement of whether the corporation holds tax exempt status;
    - c. A statement of whether the applicant has had the authority to prescribe, dispense, or administer a natural substance, drug, device limited, restricted, modified, denied, surrendered or revoked by a federal or state agency or court of law, during the one year period immediately preceding the renewal date and if so, an explanation that includes:
      - i. The name and address of the federal or state agency or court having jurisdiction over the matter; and
      - ii. The disposition of the matter; and
    - d. A statement, signed and dated by the applicant, verifying the information on the application is true and correct and the applicant is the licensee named on the application; and
  - 2. Unless exempted by A.R.S. § 32-1530, the fee required by the Board.
- C.** The Board shall grant or deny the certificate to dispense or renewal of certificate to dispense according to the time-frames in Article 7, Table 1 of this Chapter.

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 30 A.A.R. 348 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-904. Dispensing; Intravenous Nutrients**

- A.** To prevent toxicity due to the excessive intake of a natural substance, drug, or device, before dispensing the natural substance, drug, or device to an individual, a certified physician shall:
- 1. Conduct a physical examination of the individual,

- 2. Conduct laboratory tests as necessary that determine the potential for toxicity of the individual, and
  - 3. Document the results of the physical examination and laboratory tests in the individual's medical record.
- B.** For the purposes of A.R.S. § 32-1504(A)(8), a substance is considered a nutrient suitable for intravenous administration if it complies with A.R.S. § 32-1501(15)(iii).

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1302, effective July 6, 2013 (Supp. 13-2). Amended by emergency rulemaking at 21 A.A.R. 51, effective December 18, 2014, for 180 days (Supp. 14-4). Emergency renewed at 21 A.A.R. 928, effective June 5, 2015, for 180 days (Supp. 15-2). Amended by final rulemaking at 21 A.A.R. 2009, effective September 1, 2015 (Supp. 15-3).

**ARTICLE 10. DISPENSING OF A NATURAL SUBSTANCE, DRUG OR DEVICE****R4-18-1001. Certificate to Dispense Required**

- A.** A doctor of naturopathic medicine may dispense a natural substance, a drug, except a schedule II controlled substance that is an opioid, or a device to a patient for a condition that is being diagnosed or treated by the doctor. A doctor who holds a current medical license with the board shall obtain a certificate to dispense annually if the doctor:
- 1. Maintains a supply of Natural Substances as defined in A.R.S. § 32-1501(23), controlled substances as defined in A.R.S. § 32-1501(12), prescription-only drugs as defined in A.R.S. § 32-1501(17), or prescription-only devices as defined in A.R.S. § 32-1581(H)(i), excluding manufacturer's samples;
  - 2. Prescribes the items listed in subsection (A)(1) to a patient of the doctor for use outside the office;
  - 3. Obtains payment for the items listed in subsection (A)(1), including payment from a fulfillment center; or
  - 4. Administers substances approved for intravenous administration pursuant to A.R.S. § 32-1501(15)(a)(i)(ii)(iii).
- B.** To obtain a certificate to dispense, a doctor shall:
- 1. Submit the application form referenced in R4-18-903;
  - 2. Submit a copy of the doctor's current Drug Enforcement Administration certificate of registration, for each location from which the doctor will dispense a controlled substance; and
  - 3. Submit the fee required under R4-18-107, unless the doctor is exempt from paying the fee pursuant to A.R.S. § 32-1530. A doctor applying for exemption is required to submit proof of exempt status with the application.
- C.** A doctor shall renew the certificate to dispense by July 1 of each year. If a doctor makes a timely and complete application to renew the certificate, the doctor may continue to dispense until the Board approves or denies the renewal application.
- D.** If a doctor fails to submit a timely and complete application to renew the certificate to dispense, the doctor shall immediately cease dispensing.
- E.** If a doctor fails to comply with subsection (C), the doctor shall not dispense any natural substance, controlled substance, prescription-only drug, or prescription-only device, including substances approved for intravenous administration, until the doctor complies fully with subsection (B) and receives notice the Board approves the application.

**Historical note**

New Section made by final rulemaking at 30 A.A.R. 348

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(February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-1002. Packaging and Inventory**

- A.** A doctor shall dispense all controlled substances and prescription-only drugs in appropriate containers that are in compliance with state and federal laws.
- B.** A doctor shall ensure the natural substance, drug or device dispensed is in compliance with labeling requirements outlined in A.R.S. § 32-1581(2). For the purpose of compliance with A.R.S. § 32-1581(2), if the natural substance or device dispensed does not require a prescription, the information required may be incorporated into an accompanying instruction sheet. For a natural substance that contains multiple ingredients, the strength of each ingredient is not required to be documented, only the brand name of the supplement is required for documentation. All ingredients and amounts administered by intravenous or intramuscular administration are required to be fully documented in the patient chart.
- C.** A doctor shall:
  - 1. Secure all controlled substances in a locked cabinet or room;
  - 2. Control access to the locked cabinet or room by a written procedure that include, at a minimum:
    - a. Designation of the persons who have access to the locked room, and
    - b. Procedures for recording requests for access to the locked cabinet or room;
  - 3. Make a written procedure required under subsection (C)(2) available on demand by the Board or its authorized representative for inspection and copying;
  - 4. Store prescription-only drugs so they are not accessible to patients; and
  - 5. Store controlled substances and prescription-only drugs not requiring refrigeration in an area where the temperature does not exceed 85 degrees Fahrenheit.
- D.** A doctor shall maintain an ongoing dispensing log for all controlled substances and prescription-only drugs dispensed by the physician. The dispensing log shall include the following:
  - 1. A separate inventory sheet for each controlled substance and prescription-only drug;
  - 2. The date the drug is dispensed;
  - 3. The patient's name;
  - 4. The name of the controlled substance or prescription-only drug, strength, dosage, form, and name of manufacturer;
  - 5. The number of dosage units dispensed;
  - 6. A running total of each controlled substance or prescription-only drug dispensed; and
  - 7. The written signature of the doctor next to each entry.
- E.** A doctor may use a computer to maintain the dispensing log required under subsection (D) if the dispensing log is password protected and quickly accessible through either on-screen viewing or printing a copy.
- F.** This Section does not apply to a prepackaged manufacturer sample of a controlled substance or prescription-only drug unless otherwise provided by federal law.

- G.** The doctor must report the dispensing of controlled substances in compliance with the Arizona Controlled Substance Prescription Monitoring Program.

**Historical note**

New Section made by final rulemaking at 30 A.A.R. 348 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-1003. Recordkeeping and Reporting Shortages**

- A.** A doctor who dispenses a controlled substance or prescription-only drug shall ensure an original prescription order for the controlled substance or prescription-only device is dated, consecutively numbered in the order in which it is originally dispensed, and filed separately from patient medical records. The doctor shall ensure original prescription orders are maintained in three separate files, as follows:
  - 1. Schedule II controlled substances;
  - 2. Schedule III, IV and V controlled substances; and
  - 3. Prescription-only drugs.
- B.** A doctor shall ensure purchase orders and invoices are maintained for all controlled substances and prescription-only drugs dispensed, whether for profit or not for profit, for three years from the date of the purchase order or invoice. Purchase orders and invoices shall be maintained in three separate files as follows:
  - 1. Schedule II controlled substances only;
  - 2. Schedule III, IV and V controlled substances; and
  - 3. All other prescription-only drugs.
- C.** A doctor who discovers a theft or loss of a prescription only drug from the doctors office shall:
  - 1. Immediately notify the local law enforcement agency,
  - 2. Provide the local law enforcement agency with a written report, and
  - 3. Send a copy of the report provided under subsection (C)(2) to the Drug Enforcement Administration and Board within seven days of the discovery.

**Historical note**

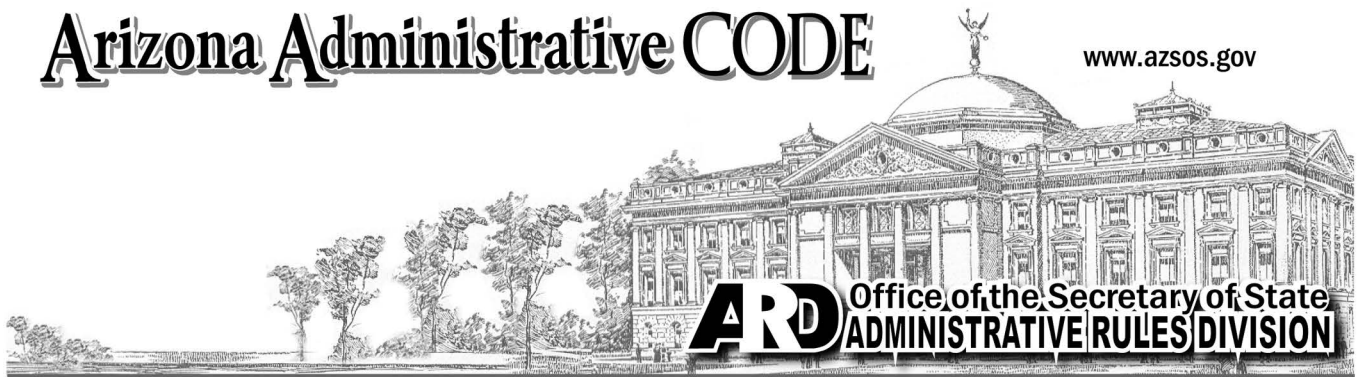
New Section made by final rulemaking at 30 A.A.R. 348 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).

**R4-18-1004. Inspections**

- A.** A doctor shall cooperate with and allow access to the doctor's office and records for inspection of dispensing practices by the Board or its authorized representative.
- B.** The Board shall revoke a doctor's certificate to dispense if the doctor's license is suspended, revoked or surrendered.
- C.** The certificate automatically expires if:
  - 1. The doctor fails to renew the medical license in a timely manner; or
  - 2. The doctor fails to renew the certificate in a timely manner.
- D.** A doctor who holds a certificate and is not currently under investigation, may request the certificate be cancelled.

**Historical note**

New Section made by final rulemaking at 30 A.A.R. 348 (February 23, 2024), effective April 1, 2024 (Supp. 24-1).



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Supp. 24-4

## TITLE 4. PROFESSIONS AND OCCUPATIONS CHAPTER 19. BOARD OF NURSING

The table of contents on page one contains links to the referenced page numbers in this Chapter.  
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

[R4-19-207.](#)    [New Programs; Proposal Approval; Provisional  
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**The release of this Chapter in Supp. 24-4 replaces Supp. 24-2, 1-62 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

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Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

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An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 19. BOARD OF NURSING

Authority: A.R.S. § 32-1606 et seq.

## Supp. 24-4

*Editor's Note: The Arizona State Board of Nursing amended Sections in this Chapter under an exemption from the provisions of A.R.S. Title 41, Chapter 6 under Laws 2015, Chapter 262 § 22. Exemption from A.R.S. Title 41, Chapter 6 means the Board was not required to submit proposed rules for publication in the Arizona Administrative Register, conduct a public hearing on the rules, or required to submit the rules for approval by the Governor's Regulatory Review Council. Refer to the historical notes for more information (Supp. 16-2).*

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 19. BOARD OF NURSING

**ARTICLE 1. DEFINITIONS AND TIME-FRAMES****R4-19-101. Definitions**

“Abuse” means a misuse of power or betrayal of trust, respect, or intimacy by a nurse, nursing assistant, or applicant that causes or is likely to cause physical, mental, emotional, or financial harm to a client.

“Administer” means the direct application of a medication to the body of a patient by a nurse, whether by injection, inhalation, ingestion, or any other means.

“Admission cohort” means a group of students admitted at the same time to the same curriculum in a regulated nursing, nursing assistant, or advanced practice nursing program or entering the first clinical course in a regulated program at the same time. “Same time” means on the same date or within a narrow range of dates pre-defined by the program.

“Advance practice registered nurse (APRN)” means either a registered nurse practitioner (RNP), certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), or clinical nurse specialist (CNS), certified by the Board.

“Applicant” means a person seeking licensure, certification, prescribing, or prescribing and dispensing privileges, or an entity seeking approval or re-approval, if applicable, of a:

- CNS or RNP nursing program,
- Credential evaluation service,
- Nursing assistant training program,
- Nursing program,
- Nursing program change, or
- Refresher program.

“Approved national nursing accrediting agency” means an organization recognized by the United States Department of Education as an accrediting agency for a nursing program.

“Assign” means a nurse designates nursing activities to be performed by another nurse that are consistent with the other nurse’s scope of practice.

“Certificate or diploma in practical nursing” means the document awarded to a graduate of an educational program in practical nursing.

“Certified medication assistant” means a certified nursing assistant who meets Board qualifications and is additionally certified by the Board to administer medications under A.R.S. § 32-1650 et. seq.

“CES” means credential evaluation service.

“Client” means a recipient of care and may be an individual, family, group, or community.

“Clinical instruction” means the guidance and supervision provided by a nursing, nursing assistant or medication assistant program faculty member while a student is providing client care.

“CMA” means certified medication assistant.

“CNA” means a certified nursing assistant, as defined in A.R.S. § 32-1601(4).

“CNS” means clinical nurse specialist, as defined in A.R.S. § 32-1601(7).

“Collaborate” means to establish a relationship for consultation or referral with one or more licensed physicians on an as-needed basis. Supervision of the activities of a registered nurse practitioner by the collaborating physician is not required.

“Contact hour” means a unit of organized learning, which may be either clinical or didactic and is either 60 minutes in length or is otherwise defined by an accrediting agency recognized by the Board.

“Continuing education activity” means a course of study related to nursing practice that is awarded contact hours by an accrediting agency recognized by the Board, or academic credits in nursing or medicine by a regionally or nationally accredited college or university.

“CRNA” means a certified registered nurse anesthetist as defined in A.R.S. § 32-1601(5).

“DEA” means the federal Drug Enforcement Administration.

“Dispense” means to deliver a controlled substance or legend drug to an ultimate user.

“Dual relationship” means a nurse or CNA simultaneously engages in both a professional and nonprofessional relationship with a patient or resident or a patient’s or resident’s family that is avoidable, non-incidental, and results in the patient or resident or the patient’s or resident’s family being exploited financially, emotionally, or sexually.

“Eligibility for graduation” means that the applicant has successfully completed all program and institutional requirements for receiving a degree or diploma but is delayed in receiving the degree or diploma due to the graduation schedule of the institution.

“Endorsement” means the procedure for granting an Arizona nursing license to an applicant who is already licensed as a nurse in another state or territory of the United States and has passed an exam as required by A.R.S. §§ 32-1633 or 32-1638 or an Arizona nursing assistant or medication assistant certificate to an applicant who is already listed on a nurse aide register or certified as a medication assistant in another state or territory of the United States.

“Episodic nursing care” means nursing care at nonspecific intervals that is focused on the current needs of the individual.

“Failure to maintain professional boundaries” means any conduct or behavior of a nurse or CNA that, regardless of the nurse’s or CNA’s intention, is likely to lessen the benefit of care to a patient or resident or a patient’s or resident’s family or places the patient, resident or the patient’s or resident’s family at risk of being exploited financially, emotionally, or sexually.

“Family,” as applied to R4-19-511, means individuals who are related by blood, marriage, adoption, legal guardianship, or domestic partnership, or who are cohabitating or romantically involved.

“Family Member” means a licensed health aide (LHA) who is an adult (at least 18 years old) and has the following relationship with the LHA’s one patient:

1. Spouse,
2. Children/step children,
3. Son/daughter-in-law,

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4. Grandchildren,
5. Siblings/step siblings,
6. Parents/step parents/adoptive parents,
7. Grandparents,
8. Mother/father-in-law,
9. Brother/sister-in-law, or
10. Legal guardian.

“Full approval” means the status granted by the Board when a nursing program, after graduation of its first class, demonstrates the ability to provide and maintain a program in accordance with the standards provided by A.R.S. Title 32, Chapter 15 and this Chapter.

“Good standing” means the license of a nurse, or the certificate of a nursing assistant, is current, and the nurse or nursing assistant is not presently subject to any disciplinary action, consent order, or settlement agreement.

“Independent nursing activities” means nursing care within an RN’s scope of practice that does not require authorization from another health professional.

“Initial approval” means the permission, granted by the Board, to an entity to establish a nursing assistant training program, after the Board determines that the program meets the standards provided by A.R.S. Title 32, Chapter 15 and this Chapter.

“LHA”, means a licensed health aide who meets Board qualifications as defined by A.R.S. § 32-1601(14).

“Licensure by examination” means the granting of permission to practice nursing based on an individual’s passing of a prescribed examination and meeting all other licensure requirements.

“LPN” means licensed practical nurse.

“NCLEX” means the National Council Licensure Examination.

“Nurse” means a licensed practical or registered nurse.

“Nursing diagnosis” means a clinical judgment, based on analysis of comprehensive assessment data, about a client’s response to actual and potential health problems or life processes. Nursing diagnosis statements include the actual or potential problem, etiology or risk factors, and defining characteristics, if any.

“Nursing process” means applying problem-solving techniques that require technical and scientific knowledge, good judgment, and decision-making skills to assess, plan, implement, and evaluate a plan of care.

“Nursing program” means a formal course of instruction designed to prepare its graduates for licensure as registered or practical nurses.

“Nursing program administrator” means a nurse educator who meets the requirements of A.R.S. Title 32, Chapter 15 and this Chapter and has the administrative responsibility and authority for the direction of a nursing program.

“Nursing program faculty member” means an individual working full or part time within a nursing program who is responsible for either developing, implementing, teaching,

evaluating, or updating nursing knowledge, clinical skills, or curricula.

“Nursing-related activities or duties” means client care tasks for which education is provided by a basic nursing assistant training program.

“P & D” means prescribing and dispensing.

“Parent institution” means the educational institution in which a nursing program, nursing assistant training program or medication assistant program is conducted.

“Patient” means an individual recipient of care.

“Pharmacology” means the science that deals with the study of drugs.

“Physician” means a person licensed under A.R.S. Title 32, Chapters 7, 8, 11, 13, 14, 17, or 29, or by a state medical board in the United States.

“Preceptor” means a licensed nurse or other health professional who meets the requirements of A.R.S. Title 32, Chapter 15 and this Chapter who instructs, supervises and evaluates a licensee, clinical nurse specialist, nurse practitioner or pre-licensure nursing student, for a defined period.

“Preceptorship” means a clinical learning experience by which a learner enrolled in a nursing program, nurse refresher program, clinical nurse specialist, or registered nurse practitioner program or as part of a Board order provides nursing care while assigned to a health professional who holds a license or certificate equivalent to or higher than the level of the learner’s program or in the case of a nurse under Board order, meets the qualifications in the Board order.

“Prescribe” means to order a medication, medical device, or appliance for use by a patient.

“Private business” means any individual or sole proprietorship, partnership, limited liability partnership, limited liability company, corporation or other legal business entity.

“Proposal approval” means that an institution has met the standards provided by A.R.S. Title 32, Chapter 15 and this Chapter to proceed with an application for provisional approval to establish a pre-licensure nursing program in Arizona.

“Provisional approval” means that an institution has met the standards provided by A.R.S. Title 32, Chapter 15 and this Chapter to implement a pre-licensure nursing program in Arizona.

“Refresher program” means a formal course of instruction designed to provide a review and update of nursing theory and practice.

“Register” means a listing of Arizona certified nursing assistants maintained by the Board that includes the following about each nursing assistant:

Identifying demographic information;

Date placed on the register;

Date of initial and most recent certification, if applicable; and

Status of the nursing assistant certificate, including findings of abuse, neglect, or misappropriation of property made by the Arizona Department of Health Services, sanctions imposed by the United States Department of

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Health and Human Services, and disciplinary actions by the Board.

“Resident” means a patient who receives care in a long-term care facility or other residential setting.

“RN” means registered nurse.

“RNP” means a registered nurse practitioner as defined in A.R.S. § 32-1601(20).

“SBTPE” means the State Board Test Pool Examination.

“School nurse” means a registered nurse who is certified under R4-19-309.

“Secure examination” means a written test given to an examinee that:

Is administered under conditions designed to prevent cheating;

Is taken by an individual examinee without access to aides, textbooks, other students or any other material that could influence the examinee’s score; and,

After opportunity for examinee review, is either never used again or stored such that only designated employees of the educational institution are permitted to access the test.

“Self-study” means a written self-evaluation conducted by a nursing program to assess the compliance of the program with the standards listed in Article 2.

“Standards related to scope of practice” means the expected actions of any nurse who holds the identified level of licensure.

“Substance use disorder” means misuse, dependence or addiction to alcohol, illegal drugs or other substances.

“Supervision” means the direction and periodic consultation provided to an individual to whom a nursing task or patient care activity is delegated.

“Unlicensed assistive personnel” or “UAP” means a CNA or any other unlicensed person, regardless of title, to whom nursing tasks are delegated.

“Verified application” means an affidavit signed by the applicant attesting to the truthfulness and completeness of the application and includes an oath that applicant will conform to ethical professional standards and obey the laws and rules of the Board.

#### Historical Note

Former Glossary of Terms; Amended effective Nov. 17, 1978 (Supp. 78-6). Former Section R4-19-01 repealed, new Section R4-19-01 adopted effective February 20, 1980 (Supp. 80-1). Amended paragraphs (1) and (7), added paragraphs (9) through (25) effective July 16, 1984 (Supp. 84-4). Former Section R4-19-01 renumbered as Section R4-19-101 (Supp. 86-1). Amended effective November 18, 1994 (Supp. 94-4). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended effective December 22, 1995 (Supp. 95-4). Amended effective November 25, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 1712, effective April 4, 2001 (Supp. 01-2). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Pursuant to authority of A.R.S. § 41-1011(C), Laws

2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citations in the definitions of “CNA” “CNS” and “RNP” have been updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). A.R.S. section references updated under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019. (Supp. 19-2). When amended in Supp. 19-2 the Board inadvertently omitted the definition of “Full Approval” as “No Change” in its notice at 25 A.A.R. 919. The definition was included in Supp. 19-2 (Supp. 19-3). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4). Amended by final exempt rulemaking (the Board solicited comments on draft rules) at 28 A.A.R. 111 (January 7, 2022), with an effective date of January 2, 2022 (Supp. 21-4).

#### R4-19-102. Time-frames for Licensure, Certification, or Approval

##### A. In this Section:

1. “Administrative completeness” or “administratively complete” means Board receipt of all application components required by statute or rule and necessary to begin the substantive review time-frame.
2. “Application packet” means an application form provided by the Board and the documentation necessary to establish an applicant’s qualifications for licensure, certification, or approval.
3. “Comprehensive written request for additional information” means written communication after the administrative completeness time-frame by the Board to an applicant in person or at the address of record or electronic address identified on the application notifying the applicant that additional information, including missing documents is needed before the Board can grant the license. The written communication shall:
  - a. Contain a list of information required by statute or rule and necessary to complete the application or grant the license, and
  - b. Inform the applicant that the request suspends the running of days within the time-frame, and
  - c. Be effective on the date of issuance which is:
    - i. The date of its postmark, if mailed;
    - ii. The date of delivery, if delivered in person by a Board employee or agent; or
    - iii. The date of delivery to the electronic address if delivered electronically.
4. “Deficiency notice” means written communication by the Board to an applicant in person or at the address of record or electronic address identified on the application notifying the applicant that additional information, including missing documents, is needed to complete the application. The written communication shall:
  - a. Contain a list of information required by statute or rule and necessary to complete the application or grant the license;

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- b. Inform the applicant that the request suspends the running of days within the time-frame; and
- c. Be effective on the date of issuance which is:
  - i. The date of its postmark, if mailed;
  - ii. The date of delivery, if delivered in person by a Board employee or agent; or
  - iii. The date of delivery to the electronic address if delivered electronically.
- 5. "Notice of administrative completeness" means written communication by the Board to an applicant in person or at the address of record or electronic address identified on the application notifying the applicant the application contains all information required by statute or rule to complete the application.
- 6. "Overall time-frame" has the same meaning as A.R.S. § 41-1072(2).
- 7. "Substantive review time-frame" has the same meaning as A.R.S. § 41-1072(3).
- B.** In computing the time-frames in this Section, the day of the act or event from which the designated period begins to run is not included. The last day of the period is included unless it is a Saturday, Sunday, or official state holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or official state holiday.
- C.** For each type of licensure, certification, or approval issued by the Board, the overall time-frame described in A.R.S. § 41-1072(2) is listed in Table 1. An applicant may submit a written request to the Board for an extension of time in which to provide a complete application. The request for an extension of time shall be submitted to the Board office before the deadline for submission of a complete application and shall state the reason that the applicant is unable to comply with the time-frame requirements in Table 1 and the amount of additional time requested. The Board may grant an extension of time based on whether the Executive Director of the Board finds that the applicant is unable to comply within the time-frame due to circumstances beyond the applicant's control and that the additional information can reasonably be supplied during the extension of time.
- D.** For each type of licensure, certification, or approval issued by the Board, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is listed in Table 1 and begins to run when the Board receives an application packet.
  - 1. If the application packet is not administratively complete, the Board shall send a deficiency notice to the applicant. The time for the applicant to respond to a deficiency notice begins to run on the date the deficiency notice is issued.
    - a. The deficiency notice shall list each deficiency.
    - b. The applicant shall submit to the Board the missing information listed in the deficiency notice within the period specified in Table 1 for responding to a deficiency notice. The time-frame for the Board to complete the administrative review is suspended until the Board receives the missing information.
    - c. If an applicant fails to provide the missing information listed in the deficiency notice within the period specified in Table 1, the Board shall close the applicant's file and send a notice to the applicant by U.S. mail and electronically, if an electronic address is included in the application.
    - d. If the applicant is the subject of an investigation, the Board may continue to process the application. Failure of the applicant to supply the requested information may result in denial of the license or certificate based on information gathered during the investigation.
  - 2. If the application packet is administratively complete, the Board shall send a written notice of administrative completeness to the applicant.
  - 3. If the Board issues a license, certificate, or approval during the administrative completeness review time-frame, the Board shall not send a separate written notice of administrative completeness.
- E.** For each type of licensure, certification, or approval issued by the Board, the substantive review time-frame described in A.R.S. § 41-1072(3) is listed in Table 1 and begins to run on the date the notice of administrative completeness is issued.
  - 1. During the substantive review time-frame, an applicant may make a request to withdraw an application packet. The Board may deny the request to withdraw an application packet if the applicant is the subject of an investigation, based on information gathered during the investigation.
  - 2. If an applicant discloses or the Board receives allegations of unprofessional conduct as described in A.R.S. § 32-1601 or this Chapter, the Board shall review the allegations and may investigate the applicant. The Board may require the applicant to provide additional information as prescribed in subsection (E)(3) based on its assessment of whether the conduct is or might be harmful or dangerous to the health of a client or the public.
  - 3. During the substantive review time-frame, the Board may make one comprehensive written request for additional information. The applicant shall submit the additional information within the period specified in Table 1. The time-frame for the Board to complete the substantive review of the application packet is suspended from the date the comprehensive written request for additional information is issued until the Board receives the additional information.
  - 4. If the applicant fails to provide the additional information identified in the comprehensive written request for additional information within the time specified in Table 1, the Board shall close the applicant's file and send a notice to the applicant by U.S. mail and electronically, if an electronic address is included in the application. The Board may continue to process the application if the applicant is the subject of an investigation. Failure of the applicant to supply the requested information may result in denial of the license or certificate based on information gathered during the investigation.
  - 5. The Board shall grant licensure, conditional licensure, limited licensure, certification, or approval to an applicant:
    - a. Who meets the substantive criteria for licensure, certification, or approval required by A.R.S. Title 32, Chapter 15 and this Chapter; and
    - b. Whose licensure, certification, or approval is in the best interest of the public.
  - 6. The Board shall deny licensure, certification, or approval to an applicant:
    - a. Who fails to meet the substantive criteria for licensure, certification, or approval required by A.R.S. Title 32, Chapter 15 and this Chapter; or
    - b. Who has engaged in unprofessional conduct as described in A.R.S. § 32-1601 or this Chapter; and

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- c. Whose licensure, certification, or approval is not in the best interest of the public.
7. The Board's written order of denial shall meet the requirements of A.R.S. § 41-1076. The applicant may request a hearing by filing a written request with the Board within 30 days of receipt of the Board's order of denial. The Board shall conduct hearings in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

mer Section R4-19-02 renumbered and amended as Section R4-19-102 effective February 21, 1986 (Supp. 86-1).  
Section repealed effective July 19, 1995 (Supp. 95-3).

New Section adopted April 20, 1998 (Supp. 98-2).  
Amended by final rulemaking at 7 A.A.R. 1712, effective April 4, 2001 (Supp. 01-2). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**Historical Note**

Adopted effective February 20, 1980 (Supp. 80-1). For-

**Table 1. Time-frames**

Time-frames (in days)								
Type of License, Certificate, or Approval	Applicable Statute and Section	Board Overall Time-frame Without Investigation	Board Overall Time-frame With Investigation	Board Administrative Completeness Review Time-frame	Applicant Time to Respond to Deficiency Notice	Board Substantive Review Time-frame Without Investigation	Board Substantive Review Time-frame With Investigation	Applicant Time to Respond to Comprehensive Written Request
Nursing Program Proposal Approval	A.R.S. §§ 32-1606(B)(2), 32-1644; R4-19-207	150	Not applicable	60	180	90	Not applicable	120
Nursing Program Provisional Approval	A.R.S. §§ 32-1606(B)(2), 32-1644; R4-19-207	150	Not applicable	60	180	90	Not applicable	120
Nursing Program Full Approval or Re-approval	A.R.S. §§ 32-1606(B)(2), 32-1644; R4-19-208, R4-19-210	150	Not applicable	60	180	90	Not applicable	120
Nursing Program Change	A.R.S. § 32-1606(B)(1); R4-19-209	150	Not applicable	60	180	90	Not applicable	120
Refresher Program Approval or Re-approval	A.R.S. § 32-1606(B)(21); R4-19-216	150	Not applicable	60	180	90	No applicable	120
CNS or RNP Nursing Program Approval or Re-approval	A.R.S. §§ 32-1606(B)(18), 32-1644; R4-19-503	150	Not applicable	60	180	90	Not applicable	120
Credential Evaluation Service Approval or Re-approval	A.R.S. §§ 32-1634.01(A)(1), 32-1634.02(A)(1), 32-1639.01(1), 32-1639.02(1); R4-19-303	150	Not applicable	30	180	60	Not applicable	120
Licensure by Exam	A.R.S. §§ 32-1606(B)(5), 32-1633, 32-1638, and R4-19-301	150	270	30	270	120	240	150
Licensure by Endorsement	A.R.S. §§ 32-1606(B)(5), 32-1634, 32-1639, and R4-19-302	150	270	30	270	120	240	150

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Temporary License or Renewal	A.R.S. §§ 32-1605.01(B)(3), 32-1635, 32-1640; R4-19-304	60	90	30	60	30	60	90
License Renewal	A.R.S. §§ 32-1606(B)(5), 32-1642; R4-19-305	120	270	30	270	90	240	150
School Nurse Certification or Renewal	A.R.S. §§ 32-1606(B)(13), 32-1643 (A)(8); R4-19-309	150	270	30	270	120	240	150
Re-issuance or Subsequent Issuance of License	A.R.S. § 32-1664(O); R4-19-404	150	270	30	270	120	240	150
Registered Nurse Practitioner Certification or Renewal	A.R.S. §§ 32-1601(19), 32-1606(B)(21); R4-19-505, R4-19-506	150	270	30	270	120	240	150
RNP Prescribing and Dispensing Privilege	A.R.S. § 32-1601(19); R4-19-511	150	270	30	270	120	240	150
CNS Certification or Renewal	A.R.S. §§ 32-1601(6), 32-1606(B)(21); R4-19-505, R4-19-506	150	270	30	270	120	240	150
CRNA Certification or Renewal	A.R.S. § 32-1634-.03; R4-19-505; R4-19-506	150	270	30	270	120	240	150
Temporary RNP, CRNA or CNS Certificate or Renewal	A.R.S. §§ 32-1635.01, 32-1634.03; R4-19-507	60	Not applicable	30	60	30	Not applicable	60
Nursing Assistant, Medication Assistant, and LHA Training Programs Approval or Re-approval	A.R.S. §§ 32-1606(B)(11), 32-1645, 32-1650.01; R4-19-803, R4-19-804, R4-19-901, R4-19-902, R4-19-903	120	Not applicable	30	180	90	Not applicable	120
Licensed or Certified Nursing Assistant, Medication Assistant, and LHA Certification by Examination	A.R.S. §§ 32-1606(B)(11), 32-1645, 32-1647, 32-1650.02, 32-1650.03; R4-19-806 R4-19-904	150	270	30	270	120	240	150

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Licensed or Certified Nursing Assistant and Medication Assistant Certification by Endorsement	A.R.S. §§ 32-1606(B)(11), 32-1648, 32-1650.04; R4-19-807	150	270	30	270	120	240	150
Licensed or Certified Nursing Assistant and Certified Medication Assistant Renewal	A.R.S. § 32-1606(B)(11); R4-19-809	120	270	30	270	90	240	150
Re-issuance or Subsequent Issuance of a Nursing Assistant License	A.R.S. § 32-1664(O); R4-19-815	150	270	30	270	120	240	150

**Historical Note**

Table 1 adopted effective April 20, 1998 (Supp. 98-2). Amended by final rulemaking at 7 A.A.R. 1712, effective April 4, 2001 (Supp. 01-2). Table 1 amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citations in column two of "Registered Nurse Practitioner Certification or Renewal," "RNP Prescribing and Dispensing Privilege," and "CNS Certification or Renewal" have been updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1308 effective July 6, 2013 (Supp. 13-2). A.R.S. Section and Chapter Section references updated under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final exempt rulemaking (the Board solicited comments on draft rules) at 28 A.A.R. 111 (January 7, 2022), with an effective date of January 2, 2022 (Supp. 21-4).

**ARTICLE 2. ARIZONA REGISTERED AND PRACTICAL NURSING PROGRAMS; REFRESHER PROGRAMS****R4-19-201. Organization and Administration****A.** The parent institution of a nursing program shall:

1. Be accredited as a post-secondary institution, college, or university, by an accrediting body that is recognized as an accrediting body by the U.S. Department of Education.
2. Hold Arizona Private Post-secondary board approval status, if applicable.
3. Submit evidence to the board of continuing accreditation after each reaccreditation review or action.
4. Operate any RN or PN program under its post-secondary accreditation if the parent institution holds both secondary and post-secondary accreditation.
5. Notify the Board within 15 days of any change or pending change in institutional accreditation status or reporting requirements.
6. Provide adequate fiscal, physical, learning resources and adequate human resources to recruit, employ and retain sufficient numbers of qualified faculty members to support program processes and outcomes necessary for compliance with this Article.
7. Center the administrative control of the nursing program in the nursing program administrator and shall provide the support and resources necessary to meet the requirements of R4-19-203 and R4-19-204.
8. Ensure that the nursing program is an integral part of the parent institution and shall have at a minimum equivalent status with other academic units of the parent institution.
9. Appoint a sole individual to the position of nursing program administrator, and fill any program administrator vacancies within 15 days.
10. Notify the Board of any changes in program administrator within 30 days and ensure that the individual appointed meets the requirements of, and fulfills the duties specified in R4-19-203.
11. Ensure that every registered nursing program faculty member holds a current Arizona registered nurse license in good standing or multi-state privilege to practice in Arizona under A.R.S., Title 32, Chapter 15, and that every faculty member meets one of the following:
  - a. If providing didactic instruction:
    - i. At least two years of experience as a registered nurse providing direct patient care; and
    - ii. A graduate degree. The majority of the faculty members of a registered nursing program shall hold a graduate degree with a major in nursing. If the graduate degree is not in nursing, the faculty member shall hold a minimum of a baccalaureate degree in nursing.
  - b. If providing clinical instruction only, as defined in R4-19-101:
    - i. The requirements for didactic faculty, or

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- ii. A baccalaureate degree with a major in nursing and at least three years of experience as a registered nurse providing direct patient care.
- 12. Ensure that each practical nursing program faculty member holds a current Arizona registered nurse license in good standing or multi-state privilege to practice in Arizona under A.R.S. Title 32, Chapter 15, and that every faculty member meets the following:
  - a. At least two years of experience as a registered nurse providing direct patient care, and
  - b. A minimum of a baccalaureate degree with a major in nursing.

**B. A nursing program shall:**

- 1. Maintain an organizational chart that identifies the actual relationships, lines of authority, and channels of communication within the program, between the program, and between the program and the parent institution.
- 2. Develop, implement, and enforce written policies and procedures that provide:
  - a. A mechanism for student feedback into the development of academic policies and procedures and allow students to anonymously evaluate faculty, nursing courses, clinical experiences, resources and the overall program.
  - b. Personnel policies for didactic and clinical nursing faculty members including workload policies that facilitate safe and effective nursing education, including clinical experiences.
  - c. For clinical experiences, ensure that:
    - i. At least one nursing faculty member is assigned to no more than ten students while students are directly or indirectly involved in the care of patients, including precepted experiences.
    - ii. Faculty supervises all students in clinical areas in accordance with the acuity of the patient population, clinical objectives, demonstrated competencies of the student, and requirements established by the clinical agency.
    - iii. Either faculty or program-approved preceptors are on site supervising students during all patient care.
- 3. Provide the minimum number of qualified faculty members necessary for compliance with the provisions of this Article.
- 4. Develop and implement a written plan for the systematic evaluation of the total program that is based on program and student learning outcomes and that incorporates continuous improvement based on the evaluative data. The plan shall include measurable outcome criteria, logical methodology, frequency of evaluation, assignment of responsibility, actual outcomes and actions taken. The following areas shall be evaluated:
  - a. Internal structure of the program, its relationship to the parent institution, and compatibility of program policies and procedures with those of the parent institution;
  - b. Mission and goals consistent with those of the parent institution and compatible with current concepts in nursing education and practice appropriate for the type of nursing program offered;
  - c. Curriculum;
  - d. Education facilities, resources, and student support services;
  - e. Clinical resources;

- f. Student achievement of program educational outcomes;
- g. Admission and graduation data for each admission cohort, including, at a minimum, the number and percent of students who graduated within 100%, 150% or greater than 150% of time allotted in the curriculum plan.
- h. Graduate performance on the licensing examination;
- i. Protection of patient safety including but not limited to:
  - i. Student and faculty policies regarding supervision of students, practicing within scope and student safe practice;
  - ii. The integration of safety concepts within the curriculum;
  - iii. The application of safety concepts in the clinical setting; and
  - iv. Policies made under R4-19-203(C)(6).
- 5. Maintain current and accurate records of the following:
  - a. Student admission materials, courses taken, grades received, scores in any standardized tests taken, health and performance, and health information submitted to meet program or clinical requirements, for a minimum of three years after the fiscal year of program completion for academic records and one year after program completion for health records;
  - b. Faculty registered nursing license number issued by the board, evidence of fulfilling the requirements in R4-19-204, and performance evaluations for faculty employed by the parent institution. Records shall be kept current during the period of employment and retained for a minimum of three years after termination of employment;
  - c. Minutes of faculty and committee meetings for a minimum of three years;
  - d. Reports from accrediting agencies and the Board for a minimum of 10 years;
  - e. Curricular materials consistent with the requirements of R4-19-206 for the current curriculum and, previous curricula used within the past three years; and
  - f. Formal program complaints and grievances since the last site review with evidence of resolution for a minimum of three years.
- C. Prior to final approval for new nursing programs and by July 31, 2015 for existing programs, all RN nursing programs offering less than a bachelor's degree in nursing shall have a minimum of one articulation agreement with a Board approved and nationally accredited baccalaureate or higher nursing program that includes recognition of prior learning in nursing and recognition of foundational courses.

**Historical Note**

Former Section I, Part I; Amended effective January 20, 1975 (Supp. 75-1). Former Section R4-19-11 repealed, new Section R4-19-11 adopted effective February 20, 1980 (Supp. 80-1). Amended effective July 16, 1984 (Supp. 84-4). Former Section R4-19-11 renumbered as Section R4-19-201 (Supp. 86-1). Section repealed; new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final



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rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-202. Repealed****Historical Note**

Former Section I, Part II; Former Section R4-19-12 repealed, new Section R4-19-12 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-12 repealed, new Section R4-19-12 adopted effective July 16, 1984 (Supp. 84-4). Former Section R4-19-12 renumbered as Section R4-19-202 (Supp. 86-1). Section repealed; new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Repealed by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-203. Administrator; Qualifications and Duties**

- A. The nursing program administrator shall hold a current Arizona registered nurse license in good standing or multi-state privilege to practice in Arizona under A.R.S., Title 32, Chapter 15 and:
  1. For registered nursing programs:
    - a. A graduate degree with a major in nursing;
    - b. A minimum of three years work experience as a registered nurse providing direct patient care; and
    - c. If appointed to the position of nursing program administrator on or after the effective date of these rules, have a minimum of one academic year full-time experience teaching in or administering a nursing education program leading to licensure; or
  2. For practical nursing programs:
    - a. If appointed prior to the effective date of these rules, a baccalaureate degree with a major in nursing; and
    - b. If appointed on or after the effective date of these rules, the requirements of subsection (A)(1).
- B. The administrator shall have comparable status with other program administrators in the parent institution and shall report directly to an academic officer of the institution.
- C. The administrator shall have the authority and responsibility to direct the program in all its phases, including:
  1. Administering the nursing education program;
  2. Directing activities related to academics, personnel, curriculum, resources, facilities, services, program policies, and program evaluation;
  3. Preparing and administering the budget;
  4. Evaluating nursing program faculty members at a minimum:
    - a. Annually in the first year of employment and every three years thereafter;
    - b. Upon receipt of information that a faculty member, in conjunction with performance of their duties, may be engaged in conduct that is or might be:
      - i. Below a pattern of conduct the standards of the program or the parent institution,
      - ii. A pattern of conduct that is inconsistent with nursing professional standards, or
      - iii. Any conduct that is potentially or actually harmful to a patient or a student.

- c. In the areas of teaching ability and application of nursing knowledge and skills relative to the teaching assignment.
5. Together with faculty:
  - a. Developing, implementing, consistently enforcing, evaluating, and revising, as necessary:
    - i. Equivalent student and faculty policies necessary for safe patient care, including faculty supervision of clinical activities, and to meet clinical agency requirements regarding student and faculty physical and mental health, criminal background checks, substance use screens, and functional abilities.
    - ii. The program of learning including the curriculum and learning outcomes of the program, standards for the admission, progression, and graduation of students, and written policies for faculty orientation, continuous learning and evaluation.
    - iii. Student and faculty policies regarding minimal requisite nursing skills and knowledge necessary to provide safe patient care for the type of unit and patient assignment.
  - b. Participate in advisement and guidance of students.
6. Participating in activities that contribute to the governance of the parent institution.

**Historical Note**

Former Section I, Part III; Former Section R4-19-13 repealed, new Section R4-19-13 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-13 repealed, new Section R4-19-13 adopted effective July 16, 1984 (Supp. 84-4). Former Section R4-19-13 renumbered as Section R4-19-203 (Supp. 86-1). Section repealed; new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). The numbering outline under R4-19-203(C) has been corrected at the request of the Board, file number R20-02 (Supp. 19-3).

**R4-19-204. Repealed****Historical Note**

Former Section I, Part IV; Former Section R4-19-14 repealed, new Section R4-19-14 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-14 repealed, new Section R4-19-14 adopted effective July 16, 1984 (Supp. 84-4). Former Section R4-19-14 renumbered as Section R4-19-204 (Supp. 86-1). Section repealed; new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Repealed by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-205. Students; Policies and Admissions**

- A. The number of students admitted to a nursing program shall be determined by the number of qualified faculty, the size, num-

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ber and availability of educational facilities and resources, and the availability of the appropriate clinical learning experiences for students.

- B. A nursing program shall implement written student admission and progression requirements that are evidence-based, allow for a variety of clinical experiences and satisfy the licensure criteria of A.R.S. Title 32, Chapter 15 and A.A.C. Title 4 Chapter 19.
- C. A nursing program and parent institution shall:
  1. Develop and enforce written policies that are readily available to:
    - a. Students, in either the college catalogue or nursing student handbook, that address student rights, responsibilities, grievance processes, health, safety; and
    - b. Students and the public, for policies regarding, admission, readmission, transfer, advanced placement, progression, graduation, withdrawal, and dismissal.
  2. Provide accurate and complete written information that is readily available to all students and the general public about the program, including:
    - a. The nature of the program, including course sequence, prerequisites, co-requisites and academic standards;
    - b. The length of the program;
    - c. Total program costs including tuition, fees and all program related expenses;
    - d. The transferability of credits to other public and private educational institutions in Arizona; and
    - e. A clear statement regarding any technology based instruction and the technical support provided to students.
- D. A nursing program shall communicate changes in policies, procedures and program information clearly to all students, prospective students and the public and provide advance notice in a time-frame that allows those who are or may be affected to comply with the changes.

**Historical Note**

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-15 repealed, new Section R4-19-15 adopted effective July 16, 1984 (Supp. 84-4). Former Section R4-19-15 renumbered as Section R4-19-205 (Supp. 86-1). Section repealed; new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-206. Curriculum**

- A. A nursing program shall provide a written program curriculum to students that includes:
  1. Student centered outcomes for the program;
  2. A curriculum plan that identifies the prescribed course sequencing and time required;
  3. Specific course information that includes:
    - a. A course description and outline including student centered and measurable didactic, clinical, and sim-

ulation objectives, if applicable, for each unit of instruction;

- b. Graded activities to demonstrate that course objectives have been met.

- B. A nursing program administrator and faculty members shall ensure that the curriculum:
  1. Is designed so that the student is able to achieve program objectives within the curriculum plan;
  2. Is logically consistent between and within courses and structured in a manner whereby each course builds on previous learning.
  3. Incorporates established professional standards, guidelines or competencies; and
  4. Is designed so that a student who completes the program will have the knowledge and skills necessary to function in accordance with the definition and scope of practice specified in A.R.S. for a practical nurse Title 32, Chapter 15 and A.A.C. Title 4 Chapter 19, for a registered or practical nurse, as applicable.
- C. A nursing program shall provide for progressive sequencing of classroom and clinical instruction sufficient to meet the goals of the program and be organized in such a manner to allow the student to form necessary links of theoretical knowledge, clinical reasoning, and practice.
  1. A nursing program curriculum shall provide coursework that includes, but is not limited to:
    - a. Content in the biological, physical, social, psychological and behavioral sciences, professional responsibilities, legal and ethical issues, history and trends in nursing and health care, to provide a foundation for safe and effective nursing practice consistent with the level of the nursing program;
    - b. Didactic content and supervised clinical experience in the prevention of illness and the promotion, restoration and maintenance of health in patients across the life span and from diverse cultural, ethnic, social and economic backgrounds to include:
      - i. Patient centered care,
      - ii. Teamwork and collaboration,
      - iii. Evidence-based practice,
      - iv. Quality improvement,
      - v. Safety, and
      - vi. Informatics.
  2. A registered nursing program shall provide clinical instruction that includes, at a minimum, selected and guided experiences that develop a student's ability to apply core principles of registered nursing in varied settings when caring for:
    - a. Adult and geriatric patients with acute, chronic, and complex, life-threatening, medical and surgical conditions;
    - b. Peri-natal patients and families;
    - c. Neonates, infants, and children;
    - d. Patients with mental, psychological, or psychiatric conditions; and
    - e. Patients with wellness needs.
  3. A practical nursing program shall provide clinical instruction that includes, at minimum, selected and guided experiences that develop a student's ability to apply core principles of practical nursing when caring for:
    - a. Patients with medical and surgical conditions throughout the life span,
    - b. Peri-natal patients, and

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- c. Neonates, infants, and children in varied settings.
- 4. A nursing program shall assign students only to those clinical agencies that provide the experience necessary to meet the established clinical objectives of the course.
- E. A nursing program may provide precepted clinical instruction. Programs offering precepted clinical experiences shall:
  - 1. Develop and enforce policies that require preceptors to:
    - a. Be licensed nurses at or above the level of the program either by holding an Arizona license in good standing, holding multi-state privilege to practice in Arizona under A.R.S. Title 32, Chapter 15, or if practicing in a federal facility, meet requirements of A.R.S. § 32-1631(5);
    - b. For LPN preceptors, practice under the supervision required by A.R.S. Title 32, Chapter 15.
  - 2. Develop and implement policies that require a faculty member of the program to:
    - a. Together with facility personnel, select preceptors that possess clinical expertise sufficient to accomplish the goals of the preceptorship;
    - b. Supervise the clinical instruction consistent with requirements of this Article, and
    - c. Maintain accountability for student education and evaluation.
- F. A nursing program may utilize simulation in accordance with the clinical objectives of the course. Unless approved under R4-19-214, a nursing program shall not utilize simulation for an entire clinical experience with any patient population identified in subsection (D) of this Section.
- G. A nursing program shall maintain at least a 80% NCLEX® passing rate for graduates taking the NCLEX-PN® or NCLEX-RN® for the first time within 12 months of graduation.
- H. At least 45% of students enrolled in the first nursing clinical course shall graduate within 100% of the prescribed period. "Prescribed period" means the time required to complete all courses and to graduate on time according to the nursing program's curriculum plan in place at the time the student entered the program, excluding the time to complete program pre-requisite or pre-clinical courses.

**Historical Note**

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-16 repealed, former Section R4-19-17 renumbered and amended as Section R4-19-16 effective July 16, 1984 (Supp. 84-4). Former Section R4-19-16 renumbered as R4-19-206 (Supp. 86-1). Section repealed; new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citations in subsection (B)(3) were updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). A.R.S. section references updated under subsection (C)(5) under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-207. New Programs; Proposal Approval; Provisional****Approval**

- A. At a minimum of one year before establishing a nursing program, a parent institution shall submit to the Board an electronic copy of an application for proposal approval. The parent institution shall ensure that the proposal application was written by or under the direction of a registered nurse who meets the nursing program administrator requirements of R4-19-203(A) and includes the following information and documentation:
  - 1. Name and address of the parent institution;
  - 2. Statement of intent to establish a nursing program, including the academic and licensure level of the program; and:
    - a. Organizational structure of the educational institution documenting the relationship of the nursing program within the institution and the role of the nursing program administrator consistent with R4-19-201 and R4-19-203;
    - b. Evidence of institutional accreditation consistent with R4-19-201 and post-secondary approval, if applicable. The institution shall provide the most recent full reports including findings and recommendations of the applicable accrediting organization or approval agency. The Board may request additional accreditation or approval evidence.
  - c. Curriculum development documentation to include:
    - i. Student-centered outcomes for the program;
    - ii. A plan that identifies the prescribed course sequencing and time required; and
    - iii. Identification of established professional standards, guidelines or competencies upon which the curriculum will be based;
  - d. Name, qualifications, and job description of a nursing program administrator who meets the requirements of R4-19-203 and availability and job description of faculty who meet qualifications of R4-19-204;
  - e. Number of budgeted clinical and didactic faculty positions from the time of the first admission to graduation of the first class;
  - f. Evidence that the program has secured clinical sites for its projected enrollment that meet the requirements of R4-19-206;
  - g. Anticipated student enrollment per session and annually;
  - h. Documentation of planning for adequate academic facilities and secretarial and support staff to support the nursing program consistent with the requirements of R4-19-202;
  - i. Evidence of adequate program financial resources;
  - j. Tentative time schedule for planning and initiating the nursing program including faculty hiring, entry date and size of student cohorts, and obtaining and utilizing clinical placements from the expected date of proposal approval to graduation of the first cohort.
  - k. For a parent institution that has an existing nursing program in one or more U.S. jurisdictions including Arizona, evidence for each of its nursing programs that includes:
    - i. Program approval in good standing with no order entered in this or any other jurisdiction, which if entered by this state would constitute the denial of a license or a disciplinary action

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- within the meaning of A.R.S. § 32-1601, subsection 12, paragraphs (d), (e), (f), (g), (h); and
- ii. An NCLEX pass rate of at least 80% for the 12 months preceding the current application; or
  - iii. The parent institution successfully demonstrates to the Board that:
    - (1) The program is in the best interests of the public. The Board's consideration of what is in the best interests of the public shall include, but is not limited to, the geographic need for a new nursing program, the populations that would be served by the program, adequate program oversight, institutional financial security, adequacy of the program proposal, and a demonstrated history of cooperation with accrediting and regulatory bodies; and
    - (2) The program will be capable of meeting all other applicable requirements for the establishment of a nursing program.
- B.** The Board shall grant proposal approval to any parent institution that meets the requirements of subsection (A) if the Board deems that such approval is in the best interests of the public. Proposal approval expires one year from the date of Board issuance.
- C.** A parent institution that is denied proposal approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for proposal approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.
- D.** At a minimum of 180 days before planned enrollment of students, a parent institution that received proposal approval within the previous year may submit to the Board an electronic copy of an application for provisional approval. The parent institution shall ensure that the provisional approval application was written by or under the direction of a registered nurse who meets the program administrator requirements of R4-19-203(A) and includes the following information and documentation:
1. Name and address of parent institution;
  2. A self-study that provides evidence supporting compliance with R4-19-201 through R4-19-206, and
  3. Names and qualifications of:
    - a. The nursing program administrator;
    - b. Didactic nursing faculty or one or more nurse consultants who are responsible for developing the curriculum and determining nursing program admission, progression and graduation criteria;
  4. Plan for recruiting and hiring additional didactic faculty for the first semester or session of operation at least 60 days before classes begin;
  5. Plan for recruiting and hiring additional clinical nursing faculty at least 30 days before the clinical rotation begins;
  6. Final program implementation plan including dates and number of planned student admissions, recruitment and hire dates for didactic and clinical faculty for the period of provisional approval;
  7. Descriptions of available and proposed physical facilities with dates of availability; and
  8. Detailed written plan for clinical placements for all planned enrollments until graduation of the first class that is:
    - a. Based on current clinical availability and curriculum needs;
    - b. Confirms availability and commitment from proposed clinical agencies for the times and units specified.
- E.** Following an onsite evaluation conducted according to A.R.S. § 41-1009, the Board shall grant a two year provisional approval to a parent institution that meets the requirements of R4-19-201 through R4-19-206 if approval is in the best interest of the public. A parent institution that is denied provisional approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for provisional approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.
- F.** The provisional approval of a nursing program expires 12 months from the date of the grant of provisional approval if a class of nursing students is not admitted by the nursing program within that time.
- G.** One year after admission of the first nursing class into nursing courses, the program shall provide a report to the Board containing information on:
1. Implementation of the program including any differences from the plans submitted in the applications for proposal and provisional approval and an explanation of those differences; and
  2. The outcomes of the evaluation of the program according to the program's systematic evaluation plan under R4-19-201;
- H.** Following receipt of the report described in subsection (G), a representative of the Board shall conduct a site survey visit in accordance with A.R.S. § 41-1009 to determine compliance with this Article. A report of the site visit shall be provided to the Board.
- I.** If a nursing program with provisional approval fails to comply with requirements of A.R.S. Title 32, Chapter 15, or 4 A.A.C. 19, Article 4, the Board may initiate a disciplinary action. Prior to imposition of discipline against a provisional approval, the nursing program is entitled to a hearing conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-17 renumbered and amended as Section R4-19-16 effective July 16, 1984 (Supp. 84-4). Former Section R4-19-17 renumbered as R4-19-207 (Supp. 86-1). New Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4). Section made by emergency rulemaking at 30 A.A.R. 66 (January 12, 2024), with an immediate effective date of December 19, 2023; effective for 180 days (Supp. 23-4). Emergency renewed at 30 A.A.R. 2021 (June 7, 2024), effective June 17, 2024; the renewal is effective for an additional 180 days, pursuant to A.R.S. § 41-1026 (Supp. 24-2). Emergency expired on Decem-

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ber 14, 2024; new Section made by final rulemaking at 30 A.A.R. 3427 (November 15, 2024), effective December 27, 2024. The Governor's Regulatory Review Council approved this Section on July 2, 2024; the Board did not file the Notice of Final Rulemaking until October 28, 2024. Per statute, this rule became effective 60 days after filing with the Office of the Secretary of State. To review this Section effective between December 15 and December 26, 2024, refer to supplement 24-2, 4 A.A.C. 19, page 14 (Supp. 24-4).

**R4-19-208. Full Approval of a New Nursing Program**

- A.** A nursing program seeking full approval shall submit an electronic application that includes the following information and documentation:
1. Name and address of the parent institution,
  2. Date the nursing program graduated its first class of students, and
  3. A self-study report that contains evidence the program is in compliance with R4-19-201 through R4-19-206.
- B.** Following an onsite evaluation conducted according to A.R.S. § 41-1009, the Board shall grant full approval for a maximum of five years or the accreditation period for nationally accredited programs governed by R4-19-213, to a nursing program that meets the requirements of this Article and if approval is in the best interest of the public. A nursing program that is denied full approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for full approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

**Historical Note**

Adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-209. Nursing Program Change**

- A.** A nursing program administrator shall receive approval from the Board before implementing any of the following nursing program changes:
1. Curriculum or program delivery method;
  2. Increasing or decreasing the academic credits or units of the program excluding pre-requisite credits;
  3. Adding a geographical location of the program;
  4. Changing the level of educational preparation provided;
  5. Transferring the nursing program from one parent institution to another; or
  6. Establishing different admission, progression or graduation requirements for specific cohorts of the program.
- B.** The administrator shall submit an electronic copy of the following materials with the request for nursing program changes:
1. The rationale for the proposed change and the anticipated effect on the program administrator, faculty, students, resources, and facilities;
  2. A summary of the differences between the current practice and proposed change;
  3. A timetable for implementation of the change; and
  4. The methods of evaluation to be used to determine the effect of the change.

- C.** The Board shall approve a request for a nursing program change if the program meets the requirements of this Section and R4-19-201 through R4-19-206. A nursing program that is denied approval of program changes may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for program change. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-210. Renewal of Approval of Nursing Programs Not Accredited by a National Nursing Accrediting Agency**

- A.** An approved nursing program that is not accredited by an approved national nursing accrediting agency shall submit an application packet to the Board at least four months before the expiration of the current approval that includes the following:
1. Name and address of the parent institution,
  2. Evidence of current institutional accreditation status under R4-19-201,
  3. Evidence that the program has secured clinical sites for its projected enrollment that meet the requirements of R4-19-206,
  4. Copy or on-line access to:
    - a. A current catalog of the parent institution,
    - b. Current nursing program and institutional student and academic policies, and
    - c. Institutional and nursing program faculty policies and job descriptions for nursing program faculty, and
  5. An electronic copy of a self-study report that contains evidence of compliance with R4-19-201 through R4-19-206.
- B.** Following an onsite evaluation conducted according to A.R.S. § 41-1009, the Board shall renew program approval for a maximum of five years if the nursing program meets the criteria in R4-19-201 through R4-19-206 and if renewal is in the best interest of the public. The Board shall determine the term of approval that is in the best interest of the public.
- C.** If the Board denies renewal of approval, the nursing program may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for renewal of approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019

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(Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-211. Unprofessional Conduct in a Nursing Program; Reinstatement or Reissuance**

A. A disciplinary action, or denial of approval, may be issued against a nursing, refresher, pilot, or distance learning program for any of the following acts of unprofessional conduct:

1. A pattern of failure to maintain minimum standards of acceptable and prevailing educational or nursing practice, or any such failure related to student or patient health, welfare, or safety;
2. A pattern of deficiencies in compliance with the provisions of this Article, or any such deficiency related to student or patient health, welfare, or safety;
3. Utilization or substitution of students to meet staffing needs in health care facilities;
4. A pattern of non-compliance with the program's or parent institution's mission or goals, program design, objectives, or policies, or any such deficiency related to student or patient health, welfare, or safety;
5. Failure to provide the variety and number of clinical learning opportunities necessary for students to achieve program outcomes or minimal nursing competence;
6. Student enrollments without necessary faculty, facilities, or clinical experiences to achieve program outcomes or minimal nursing competence;
7. Ongoing or repetitive employment of unqualified faculty or program administrator;
8. Failure to comply with Board requirements within designated time-frames;
9. Fraud or deceit in advertising, promoting or implementing the program;
10. Material misrepresentation of fact in any application or information submitted to the Board;
11. Failure to allow Board staff to visit the program or conduct an investigation including failure to supply requested investigative documents;
12. Any other evidence that the program's conduct may be a threat to the safety and well-being of students, faculty, patients or potential patients;
13. Violation of any other state or federal laws, rules, or regulations that may indicate a threat to the safety or well-being of students, faculty, patients or potential patients.

B. If a program's approval was surrendered, rescinded, or denied, the program may reapply for reinstatement or reissuance of approval after a period prescribed by the Board, not to exceed five years. The program must comply with all application requirements in this Article, and further provide evidence of remediation of all violations that led to the rescission. The Board shall review the evidence, and reinstate or reissue approval of the program if the program has demonstrated remediation, complies with all program requirements in A.R.S. Title 32, Chapter 15, and this Chapter and reinstatement is in the best interests of the public. If reinstatement or reissuance is denied, the may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective Novem-

ber 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). R4-19-211 renumbered to R4-19-212; New Section R4-19-211 made by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-212. Repealed**

**Historical Note**

Adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). R4-19-212 renumbered to R4-19-213; New Section R4-19-212 renumbered from R4-19-211 and amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Repealed by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-213. Nursing Programs Holding National Program Accreditation; Changes in Accreditation**

- A. A nationally accredited nursing program or a program seeking national accreditation or re-accreditation shall inform the Board at least 30 days in advance of any pending visit by a nursing program accrediting agency and allow Board staff to attend all portions of the visit.
- B. Following any visit by the accrediting agency, a nursing program shall submit a complete copy of all site visit reports to the Board within 15 days of receipt by the program and notify the Board within 15 days of any change or known pending change in program accreditation status or reporting requirements.
- C. The administrator of a nursing program that loses its accreditation status or allows its accreditation status to lapse shall file an application for renewal of approval under R4-19-210 within 30 days of loss of or lapse in accreditation status.
- D. Under A.R.S. § 32-1644(D) the Board may periodically resurvey a nationally accredited program to determine compliance with this Article and require a self study report. Board site visits may be conducted in conjunction with the national accrediting team.
- E. Unless otherwise notified by the Board following receipt and review of the documents required by subsections (A) and (B), a nationally accredited nursing program continues to retain full-approval status unless the Board rescinds the approval after the program has had an opportunity for a hearing in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). R4-19-213 renumbered to R4-19-215; New Section R4-19-213 renumbered from R4-19-212 and amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-214. Pilot Programs for Innovative Approaches in Nursing Education**

- A. Under A.R.S. § 32-1606(A)(9) a nursing education program, refresher program or a certified nursing assistant program may implement a pilot program for an innovative approach by complying with the provisions of this Section. Education programs approved to implement innovative approaches shall comply

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with all other applicable provisions of A.R.S. Title 32, Chapter 15 and this Chapter.

- B.** A program applying for a pilot program shall:
  1. Hold full approval in good standing; and
  2. Have no discipline in the past two years.
- C.** The following written information shall be provided to the Board at least 90 days prior to a Board meeting to seek approval for a pilot program:
  1. Identifying information including name of program, address, responsible party and contact information;
  2. A brief description of the current program, including accreditation and Board approval status;
  3. Identification of the regulation or regulations that the proposed innovative approach would violate without pilot program board approval;
  4. Length of time for which the innovative approach is requested;
  5. Description of the innovative approach, including rationale and objectives;
  6. Explanation of how the proposed innovation differs from approaches in the current program;
  7. Available evidence supporting the innovative approach;
  8. Identification of resources that support the proposed innovative approach;
  9. Expected impact the innovative approach will have on the program, including administration, students, faculty, and other program resources;
  10. Plan for implementation and evaluation of the proposed innovation, including timeline;
  11. Additional application information as requested by the Board.
- D.** The Board shall approve an application for a pilot program that is in the best interests of the public, and meets the following criteria:
  1. Eligibility criteria in subsection (B) and application criteria in subsection (C) are met;
  2. The innovative approach will not compromise the quality of education or safe practice of students;
  3. Resources are sufficient to support the innovative approach;
  4. Rationale with available evidence supports the implementation of the innovative approach;
  5. Implementation plan is reasonable to achieve the desired outcomes of the innovative approach;
  6. Timeline provides for a sufficient period to implement and evaluate the innovative approach; and
  7. Plan for periodic evaluation is comprehensive and supported by appropriate methodology.
- E.** The Board may:
  1. Deny the application or request additional information if the program does not meet the criteria in subsections (B) and (C), or otherwise is not in the best interests of the public. The program may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying an application for a pilot program. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, and 4 A.A.C. 19, Article 6 of this Chapter.
  2. Rescind the approval of the innovation, after an opportunity for a hearing in accordance with A.R.S. Title 41, Chapter 6, and Article 6 of this Chapter, or require the program to make modifications if:

- a. The Board receives substantiated evidence indicating adverse impact on the program, students, faculty, patients, or the public,
- b. The program fails to implement or evaluate the innovative approach as presented and approved, or
- c. The program fails to maintain eligibility criteria in subsection (B).

- F.** An education program that is granted approval for an innovation shall maintain eligibility criteria in subsection (B) and submit:
  1. Progress reports conforming to the evaluation plan annually or as requested by the Board; and
  2. A final evaluation report that conforms to the evaluation plan, detailing and analyzing the outcomes data.
- G.** If the innovative approach has achieved the desired outcomes and the final evaluation has been submitted, the program may request that the innovative approach be continued.
- H.** The Board may grant the request to continue approval if the innovative approach has achieved desired outcomes and is in the best interests of the public.
- I.** If the Board denies the request to continue approval of the pilot program, the program may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying renewal of the pilot program. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 7 A.A.R. 5349, effective November 8, 2001 (Supp. 01-4). Amended by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (05-1). R4-19-214 renumbered to R4-19-216; New Section R4-19-214 made by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-215. Voluntary Termination of a Nursing Program or a Refresher Program**

- A.** The administrator of a nursing program or a refresher program shall notify the Board within 15 days of a decision to voluntarily terminate the program. The administrator shall, at the same time, submit a written plan for terminating the nursing program or refresher program. A program is considered voluntarily terminated when it no longer admits or plans to admit students after current students graduate.
- B.** The administrator shall ensure that the nursing program or refresher program is maintained, including the nursing faculty, until the last enrolled student is transferred or completes the program. At that time the Board shall remove the program from the current list of approved programs.
- C.** Within 15 days after the termination of a nursing program or refresher program, the administrator shall notify the Board of the permanent location and availability of all program records.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 451, effective March 7, 2005 (Supp. 05-1). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). R4-19-215 renumbered to R4-19-217; New Section R4-19-215 renumbered from R4-19-213 and amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019

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(Supp. 19-2).

**R4-19-216. Approval of a Refresher Program**

- A.** An applicant for approval of a refresher program for nurses whose licenses have been inactive or expired for five or more years, nurses under Board order to enroll in a refresher program, or nurses who have not met the nursing practice requirements of R4-19-312 shall submit an electronic, completed application that provides all of the following information and documentation:
1. Applicant's name, address, e-mail address, telephone number, web site address, if applicable, and fax number;
  2. Proposed starting date for the program;
  3. Name and qualifications of all instructors that meet the requirements of subsection (C);
  4. Statement describing the facilities, staff, and resources that the applicant will use to conduct the refresher program;
  5. A program and participant evaluation plan that includes student evaluation of the course, instructor, and clinical experience;
  6. Evidence of a curriculum that meets the requirements of subsection (B);
- B.** A refresher program for registered and practice nurses shall provide:
1. Didactic instruction sufficient to ensure competent and safe practice to the applicable level of the nursing license, including the following subjects, at a minimum:
    - a. Nursing process and patient centered care;
    - b. Pharmacology, medication calculation, and medication administration;
    - c. Communication and working with inter-professional teams;
    - d. Critical thinking, clinical decision making and evidence-based practice;
    - e. Delegation, management, and leadership;
    - f. Meeting psychosocial and physiological needs of adult clients with medical-surgical conditions. Other populations of care may be added to the content at the program's discretion;
    - g. Ethics; and
    - h. Informatics, to include electronic health record documentation.
  2. The program shall provide clinical experiences that, at a minimum:
    - a. Ensure that each qualified student has a verified clinical placement within six months of course enrollment;
    - b. Provide program policies for clinical placement in advance of enrollment that specify both the obligations of the school and the student regarding placement;
    - c. Validate that a student has the necessary didactic and theoretical knowledge to function safely in the specific clinical setting before starting a clinical experience;
    - d. Ensure that clinical experiences are of the type and duration to meet the course objectives.
  3. Laboratory practice hours, at the program's discretion, including simulation experiences in accordance with the clinical objectives of the course, but may not replace clinical experiences.
  4. Curriculum and other materials to students and prospective students that, include:
    - a. An overall program description including student learning objectives;
    - b. Objectives, content outline, and hours for didactic and clinical experience;
    - c. Course policies that include but are not limited to admission requirements, passing criteria, cause for dismissal, clinical requirements, grievance process and student responsibilities, cost, and length of the program.
- C.** Refresher program personnel qualifications and responsibilities:
1. An administrator of a refresher program shall:
    - a. Hold a graduate degree in nursing or a bachelor of science in nursing degree and a graduate degree in either education or a health-related field, and
    - b. Be responsible for administering and evaluating the program.
  2. A faculty member of a refresher program shall:
    - a. Hold a minimum of a bachelor of science in nursing degree,
    - b. Be responsible for implementing the curriculum and supervising clinical experiences either directly or indirectly through the use of clinical preceptors.
  3. Licensure requirements for program administrator and faculty: The administrator and faculty members shall hold a current Arizona RN license in good standing or a multi-state privilege under A.R.S., Title 32, Chapter 15.
  4. If preceptors are used for clinical experiences, the program shall adhere to the preceptorship requirements of R4-19-206(E).
  5. Licensed health care professionals not regulated by the Board may participate in course instruction consistent with their licensure and scope of practice, under the direction of the program administrator or faculty.
- D.** Program types; bonding:
1. A refresher program may be offered by:
    - a. An educational institution licensed by the State Board for Private Postsecondary Education;
    - b. A public post-secondary educational institution;
    - c. A health care institution licensed by the Arizona Department of Health Services or a health care institution authorized by the Centers for Medicare & Medicaid Services; or
    - d. A private business that meets the requirements of this Section and all other legal requirements to operate a business in Arizona;
    - e. A program funded by a local, state or federal governmental agency, such as a program within a technical school or school of nursing.
  2. If the refresher program is offered by a private business not licensed by the State Board for Private Postsecondary Education, the program shall meet the following requirements:
    - a. Hold a minimum of \$15,000 of insurance covering any potential or future claims for damages resulting from any aspect of the program or a hold a surety bond from a surety company with a rating of "A minus" or better by either Best's Credit Ratings, Moody's Investor Service, or Standard and Poor's rating service.
    - b. The program shall ensure that:
      - i. Bond or insurance distributions are limited to students or former students with a valid claim for instructional or program deficiencies;



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- ii. The amount of the bond or insurance coverage is sufficient to reimburse the full amount of collected tuition and fees for all students during all enrollment periods of the program; and
  - iii. The bond or insurance is maintained for an additional 24 months after program closure.
- E. The Board shall approve a refresher program that meets the requirements of this Section, if approval is in the best interest of the public, for a maximum term of five years. An applicant who is denied refresher program approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and Article 6 of this Chapter.
- F. The refresher program sponsor shall apply for renewal of approval in accordance with subsection (A) not later than 90 days before expiration of the current approval. The sponsor of a refresher program that is denied renewal of approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for renewal of approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, and 4 A.A.C. 19, Article 6 of this Chapter.
- G. The sponsor of an approved refresher program shall provide written notification to the Board within 15 days of a participant's completion of the program of the following:
  1. Name of the participant and whether the participant successfully completed or failed the program,
  2. Participant's license number, and
  3. End date of participant's participation in the program.
- H. The Board may approve a refresher program application from another U.S. jurisdiction for an individual applicant on a case-by-case basis if the applicant provides verifiable evidence that the refresher program substantially meets the requirements of this Section. The acceptance of the program for an individual applicant does not confer approval status upon the program.
- I. Within 30 days, a refresher program shall report to the Board changes in:
  1. Name, address, email address, web site address or phone number of the program; or
  2. Ownership including adding or deleting an owner.
- J. The Board may take disciplinary action against the approval of a refresher program after offering a hearing conducted in accordance with A.R.S. Title 41, Chapter 6, and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

New Section R4-19-216 renumbered from R4-19-214 and amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020; clerical error corrected at the request of the Board, "of a" removed before the words, "completed application" and comma added after the word "electronic" in subsection A (Supp. 20-4).

**R4-19-217. Distance Learning Nursing Programs; Out-of-State Nursing Programs**

- A. An out-of-state nursing program that is in good standing in another state in the United States and plans to provide distance-based didactic instruction and on-ground clinical

instruction in Arizona shall comply with the application requirements of R4-19-207 and R4-19-208. The program shall employ at least one faculty member who is physically present in this state to coordinate the education and clinical experience.

- B. Any nursing program that delivers didactic instruction in Arizona by distance learning methods shall ensure that the methods of instruction are compatible with the program curriculum plan and enable a student to meet the goals, competencies, and objectives of the educational program and standards of the Board, A.R.S. Title 32, Chapter 15, and this Chapter.
  1. A distance learning nursing program shall establish a means for assessing individual student outcomes, and program outcomes including, at minimum, student learning outcomes, student retention, student satisfaction, and faculty satisfaction.
  2. For out-of-state nursing programs, the program shall be within the jurisdiction of and regulated by an equivalent United States nursing regulatory authority in the state from which the program originates, unless also providing clinical experience in Arizona.
  3. Didactic faculty members shall be licensed in the state of origination of a distance learning nursing program and in Arizona or hold a multi-state compact license unless exempt under A.R.S. § 32-1631(8). Clinical supervising faculty shall be licensed in the location of the clinical activity.
  4. A distance learning nursing program shall provide students with supervised clinical and laboratory experiences so that program objectives are met and didactic learning is validated by supervised, on-ground clinical and laboratory experiences.
  5. A distance-learning nursing program shall provide students with adequate access to technology, resources, technical support, and the ability to interact with peers, preceptors, and faculty.
- C. A nursing program, located in another state or territory of the United States, that wishes to provide clinical experiences in Arizona under A.R.S. § 32-1631(3), shall obtain Board approval before offering or conducting a clinical session. To obtain approval, the program shall submit a proposal package that contains:
  1. A self study, describing the program's compliance with R4-19-201 through R4-19-206; and
  2. A statement regarding, the number and type of student placements planned, and written commitment by the clinical facilities to provide the necessary clinical experiences, the name and qualifications of faculty licensed in Arizona and physically present in the facility who will supervise the experience and verification of good standing of the program in the jurisdiction of origin.
- D. The Board may require a nursing program approved under this Section to file periodic reports to determine compliance with the provisions of this Article. A program shall submit a report to the Board within 30 days of the date on a written request from the Board or by the due date stated in the request if the due date is after the normal 30-day period.
- E. The Board shall approve an application to conduct clinical instruction in Arizona that meets the requirements in A.R.S. Title 32, Chapter 15 and this Chapter, and is in the best interest of the public. An applicant who is denied approval to conduct clinical instruction in Arizona may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for approval. Hear-

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ings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

- F. If the Board finds that a nursing program located and approved in another state or territory of the United States does not meet requirements for nursing programs prescribed in this Article the Board may take other disciplinary action depending on the severity of the offense after offering a hearing conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.
1. Students enrolled at the time of rescission of approval shall not be granted licensure unless the applicant meets all applicable licensure requirements.
  2. The Board shall ensure that the applicant has completed a curriculum that is equivalent to that of an approved nursing program.

**Historical Note**

New Section R4-19-217 renumbered from R4-19-215 and amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**ARTICLE 3. LICENSURE****R4-19-301. Licensure by Examination**

- A. An applicant for licensure by examination shall:

1. Submit a verified application to the Board on a form furnished by the Board that provides the following information about the applicant:
  - a. Full legal name and all former names used by the applicant;
  - b. Address of Record, including declared primary state of residence, e-mail address, and telephone number;
  - c. Place and date of birth;
  - d. Ethnic category and marital status, at the applicant's discretion;
  - e. Social Security number for an applicant who lives or works in the United States;
  - f. Post-secondary education, including the names and locations of all schools attended, graduation dates, and degrees received, if applicable;
  - g. Current employer or practice setting, including address, position, and dates of service, if employed or practicing in nursing or health care;
  - h. Information regarding the applicant's compliance with the practice or education requirements in R4-19-312;
  - i. Any state, territory, or country in which the applicant holds or has held a registered or practical nursing license and the license number and status of the license, including original state of licensure, if applicable;
  - j. The date the applicant previously filed an application for licensure in Arizona, if applicable;
  - k. Responses to questions regarding the applicant's background on the following subjects:
    - i. Current investigation or pending disciplinary action by a nursing regulatory agency in the United States or its territories;
    - ii. Action taken on a nursing license by any other state;

- iii. Undesignated offenses, felony charges, convictions and plea agreements, including deferred prosecution;
- iv. Misdemeanor charges, convictions and plea agreements, including deferred prosecution, that are required to be reported under A.R.S. § 32-3208;
- v. Unprofessional conduct as defined in A.R.S. § 32-1601;
- vi. Substance use disorder within the last 5 years;
- vii. Current participation in an alternative to discipline program in any other state;

- l. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background; and
  - m. Certification in nursing including category, specialty, name of certifying body, date of certification, and expiration date.
2. Submit proof of United States citizenship or alien status as specified in A.R.S. § 41-1080;
  3. Submit a completed fingerprint card on a form provided by the Board or prints for the purpose of obtaining a criminal history report under A.R.S. § 32-1606 if the applicant has not submitted a fingerprint card or prints to the Board within the last two years; and
  4. Pay the applicable fees.
- B. If an applicant is a graduate of a pre-licensure nursing program in the United States that has been assigned a program code by the National Council of State Boards of Nursing during the period of the applicant's attendance, the applicant shall submit one of the following:
1. If the program is an Arizona-approved program, the transcript required in subsection (B)(2) or a statement signed by a nursing program administrator or designee verifying that:
    - a. The applicant graduated from or is eligible to graduate from a registered nursing program for a registered nurse applicant; or
    - b. The applicant graduated from or is eligible to graduate from a practical nursing program or graduated from a registered nursing program and completed Board-prescribed role delineation education for a practical nurse applicant; or
  2. If the program is located either in Arizona or in another state or territory and meets educational standards that are substantially comparable to Board standards for educational programs under Article 2 when the applicant completed the program, an official transcript sent directly from one of the following as:
    - a. Evidence of graduation or eligibility for graduation from a diploma registered nursing program, associate degree registered nursing program, or baccalaureate or higher degree registered nursing program for a registered nurse applicant.
    - b. Evidence of graduation or eligibility for graduation of a practical nursing program, associate degree registered nursing program, or baccalaureate or higher degree registered nursing program for a practical nurse applicant.
- C. If an applicant is a graduate of a pre-licensure international nursing program and lacks items required in subsection (B), the applicant shall comply with subsection (A), submit a self report on the status of any international nursing license, and submit the following:

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1. To demonstrate nursing program equivalency, one of the following:
    - a. If the applicant graduated from a Canadian nursing program, evidence of a passing score on the English language version of either the Canadian Nurses' Association Testing Service, the Canadian Registered Nurse Examination, NCLEX or an equivalent examination;
    - b. A Certificate or Visa Screen Certificate issued by the Commission on Graduates of Foreign Nursing Schools (CGFNS), or a report from CGFNS that indicates an applicant's program is substantially comparable to a U.S. program; or
    - c. A report from any other credential evaluation service (CES) approved by the Board.
  2. If a graduate of an international pre-licensure nursing program subsequently obtains a degree in nursing from an accredited U.S. nursing program, the requirement for a CES equivalency report may be waived by the Board, however the applicant is not eligible for a multi-state compact license.
  3. If an applicant's pre-licensure nursing program provided classroom instruction, textbooks, or clinical experiences in a language other than English, a test of written, oral, and spoken English is required. Clinical experiences are deemed to have been provided in a language other than English if the principal or official language of the country or region where the clinical experience occurred is a language other than English, according to the United States Department of State.
  4. An applicant who is required to demonstrate English language proficiency shall ensure that one of the following is submitted to the Board directly from the testing or certifying agency:
    - a. Evidence of a minimum score of 84 with a minimum speaking score of 26 on the Internet-based Test of English as a Foreign Language (TOEFL),
    - b. Evidence of a minimum score of 6.5 overall with minimum of 6.0 on each module of the Academic Exam of the International English Language Test Service (IELTS) Examination,
    - c. Evidence of a minimum score of 55 overall with a minimum score of 50 on each section of the Pearson Test of English Academic exam.
    - d. A Visa Screen Certificate from CGFNS,
    - e. A CGFNS Certificate,
    - f. Evidence of a similar minimum score on another written and spoken English proficiency exam determined by the Board to be equivalent to the other exams in this subsection, or
    - g. Evidence of employment for a minimum of 960 hours within the past five years as a nurse in a country or territory where the principal language is English, according to the United States Department of State.
- D.** An applicant for a registered nurse license shall attain one of the following:
1. A passing score on the NCLEX-RN;
  2. A score of 1600 on the NCLEX-RN, if the examination was taken before July 1988; or
  3. A score of not less than 350 on each part of the SBTPE for registered nurses.
- E.** An applicant for a practical nurse license shall attain:
1. A passing score on the NCLEX-PN;
  2. A score of not less than 350 on the NCLEX-PN, if the examination was taken before October 1988; or
  3. A score of not less than 350 on the SBTPE for practical nurses.
- F.** The Board shall grant a license to practice as a registered or practical nurse to any applicant who meets the criteria established in statute and this Article. An applicant who is denied a license by examination may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the license. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.
- G.** If the Board receives an application from a graduate of a nursing program and the program's approval was rescinded under R4-19-212 at any time during the applicant's nursing education, the Board shall ensure that the applicant has completed a basic curriculum that is equivalent to that of a Board-approved nursing program and may do any of the following:
1. Grant licensure, if the program's approval was reinstated during the applicant's period of enrollment and the program provides evidence that the applicant completed a curriculum equivalent to that of a Board-approved nursing program;
  2. By order, require successful completion of remedial education while enrolled in a Board approved nursing program which may include clinical experiences, before granting licensure; or
  3. Return or deny the application if the education was not equivalent and no remediation is possible.

**Historical Note**

Former Section II, Part I; Amended effective January 20, 1975 (Supp. 75-1). Amended effective December 7, 1976 (Supp. 76-5). Former Section R4-19-24 repealed, new Section R4-19-24 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-24 repealed, new Section R4-19-24 adopted effective May 9, 1984 (Supp. 84-3). Former Section R4-19-24 renumbered as Section R4-19-301 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-302. Licensure by Endorsement**

- A.** An applicant for a license by endorsement shall submit all of the information required in R4-19-301(A).
- B.** In addition to the information required in subsection (A), an applicant for a license by endorsement shall:
1. Submit evidence of a passing examination score in accordance with:
    - a. R4-19-301(E) for a registered nurse applicant, or
    - b. R4-19-301(F) for a practical nurse applicant.
  2. Submit the following:
    - a. Evidence of previous or current license in another state or territory of the United States,
    - b. Information related to the nurse's practice for the purpose of collecting nursing workforce data, and

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- c. One of the following:
  - i. Completion of a pre-licensure nursing program that has been assigned a nursing program code by the National Council of State Boards of Nursing (NCSBN) at the time of program completion and the program meets educational standards substantially comparable to Board standards for educational programs in Article 2;
  - ii. If the applicant completed a pre-licensure nursing program that has been assigned a program code by the NCSBN but the program's approval was rescinded under A.R.S. § 32-1606(B)(8) or removed from the list of approved programs under A.R.S. § 32-1644(D) or R4-19-212 during the applicant's enrollment in the program, proof of completion of the program and completion of any remedial education required by the Board to mitigate the deficiencies in the applicant's initial nursing program;
  - iii. If the applicant graduated from a U.S. nursing program before 1986 and the applicant was issued an initial license in another state or territory of the United States without being required to obtain additional education or experience, proof both of program completion and initial licensure without additional educational or experiential requirements;
  - iv. If the applicant graduated from an international nursing program, proof of meeting the requirements in R4-19-301.
  - v. If the Board finds that the documentation submitted by the applicant does not fulfill one of the requirements in (B)(2)(b)(i) through (iv), but the applicant has submitted verified employer evaluations demonstrating applicant's safe practice as a registered or practical nurse in another state for a minimum of two years full-time during the past three years and applicant otherwise meets licensure requirements, the Board may grant a single-state only license if the Board determines that licensure is in the best interest of the public.

- C. The Board shall grant a license to practice as a registered or practical nurse to any applicant who meets the criteria established in statute and this Article. An applicant who is denied a license by endorsement may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the license. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Former Section II, Part II; Amended effective December 7, 1976 (Supp. 76-5). Former Section R4-19-25 repealed, new Section R4-19-25 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-25 repealed, new Section R4-19-25 adopted effective May 9, 1984 (Supp. 84-3). Former Section R4-19-25 renumbered and amended as Section R4-19-302 effective February 21, 1986 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 1483, effective

June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

**R4-19-303. Requirements for Credential Evaluation Service**

- A. A CES seeking Board approval shall submit documentation to the Board demonstrating that it:
  - 1. Provides a credential evaluation to determine comparability of registered nurse or practical nurse programs in other countries to nursing education in the United States;
  - 2. Evaluates original source documents;
  - 3. Has five or more years of experience in evaluating nursing educational programs or employs personnel that have this experience;
  - 4. Employs staff with expertise in evaluating nursing programs;
  - 5. Has access to resources pertinent to the field of nursing education and the evaluation of nursing programs;
  - 6. Issues a report on each applicant, and supplies the Board with a sample of such a report, regarding the comparability of the applicant's nursing educational program to nursing education in the United States that includes:
    - a. The current name of the applicant including any names formerly used by the applicant;
    - b. Source and description of the documents evaluated;
    - c. Name and nature of the nursing education program, including status of the parent institution;
    - d. Dates applicant attended;
    - e. References consulted;
    - f. A seal or some other security measure;
    - g. Notification of any falsification or misrepresentation of documents by the applicant;
    - h. A report on licensure examination results for the applicant, if an exam was required for licensure in the international jurisdiction; and
    - i. The status of any international nursing licenses held by the applicant.
  - 7. Has a quality control program that includes at a minimum:
    - a. Standards regarding the use of original documents;
    - b. Verification of authenticity of documents and translations;
    - c. Processes and procedures to prevent and detect fraud;
    - d. Policies for maintaining confidentiality of applicant educational records;
    - e. Responsiveness to applicants, including ensuring that reports are issued no later than eight weeks from the receipt of an applicant's documents; and
    - f. Tracking of and notification to the Board of any trends in falsification or misrepresentation of documents;
  - 8. Follows or exceeds the standards of the National Association of Credentialing Services (NACES) or an equivalent organization;
  - 9. Responds to Board requests for information in a timely and thorough manner; and
  - 10. Agrees to notify the Board before any changes in any of the above criteria.
- B. If a CES fails to comply with the provisions of subsection (A), the Board may rescind its approval of the CES.
- C. The Board shall approve a credential evaluation service that meets the criteria established in this Section. A CES applicant who is denied approval or whose approval is revoked may request a hearing by filing a written request with the Board

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within 30 days of service of the Board's order denying the approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Former Section II, Part III; Former Section R4-19-26 repealed, new Section R4-19-26 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-26 renumbered and amended as Section R4-19-27, new Section R4-19-26 adopted effective May 9, 1984 (Supp. 84-3). Former Section R4-19-27 renumbered as Section R4-19-303 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 5 A.A.R. 1802, effective May 18, 1999 (Supp. 99-2). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-303 renumbered to R4-19-304; new Section R4-19-303 made by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

**R4-19-304. Temporary License**

- A. Subject to subsection (B), the Board shall issue a temporary license if:
  1. An applicant:
    - a. Is qualified under:
      - i. A.R.S. § 32-1635 and applies for a temporary registered nursing license, or is qualified under A.R.S. § 32-1640 and applies for a temporary practical nursing license; and
      - ii. R4-19-301 for applicants for licensure by examination, or is qualified under R4-19-302 for applicants for licensure by endorsement; and
    - b. Submits an application for a temporary license with the applicable fee required under A.R.S. § 32-1643(A)(9); and
    - c. Submits an application for a license by endorsement or examination with the applicable fee required under A.R.S. § 32-1643(A).
  2. An applicant is seeking a license by examination, meets the requirements of R4-19-312(D), and the Board receives the applicant's fingerprint card or fingerprints; or
  3. An applicant is seeking a license by endorsement, meets the requirements in R4-19-312(B), and the applicant submits evidence that the applicant has a current license in good standing in another state or territory of the United States or, if no current license, a previous license in good standing that was not the subject of an investigation or pending discipline; or
  4. An applicant who does not meet the practice requirements in R4-19-312(B) or (D), but provides evidence that the applicant has applied for enrollment in a refresher or other competency program approved by the Board, may practice nursing under a temporary license during the clinical portion of the program only.
- B. An applicant who has a criminal history, a history of disciplinary action by a regulatory agency, a pending complaint before the Board, or answers affirmatively to any criminal background or disciplinary question in the application is not eligible for a temporary license or extension of a temporary license without Board approval.

- C. A temporary license is valid for a maximum of 12 months unless extended for good cause under subsection (D) of this Section.
- D. An applicant with a temporary license may apply for and the Board, the Executive Director or the Executive Director's designee may grant an extension of the temporary license period for good cause. Good cause means reasons beyond the control of the temporary licensee, such as unavoidable delays in obtaining information required for licensure.
- E. An applicant who receives a temporary license but does not meet the criteria for a regular license within the established period under subsections (C) and (D) is no longer eligible for a temporary license except for the purpose of completing a refresher or other competency program under subsection (A)(4) of this Section.

**Historical Note**

Former Section II, Part IV; Amended effective January 20, 1975 (Supp. 75-1). Former Section R4-19-27 repealed, new Section R4-19-27 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-27 renumbered and amended as Section R4-19-28. Former Section R4-19-26 renumbered and amended as Section R4-19-27 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-27 renumbered and amended as Section R4-19-304 effective February 21, 1986 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-304 renumbered to R4-19-305; new Section R4-19-304 renumbered from R4-19-303 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Chapter Section references updated under subsections (A)(2) and (A)(4) under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-305. License Renewal**

- A. An applicant for renewal of a registered or practical nursing license shall:
  1. Submit a verified application to the Board on a form furnished by the Board that provides all of the following information about the applicant:
    - a. Full legal name, address of record, e-mail address, telephone number and declared primary state of residence;
    - b. A listing of all states in which the applicant is currently licensed, or, since the last renewal, was previously licensed or has been denied licensure;
    - c. Marital status and ethnic category, at the applicant's discretion;
    - d. Information regarding qualifications, including:
      - i. Educational background;
      - ii. Employment status;
      - iii. Practice setting; and
      - iv. Other information related to the nurse's practice for the purpose of collecting nursing workforce data.
    - e. Responses to questions regarding the applicant's background on the following subjects:

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- i. Criminal convictions for offenses involving drugs or alcohol since the time of last renewal;
  - ii. Undesignated offenses and felony charges, convictions and plea agreements including deferred prosecution;
  - iii. Misdemeanor charges, convictions and plea agreements, including deferred prosecution, that are required to be reported under A.R.S. § 32-3208;
  - iv. Unprofessional conduct as defined in A.R.S. § 32-1601 since the time of last renewal;
  - v. Substance use disorder within the last five years;
  - vi. Current participation in an alternative to discipline program in any other state; and
  - vii. Disciplinary action or investigation related to the applicant's nursing license by any other state nursing regulatory agency since the last renewal.
- f. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
  - g. Information related to the applicant's current or most recent nursing practice setting, including position, address, telephone number, and dates of practice;
  - h. Information regarding the applicant's compliance with the practice or education requirements in R4-19-312;
  - i. National certification in nursing including specialty, name of certifying body, date of certification, certification number, and expiration date, if applicable; and for an applicant certified as a registered nurse practitioner or clinical nurse specialist the patient population of the certification; and
- 2. Pay fees for renewal authorized by A.R.S. § 32-1643(A)(6); and
  - 3. Pay an additional fee for late renewal authorized by A.R.S. § 32-1643(A)(7) if the application for renewal is submitted after May 1 of the year of renewal.
- B.** A license expires on August 1 of the year of renewal indicated on the license.
  - C.** A licensee who fails to submit a renewal application before expiration of a license shall not practice nursing until the Board issues a renewal license.
  - D.** If the applicant holds a license or certificate that has been or is currently revoked, surrendered, denied, suspended or placed on probation in another jurisdiction, the applicant is not eligible to renew or reactivate a license until a review or investigation has been completed and a decision regarding eligibility for renewal or reactivation is made by the Board.
  - E.** The Board shall renew the license of any registered or practical nurse applicant who meets the criteria established in statute and this Article. An applicant who is denied renewal of a license may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying renewal of the license. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Former Section II, Part V; Repealed effective January 20, 1975 (Supp. 75-1). New Section R4-19-28 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-28 renumbered and amended as Section R4-19-29. Former Section R4-19-27 renumbered and amended as Section R4-19-28 effective May 9, 1984 (Supp. 84-3).

Former Section R4-19-28 renumbered and repealed as Section R4-19-305 effective February 21, 1986 (Supp. 86-1). New Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-305 renumbered to R4-19-306; new Section R4-19-305 renumbered from R4-19-304 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-306. Inactive License**

- A.** A licensee in good standing may submit to the Board either as a separate written document or as part of the renewal application, a request to transfer to inactive status, or retirement status under A.R.S. §§ 32-1606(A)(10) and 32-1636(E).
- B.** The Board shall send a written notice to the licensee granting inactive or retirement status or denying the request. A licensee denied a request for transfer to inactive or retirement status may request a hearing by filing a written request with the Board within 30 days of service of the denial of the request. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Former Section II, Part VI; Amended effective January 20, 1975 (Supp. 75-1). Amended effective December 7, 1976 (Supp. 76-5). Former Section R4-19-29 repealed, new Section R4-19-29 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-29 renumbered and amended as Section R4-19-30 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-28 renumbered and amended as Section R4-19-29 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-29 renumbered as Section R4-19-306 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-306 renumbered to R4-19-307; new Section R4-19-306 renumbered from R4-19-305 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

**R4-19-307. Repealed****Historical Note**

Former Section II, Part VII; Former Section R4-19-30 renumbered and amended as Section R4-19-45, new Section R4-19-30 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-30 renumbered and amended as Section R4-19-31. Former Section R4-19-29 renumbered and amended as R4-19-30 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-29 renumbered and amended as Section R4-19-307 effective February 21, 1986 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-307 renumbered to R4-19-308; new Section R4-19-307 renumbered from R4-19-306 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004

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(Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Repealed by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-308. Change of Name or Address**

- A. A licensee or applicant shall notify the Board, in writing or electronically through the Board website, of any legal change in name within 30 days of the change, and submit a copy of the official document verifying the name change.
- B. A licensee or applicant shall notify the Board in writing or electronically through the Board website of any change in address of record, and residential address, if different, within 30 days.

**Historical Note**

Former Section II, Part VII; Former Section R4-19-31 repealed, new Section R4-19-31 adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-31 renumbered and amended as Section R4-19-32. Former Section R4-19-30 renumbered and amended as Section R4-19-31 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-31 renumbered as Section R4-19-308 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended effective December 3, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 4819, effective December 7, 2000 (Supp. 00-4). Former Section R4-19-308 renumbered to R4-19-309; new Section R4-19-308 renumbered from R4-19-307 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-309. School Nurse Certification Requirements**

- A. An applicant for initial school nurse certification shall hold a current license in good standing or multistate privilege to practice as a registered nurse in Arizona.
- B. An initial or renewal of certificate expires six years after the issue date on the certificate.
- C. The Board shall grant a school nurse certificate to any applicant who meets the criteria established in statute and this Article. An applicant who is denied a school nurse certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the certificate. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Former Section II, Part IX; Repealed effective February 20, 1980 (Supp. 80-1). Former Section R4-19-31 renumbered and amended as Section R4-19-32 effective May 9, 1984 (Supp. 84-3). Former Section R4-19-32 renumbered as Section R4-19-309 (Supp. 86-1). Repealed effective July 19, 1995 (Supp. 95-3). New Section made by final rulemaking at 8 A.A.R. 1813, effective March 20, 2002 (Supp. 02-1). Former Section R4-19-309 renumbered to R4-19-311; new Section R4-19-309 renumbered from R4-19-308 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019

(Supp. 19-2).

**R4-19-310. Certified Registered Nurse**

A registered nurse who has been certified by a nursing certification organization accredited by the Accreditation Board for Specialty Nursing Certification, the National Commission for Certifying Agencies, or an equivalent accrediting agency as determined by the Board is deemed certified for the purposes of A.R.S. § 32-1601(5).

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). A.R.S. Section reference updated under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3).

**R4-19-311. Nurse Licensure Compact**

The Board shall implement A.R.S. §§ 32-1668 and 32-1669 according to the provisions of the Nurse Licensure Compact Model Rules and Regulations for RNs and LPN/VNs, published by the National Council of State Boards of Nursing, Inc., 111 E. Wacker Dr., Suite 2900, Chicago, IL 60601, [www.ncsbn.org](http://www.ncsbn.org), November 13, 2012, and no later amendments or editions, which is incorporated by reference and on file with the Board.

**Historical Note**

New Section renumbered from R4-19-309 and amended by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Amended by final rulemaking at 18 A.A.R. 2485, effective September 11, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 2852, effective September 11, 2013 (Supp. 13-3).

**R4-19-312. Practice Requirement**

- A. The Board shall not issue a license or renew the license of an applicant who does not meet the applicable requirements in subsections (B), (C), and (D).
- B. An applicant for licensure by endorsement or renewal shall either have completed a post-licensure nursing program or practiced nursing at the applicable level of licensure for a minimum of 960 hours in the five years before the date on which the application is received. This requirement is satisfied if the applicant verifies that the applicant has:
  1. Completed a post-licensure nursing education program at a school that is accredited under R4-19-201(A) and obtained a degree, or an advanced practice certificate in nursing within the past five years; or
  2. Practiced for a minimum of 960 hours within the past five years where the nurse:
    - a. Worked for compensation or as a volunteer, as a licensed nurse in the United States or an international jurisdiction, and performed one or more acts under A.R.S. § 32-1601(21) as an RN if applying for RN renewal or licensure or A.R.S. § 32-1601(17) as an LPN if applying for LPN renewal or licensure; or
    - b. Held a position for compensation or as a volunteer in the United States or an international jurisdiction that required or recommended, in the job description, the level of licensure being sought or renewed; or
    - c. Engaged in clinical practice as part of an RN-to-Bachelor of Science in Nursing, Masters, Doctoral or Nurse Practitioner program.
- C. Care of family members does not meet the requirements of subsection (B)(2) unless the applicant submits evidence:
  1. That the applicant is providing care as part of a medical foster home; or

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2. That the specific care provided by the applicant was:
  - a. Ordered by another health care provider who is authorized to prescribe and was responsible for the care of the patient,
  - b. The type of care would typically be authorized by a third-party payer, and
  - c. The care was documented and reviewed by the health care provider.
- D. An applicant for licensure by either examination or endorsement, who does not meet the requirements of subsection (B), shall have completed the clinical portion of a pre-licensure nursing program within two years of the date of licensure.
- E. A licensee or applicant who fails to satisfy the requirements of subsection (B) or (D), shall submit evidence of satisfactory completion of a Board-approved refresher or competency program. The Board may issue a temporary license stamped "for refresher course only" to any applicant who meets all requirements of this Article except subsection (B) or (D) and provides evidence of applying for enrollment in a Board-approved refresher or competency program.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citations in subsection (B)(2)(a) were updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2). A.R.S. Section references updated under subsection (B)(2)(a) under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2).

**R4-19-313. Background**

- A. All applicants convicted of a sexual offense involving a minor or performing a sexual act against the will of another person shall be subject to a Board order under A.R.S. § 32-1664(F) and R4-19-405 unless the individual is precluded from licensure under A.R.S. § 32-1606(B)(17). If the evaluation identifies sexual behaviors of a predatory nature, the Board shall deny licensure or renewal of licensure.
- B. All individuals reporting a substance use disorder in the last five years may be subject to a Board order for an evaluation under A.R.S. § 32-1664(F) and R4-19-405 to determine safety to practice.
- C. The Board may order the evaluation of other individuals on a case-by-case basis under A.R.S. § 32-1664(F) and R4-19-405.

**Historical Note**

New Section made by final rulemaking at 19 A.A.R. 1308, effective July 6, 2013 (Supp. 13-2).

**ARTICLE 4. REGULATION****R4-19-401. Standards Related to Licensed Practical Nurse Scope of Practice**

- A. A licensed practical nurse shall engage in practical nursing as defined in A.R.S. § 32-1601 only under the supervision of a registered nurse or licensed physician.
- B. A LPN's nursing practice is limited to those activities for which the LPN has been prepared through basic practical nursing education in accordance with A.R.S. § 32-1637(1) and those additional skills that are obtained through subsequent

nursing education and within the scope of practice of a LPN as determined by the Board.

**C. A LPN shall:**

1. Practice within the legal boundaries of practical nursing within the scope of practice authorized by A.R.S. Title 32, Chapter 15 and 4 A.A.C. 19;
2. Demonstrate honesty and integrity;
3. Base nursing decisions on nursing knowledge and skills, the needs of clients, and licensed practical nursing standards;
4. Accept responsibility for individual nursing actions, decisions, and behavior in the course of practical nursing practice.
5. Maintain competence through ongoing learning and application of knowledge in practical nursing practice.
6. Protect confidential information unless obligated by law to disclose the information;
7. Report unprofessional conduct, as defined in A.R.S. § 32-1601(24) and further specified in R4-19-403 and R4-19-814, to the Board;
8. Respect a client's rights, concerns, decisions, and dignity;
9. Maintain professional boundaries; and
10. Respect a client's property and the property of others.

**D. In participating in the nursing process and implementing client care across the lifespan, a LPN shall:**

1. Contribute to the assessment of the health status of clients by:
  - a. Recognizing client characteristics that may affect the client's health status;
  - b. Gathering and recording assessment data;
  - c. Demonstrating attentiveness by observing, monitoring, and reporting signs, symptoms, and changes in client condition in an ongoing manner to the supervising registered nurse or physician;
2. Contribute to the development and modification of the plan of care by:
  - a. Planning episodic nursing care for a client whose condition is stable or predictable;
  - b. Assisting the registered nurse or supervising physician in identification of client needs and goals; and
  - c. Determining priorities of care together with the supervising registered nurse or physician;
3. Implement aspects of a client's care consistent with the LPN scope of practice in a timely and accurate manner including:
  - a. Following nurse and physician orders and seeking clarification of orders when needed;
  - b. Administering treatments, medications, and procedures;
  - c. Attending to client and family concerns or requests;
  - d. Providing health information to clients as directed by the supervising RN or physician or according to an established educational plan;
  - e. Promoting a safe client environment;
  - f. Communicating relevant and timely client information with other health team members regarding:
    - i. Client status and progress,
    - ii. Client response or lack of response to therapies,
    - iii. Significant changes in client condition, and
    - iv. Client needs and special requests, and
  - g. Documenting the nursing care the LPN provided;
4. Contribute to evaluation of the plan of care by:
  - a. Gathering, observing, recording, and communicating client responses to nursing interventions; and



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- b. Modifying the plan of care in collaboration with a registered nurse based on an analysis of client responses.
- E. A LPN assigns and delegates nursing activities. The LPN shall:
1. Assign nursing care within the LPN scope of practice to other LPNs;
  2. Delegate nursing tasks to unlicensed assistive personnel (UAPs). In maintaining accountability for the delegation, the LPN shall ensure that the:
    - a. UAP has the education, legal authority, and demonstrated competency to perform the delegated task;
    - b. Tasks delegated are consistent with the UAP's job description and can be safely performed according to clear, exact, and unchanging directions;
    - c. Results of the task are reasonably predictable;
    - d. Task does not require assessment, interpretation, or independent decision making during its performance or at completion;
    - e. Selected client and circumstances of the delegation are such that delegation of the task poses minimal risk to the client and the consequences of performing the task improperly are not life-threatening;
    - f. LPN provides clear directions and guidelines regarding the delegated task or, for routine tasks on stable clients, verifies that the UAP follows each written facility policy or procedure when performing the delegated task;
    - g. LPN provides supervision and feedback to the UAP; and
    - h. LPN observes and communicates the outcomes of the delegated task.
- Historical Note**  
Former Section III, Part II; Amended effective February 20, 1980 (Supp. 80-1). Former Section R4-19-42 renumbered as Section R4-19-401 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Subsection (C)(7) amended at request of Board, Office File No. M11-423, filed November 18, 2011 (Supp. 11-4). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citation in subsection (C)(7) was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). A.R.S. Section reference updated under subsection (C)(7) under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3).
- R4-19-402. Standards Related to Registered Nurse Scope of Practice**
- A. A registered nurse (RN) shall perform only those nursing activities for which the RN has been prepared through basic registered nursing education and those additional skills which are obtained through subsequent nursing education and within the scope of practice of an RN as determined by the Board.
- B. A RN shall:
1. Practice within the legal boundaries of registered nursing within the scope of practice authorized by A.R.S. Title 32, Chapter 15 and 4 A.A.C. 19;
  2. Demonstrate honesty and integrity;
  3. Base nursing decisions on nursing knowledge and skills, the needs of clients, and registered nursing standards;
  4. Accept responsibility for individual nursing actions, decisions, and behavior in the course of registered nursing practice;
  5. Maintain competence through ongoing learning and application of knowledge in registered nursing practice;
  6. Protect confidential information unless obligated by law to disclose the information;
  7. Report unprofessional conduct, as defined in A.R.S. § 32-1601(24) and further specified in R4-19-403 and R4-19-814, to the Board;
  8. Respect a client's rights, concerns, decisions, and dignity;
  9. Maintain professional boundaries;
  10. Respect a client's property and the property of others; and
  11. Advocate on behalf of a client to promote the client's best interest.
- C. In utilizing the nursing process to plan and implement nursing care for clients across the life-span, a RN shall:
1. Conduct a nursing assessment of a client in which the nurse:
    - a. Recognizes client characteristics that may affect the client's health status;
    - b. Gathers or reviews comprehensive subjective and objective data and detects changes or missing information;
    - c. Applies nursing knowledge in the integration of the biological, psychological, and social aspects of the client's condition; and
    - d. Demonstrates attentiveness by providing ongoing client surveillance and monitoring;
  2. Use critical thinking and nursing judgment to analyze client assessment data to:
    - a. Make independent nursing decisions and formulate nursing diagnoses; and
    - b. Determine the clinical implications of client signs, symptoms, and changes, as either expected, unexpected, or emergent situations;
  3. Based on assessment and analysis of client data, plan strategies of nursing care and nursing interventions in which the nurse:
    - a. Identifies client needs and goals;
    - b. Formulates strategies to meet identified client needs and goals;
    - c. Modifies defined strategies to be consistent with the client's overall health care plan; and
    - d. Prioritizes strategies based on client needs and goals;
  4. Provide nursing care within the RN scope of practice in which the nurse:
    - a. Administers prescribed aspects of care including treatments, therapies, and medications;
    - b. Clarifies health care provider orders when needed;
    - c. Implements independent nursing activities consistent with the RN scope of practice;
    - d. Institutes preventive measures to protect client, others, and self;
    - e. Intervenes on behalf of a client when problems are identified;
    - f. Promotes a safe client environment;
    - g. Attends to client concerns or requests;
    - h. Communicates client information to health team members including:
      - i. Client concerns and special needs;

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- ii. Client status and progress;
  - iii. Client response or lack of response to interventions; and
  - iv. Significant changes in client condition; and
- 5. Evaluate the impact of nursing care including the:
  - a. Client's response to interventions;
  - b. Need for alternative interventions;
  - c. Need to communicate and consult with other health team members; and
  - d. Need to revise the plan of care;
- 6. Provide comprehensive nursing and health care education in which the RN:
  - a. Assesses and analyzes educational needs of learners;
  - b. Plans educational programs based on learning needs and teaching-learning principles;
  - c. Ensures implementation of an educational plan either directly or by delegating selected aspects of the education to other qualified persons; and
  - d. Evaluates the education to meet the identified goals;
- D.** A RN assigns and delegates nursing activities. The RN shall:
  - 1. Assign nursing care within the RN scope of practice to other RNs;
  - 2. Assign nursing care to a LPN within the LPN scope of practice based on the RN's assessment of the client and the LPN's ability;
  - 3. Supervise, monitor, and evaluate the care assigned to a LPN; and
  - 4. Delegate nursing tasks to UAPs. In maintaining accountability for the delegation, an RN shall ensure that the:
    - a. UAP has the education, legal authority, and demonstrated competency to perform the delegated task;
    - b. Tasks delegated are consistent with the UAP's job description and can be safely performed according to clear, exact, and unchanging directions;
    - c. Results of the task are reasonably predictable;
    - d. Task does not require assessment, interpretation, or independent decision making during its performance or at completion;
    - e. Selected client and circumstances of the delegation are such that delegation of the task poses minimal risk to the client and the consequences of performing the task improperly are not life-threatening;
    - f. RN provides clear directions and guidelines regarding the delegated task or, for routine tasks on stable clients, verifies that the UAP follows each written facility policy or procedure when performing the delegated task;
    - g. RN provides supervision and feedback to the UAP; and
    - h. RN observes and communicates the outcomes of the delegated task.

**Historical Note**

Former Section III, Part I; Amended effective February 20, 1980 (Supp. 80-1). Former Section R4-19-43 renumbered as Section R4-19-402 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Section repealed, new Section made by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Subsection (B)(7) amended at request of Board, Office File No. M11-423, filed November 18, 2011 (Supp. 11-4). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of

definitions. Therefore the A.R.S. citation in subsection (B)(7) was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). A.R.S. Section reference updated under subsection (B)(7) under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3).

**R4-19-403. Unprofessional Conduct**

For purposes of A.R.S. § 32-1601(24)(d), any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public includes one or more of the following:

1. A pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice;
2. Intentionally or negligently causing physical or emotional injury;
3. Failing to maintain professional boundaries or engaging in a dual relationship with a patient, resident, or any family member of a patient or resident;
4. Engaging in sexual conduct with a patient, resident, or any family member of a patient or resident who does not have a pre-existing relationship with the nurse, or any conduct in the work place that a reasonable person would interpret as sexual;
5. Abandoning or neglecting a patient who requires immediate nursing care without making reasonable arrangement for continuation of care;
6. Removing a patient's life support system without appropriate medical or legal authorization;
7. Failing to maintain for a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient;
8. Falsifying or making a materially incorrect, inconsistent, or unintelligible entry in any record:
  - a. Regarding a patient, health care facility, school, institution, or other work place location; or
  - b. Pertaining to obtaining, possessing, or administering any controlled substance as defined in the federal Uniform Controlled Substances Act, 21 U.S.C. 801 et seq., or Arizona's Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27;
9. Failing to take appropriate action to safeguard a patient's welfare or follow policies and procedures of the nurse's employer designed to safeguard the patient;
10. Failing to take action in a health care setting to protect a patient whose safety or welfare is at risk from incompetent health care practice, or to report the incompetent health care practice to employment or licensing authorities;
11. Failing to report to the Board a licensed nurse whose work history includes conduct, or a pattern of conduct, that leads to or may lead to an adverse patient outcome;
12. Assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse;
13. Failing to supervise a person to whom nursing functions are delegated;
14. Delegating services that require nursing judgment to an unauthorized person;
15. Removing, without authorization, any money, property, or personal possessions, or requesting payment for services not performed from a patient, employer, co-worker, or member of the public.
16. Removing, without authorization, a narcotic, drug, controlled substance, supply, equipment, or medical record

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- from any health care facility, school, institution, or other work place location;
17. A pattern of using or being under the influence of alcohol, drugs, or a similar substance to the extent that judgment may be impaired and nursing practice detrimentally affected, or while on duty in any health care facility, school, institution, or other work location;
  18. Obtaining, possessing, administering, or using any narcotic, controlled substance, or illegal drug in violation of any federal or state criminal law, or in violation of the policy of any health care facility, school, institution, or other work location at which the nurse practices;
  19. Providing or administering any controlled substance or prescription-only drug for other than accepted therapeutic or research purposes;
  20. Engaging in fraud, misrepresentation, or deceit in taking a licensing examination or on an initial or renewal application for a license or certificate;
  21. Impersonating a nurse licensed or certified under this Chapter;
  22. Permitting or allowing another person to use the nurse's license for any purpose;
  23. Advertising the practice of nursing with untruthful or misleading statements;
  24. Practicing nursing without a current license or while the license is suspended, or practicing as a nurse practitioner without current national certification, if required pursuant to R4-19-505;
  25. Failing to:
    - a. Furnish in writing a full and complete explanation of a matter reported pursuant to A.R.S. § 32-1664, or
    - b. Respond to a subpoena issued by the Board;
  26. Making a written false or inaccurate statement to the Board or the Board's designee in the course of an investigation;
  27. Making a false or misleading statement on a nursing or health care related employment or credential application concerning previous employment, employment experience, education, or credentials;
  28. If a licensee or applicant is charged with a felony or a misdemeanor involving conduct that may affect patient safety, failing to notify the Board in writing, as required under A.R.S. § 32-3208, within 10 days of being charged. The licensee or applicant shall include the following in the notification:
    - a. Name, address, telephone number, social security number, and license number, if applicable;
    - b. Date of the charge; and
    - c. Nature of the offense;
  29. Failing to notify the Board, in writing, of a conviction for a felony or an undesignated offense within 10 days of the conviction. The nurse or applicant shall include the following in the notification:
    - a. Name, address, telephone number, social security number, and license number, if applicable;
    - b. Date of the conviction; and
    - c. Nature of the offense;
  30. For a registered nurse granted prescribing privileges, any act prohibited under R4-19-511(D); or
  31. Practicing in any other manner that gives the Board reasonable cause to believe the health of a patient or the public may be harmed.

mer Section R4-19-44 repealed, new Section R4-19-44 adopted effective May 9, 1984 (Supp. 84-3). Amended by adding Paragraphs 18 through 22 effective July 16, 1984 (Supp. 84-4). Former Section R4-19-44 renumbered and amended as Section R4-19-403 effective February 21, 1986 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Antiquated statute reference in opening subsection revised at the request of Board under A.R.S. § 41-1011(C), Office File No. M11-189, filed May 16, 2011 (Supp. 11-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citation in the opening subsection was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). A.R.S. Section reference updated under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-404. Re-issuance or Subsequent Issuance of License**

- A. The Board may restore a license to a nurse whose license has been suspended after the period of suspension if the licensee provides written evidence that all requirements or conditions prescribed or ordered in the consent agreement or Board order for suspension have been met to the satisfaction of the Board. The Board may place conditions or limitations on the restored license. The license of a nurse who fails to provide such evidence of fulfilling the requirements or conditions prescribed by the Board shall remain on suspended status until such submission and acceptance by the Board.
- B. A person whose nursing license is denied, revoked, or voluntarily surrendered under A.R.S. § 32-1663 may apply to the Board to issue or re-issue the license:
  1. Five years from the date of denial or revocation, or
  2. In accordance with the terms of a voluntary surrender agreement.
- C. A person who applies for issuance or re-issuance of a license under the conditions of subsection (B) is subject to the following terms and conditions:
  1. The person shall submit a written application for issuance or re-issuance of the license that contains substantial evidence that the basis for surrendering, denying, or revoking the license has been removed and that the issuance or re-issuance of the license will not be a threat to public health or safety.
  2. Safe practice.
    - a. Under A.R.S. § 32-1664(F), the Board for reasonable cause may require a combination of mental, physical, nursing competency, psychological, or psychiatric evaluations, or any combination of evaluations, reports, and affidavits that the Board considers necessary to determine the person's competence and conduct to safely practice nursing.
    - b. Under A.R.S. 32-1664(K) the Board may issue subpoenas and compel the attendance of witnesses and the production of records and documentary evidence relevant to the person's ability to safely practice nursing.

**Historical Note**

Adopted effective February 20, 1980 (Supp. 80-1). For-

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3. After receipt of the application, the information required under subsection (C)(2), and the completion of an investigation, the Board shall place the application on the agenda of a regularly scheduled Board meeting.
4. After consideration of the application and any information required under subsection (C)(2), the Board may:
  - a. Grant the license with or without conditions or limitations;
  - b. If other licensure requirements have been met, grant, with or without conditions, a temporary license for the sole purpose of allowing the applicant to successfully complete an approved nurse refresher course; or
  - c. Deny the license if the Board determines that licensure might be harmful or dangerous to the health of a patient or the public.
5. If the Board orders a refresher course described in subsection (C)(4)(b) the Board shall consider the applicant's performance in the approved refresher course and any other evidence, if available, of the applicant's safety to practice, and either deny the license under subsection (C)(4)(c) or grant the license with or without conditions or limitations.
6. An applicant who is denied issuance or re-issuance of a license shall have 30 days from the date of issuance of the notice of denial from the Board to file a written request for hearing with the Board. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

**Historical Note**

Former Section R4-19-30 renumbered and amended as Section R4-19-45 effective February 20, 1980 (Supp. 80-1). Former Section R4-19-45 renumbered as Section R4-19-404 (Supp. 86-1). Section repealed, new Section adopted effective July 19, 1995 (Supp. 95-3). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4).

**R4-19-405. Board-ordered Evaluations**

- A. Under A.R.S. § 32-1664(F), the Board may order a licensee or CNA certificate-holder to undergo an evaluation by an independent qualified evaluator for the purposes of determining the licensee's or certificate holder's safety and competence to practice. Evaluations may be in the areas of:
  1. Nursing knowledge or skills or both;
  2. Mental functioning, including but not limited to neuropsychological evaluation, and other cognition evaluations;
  3. Medical status including but not limited to medical review of drug screen results, chronic pain evaluation, physical examination, and biological testing;
  4. Psychiatric or psychological status including but not limited to substance abuse evaluation, boundary or sexual misconduct evaluations, and psychological testing; or
  5. Other similar evaluations that the Board determines are necessary to evaluate a licensee or certificate holder's ability to safely practice.
- B. Before making the decision to order the evaluation, the Board shall review the allegations and investigative findings.
- C. The Board retains the discretion to use an evaluator based on the evaluator's licensure history, the Board's past experience with the evaluator, and the quality of the evaluation provided. Before conducting a Board-ordered evaluation, a potential evaluator shall submit documentation that the evaluator:
  1. Possesses expertise and educational credentials in the area that the Board has ordered an evaluation;
  2. Holds a license or certificate in good standing with a licensing or certifying board located in the United States and discloses any past licensure disciplinary actions and criminal history;
  3. Will provide equipment and environmental conditions necessary to conduct a valid evaluation;
  4. Has no current or past treatment, collegial, or social relationship with the licensee or certificate holder, any family member of the licensee or certificate holder, or the licensee's or certificate holder's legal counsel;
  5. Will not enter into a treatment relationship with the licensee or certificate holder unless the relationship is unavoidable due to geographical location or the specific expertise of the evaluator; and
  6. Agrees to keep information provided by the Board under subsection (D) confidential as evidenced by a signed confidentiality agreement provided by the Board.

- D. Upon receipt of the evaluator's signed confidentiality agreement, the Board may provide confidential investigative information and documents to the evaluator for the purpose of disclosing the reason for the evaluation, the focus of the evaluation, and the conduct causing the Board to order the evaluation including:
  1. The complaint and all information that has been received during the investigation of the complaint. Documents may include but are not limited to employment records, medical records, arrest records, conviction and sentencing records, excluding FBI fingerprint results, drug screen results, pharmacy profiles, witness statements, past licensure history, and a summary of information obtained during investigative interviews; and
  2. The specific questions for which the Board is seeking answers; and
- E. The evaluator shall provide the following information to the Board:
  1. A professional report that is objective, thorough, timely, accurate, and defensible;
  2. Evaluation findings including diagnosis if appropriate and assessment of ability to practice safely;
  3. Recommendations for further evaluation, treatment, and remediation; and
  4. Suggestions for assuring safe practice and compliance with treatment and remediation recommendations, if any.

**Historical Note**

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-46 renumbered and amended as Section R4-19-405 effective February 21, 1986 (Supp. 86-1). Repealed effective July 19, 1995 (Supp. 95-3). New Section made by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4).

**ARTICLE 5. ADVANCED PRACTICE REGISTERED NURSING****R4-19-501. Roles and Population Foci of Advanced Practice Registered Nursing (APRN); Certification Programs**

- A. The Board recognizes the following APRN roles:
  1. Registered nurse practitioner (RNP) in a population focus;
  2. Clinical Nurse Specialist (CNS) in a population focus;
  3. Certified Registered Nurse Anesthetist (CRNA);
  4. Certified Nurse Midwife (CNM).

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- B.** RNPs and CNSs shall practice within one or more population foci, consistent with their education and certification. Population foci include:
1. Family-individual across the life span;
  2. Adult-gerontology primary or acute care;
  3. Neonatal;
  4. Pediatric primary or acute care;
  5. Women's health-gender related;
  6. Psychiatric-mental health;
  7. Other foci that have been recognized by the Board previously and new foci that meet the following conditions:
    - a. There is an accredited educational program and a national certifying process that meets the requirements of subsection (C); and
    - b. The focus is broad enough for an educational program to be developed that prepares a registered nurse to function both within the scope of practice of the role and population focus.
- C.** Certified Nurse Midwives shall practice within a population focus consistent with their education, specifically women's health gender-related care, including childbirth and neonatal care.
- D.** The Board shall accept advanced practice certifications from programs that meet the following qualifications:
1. The certification program:
    - a. Is accredited by the National Commission for Certifying Agencies, the Accreditation Board for Specialty Nursing Certification, or an equivalent organization as determined by the Board;
    - b. Establishes educational requirements for certification that are consistent with the requirements in R4-19-505;
    - c. Has an application process and credential review that requires an applicant to submit original source documentation of the applicant's education and clinical practice in the advanced practice role and population focus, if applicable, for which certification is granted; and
    - d. Is national in the scope of its credentialing.
  2. The certification program uses an examination as a basis for certification in the advanced practice role and population focus, as applicable that meets all of the following criteria:
    - a. The examination is based upon job analysis studies conducted using standard methodologies acceptable to the testing community both initially and every five years;
    - b. The examination assesses entry-level practice in the advanced practice role and population focus, if applicable;
    - c. The examination assesses the knowledge, skills, and abilities essential for the delivery of safe and effective advanced nursing care to clients;
    - d. Examination items are reviewed for content validity, cultural sensitivity, and correct scoring using an established mechanism, both before first use and periodically; items are reviewed for currency at least every three years;
    - e. The examination is evaluated for psychometric performance and conforms to psychometric standards that are routinely utilized for other types of high-stakes testing;
    - f. The passing standard is established using accepted psychometric methods and is re-evaluated periodically;
    - g. Examination security is maintained through established procedures;
    - h. A re-take policy is in place; and
    - i. Conditions for taking the certification examination are consistent with standards of the testing community;
  3. Certification is issued upon passing the examination and meeting all other certification requirements;
  4. The certification program periodically provides for re-certification that includes review of qualifications and continued competence;
  5. The certification program provides timely communication to the Board regarding licensee or applicant certification status, changes in an individual's certification status, exam results and changes in the certification program, including qualifications, test plan, and scope of practice; and
  6. The certification program has an evaluation process to provide quality assurance in its certificate program.
- E.** The Board shall determine whether a certification program meets the requirements of this Section. The following certification programs meet the requirements of this Section as of the effective date of this rulemaking:
1. For RNP, and CNM (consistent with R4-19-501(C) and (D)):
    - a. American Academy of Nurse Practitioner certification programs:
      - i. Adult nurse practitioner,
      - ii. Family nurse practitioner,
      - iii. Gerontologic nurse practitioner,
      - iv. Adult health-gerontological nurse practitioner.
    - b. American Nurses Credentialing Center certification programs:
      - i. Acute care nurse practitioner (adult/gerontology),
      - ii. Adult nurse practitioner,
      - iii. Family nurse practitioner,
      - iv. Gerontological nurse practitioner,
      - v. Pediatric nurse practitioner,
      - vi. Adult psychiatric and mental health nurse practitioner,
      - vii. Family psychiatric and mental health nurse practitioner,
      - viii. Adult health-gerontological nurse practitioner,
    - c. Pediatric Nursing Certification Board certification programs:
      - i. Pediatric nurse practitioner primary care,
      - ii. Pediatric nurse practitioner acute care,
    - d. National Certification Corporation for Obstetric, Gynecological, and Neonatal Nursing Specialties certification programs:
      - i. Women's health nurse practitioner,
      - ii. Neonatal nurse practitioner,
    - e. For a nurse-midwife, the American Midwifery Certification Board certification program in nurse midwifery,
    - f. AACN Certification Corporation certification programs:
      - i. Adult acute care nurse practitioner,
      - ii. Adult-gerontology acute care nurse practitioner,

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2. For CNS:
    - a. AACN Certification Corporation certification programs:
      - i. Adult acute and critical care CNS,
      - ii. Pediatric acute and critical care CNS,
      - iii. Neonatal acute and critical care CNS,
    - b. American Nurses Credentialing Center certification:
      - i. Adult psychiatric-mental health CNS,
      - ii. Family psychiatric-mental health CNS,
      - iii. Gerontological CNS,
      - iv. Adult health CNS,
      - v. Pediatric CNS.
  3. For CRNA, the National Board of Certification and Recertification for Nurse Anesthetists.
- F.** The Board shall approve a certification program that meets the criteria established in this Section. An entity that seeks approval of a certification program and is denied approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10.
- Historical Note**
- Former Section IV, Part I. Former Section R4-19-53 renumbered as Section R4-19-501 (Supp. 86-1). Former Section R4-19-501 renumbered to R4-19-502, new Section R4-19-501 adopted effective November 18, 1994 (Supp. 94-4). Amended effective November 25, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 3213, effective July 12, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (05-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).
- R4-19-502. Requirements for APRN Programs**
- A.** An educational institution or other entity that offers an APRN program in this state for RNP, CNM, or CNS roles shall ensure that the program:
1. Is offered by or affiliated with a college or university that is accredited under A.R.S. § 32-1644;
  2. For new programs, the college or university offering the program has at least one additional nationally accredited nursing program as defined in R4-19-101 or otherwise provides substantial evidence of the ability to attain national APRN program accreditation for all graduating cohorts;
  3. Is a formal educational program, that is part of a masters or doctoral program or a post-masters program in nursing with a concentration in an advanced practice registered nursing role and population focus under R4-19-501;
  4. Is nationally accredited, or has achieved candidacy status for national accreditation by an approved national nursing accrediting agency as defined in R4-19-101;
  5. Offers a curriculum that covers the scope of practice for both the role of advanced practice as specified in A.R.S. § 32-1601 and the population focus including:
    - a. Three separate graduate level courses in:
      - i. Advanced physiology and pathophysiology, including general principles across the lifespan;
      - ii. Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches;
    - iii. Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad category agents;
  - b. Diagnosis and management of diseases across practice settings including diseases representative of all systems;
  - c. Preparation that provides a basic understanding of the principles for decision making in the identified role;
  - d. Preparation in the core competencies for the identified APRN role including legal, ethical and professional responsibilities; and
  - e. Role preparation in an identified population focus under R4-19-501.
6. Verifies that each student has an unencumbered license to practice as an RN in the state of clinical practice;
7. Includes a minimum of 500 hours of faculty supervised clinical practice (programs that prepare students for more than one role or population focus shall have 500 hours of clinical practice in each role and population focus);
8. Notifies the Board of any changes in hours of clinical practice, accreditation status, denial or deferral of accreditation or program administrator and responds to Board requests for information;
9. Has financial resources sufficient to support accreditation standards and the educational goals of the program;
10. Establishes academic, professional, and conduct standards that determine admission to the program, progression in the program, and graduation from the program that are consistent with sound educational practices and recognized standards of professional conduct;
11. Establishes provisions for advanced placement for individuals holding a graduate degree in nursing who are seeking education in an APRN role and population focus, provided that advanced placement students master the same APRN competencies as students in the graduate-level APRN program; and
12. Provides the Board an application for approval under the provisions of R4-19-209(B) before making changes to the:
  - a. Scope of the program, or
  - b. Level of educational preparation provided.
- B.** A CNS, CNM, or RNP program shall appoint the following personnel:
1. An APRN program administrator who:
    - a. Holds a current unencumbered RN license or multi-state privilege to practice in Arizona and a current unencumbered APRN certificate issued by the Board;
    - b. Holds an earned doctorate in nursing or health-related field if appointed after the effective date of this Section;
    - c. Has at least two years clinical experience as an APRN; and
    - d. Holds current national certification as an APRN.
  2. A lead faculty member who is educated and certified both nationally and by the Board in the same role and population focus to coordinate the educational component for the role and population focus in the advanced practice registered nursing program.

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3. Nursing faculty to teach any APRN course that includes a clinical learning experience who have the following qualifications:
  - a. A current unencumbered RN license or multi-state privilege to practice registered nursing in Arizona,
  - b. A current unencumbered Arizona APRN certificate,
  - c. A graduate degree in nursing or a health related field in the population focus,
  - d. Two years of APRN clinical experience, and
  - e. Current knowledge, competence and certification as an APRN in the role and population focus consistent with teaching responsibilities.
4. Adjunct or part-time clinical faculty employed solely to supervise clinical nursing experiences shall meet all of the faculty qualifications for the APRN program they are teaching.
5. Interdisciplinary faculty who teach non-clinical courses shall have advanced preparation in the areas of course content.
6. Clinical preceptors may be used to enhance faculty-directed clinical learning experiences, but not to replace faculty. A clinical preceptor shall be approved by program administration or faculty and:
  - a. Hold a current unencumbered license or multistate privilege to practice as a registered nurse or physician in the state in which the preceptor practices or, if employed by the federal government, holds a current unencumbered RN or physician license in the United States;
  - b. Have at least one year clinical experience as a physician or an advanced practice nurse
  - c. Practice in a population focus comparable to that of the APRN program;
  - d. For nurse preceptors, have at least one of the following:
    - i. Current national certification in the advanced practice role and population focus of the course or program in which the student is enrolled;
    - ii. Current Board certification in the advanced practice role and population focus of the course or program in which the student is enrolled; or
    - iii. If an advanced practice preceptor cannot be found who meets the requirements of subsection (B)(6)(d)(i) or (ii), educational and experiential qualifications that will enable the preceptor to precept students in the program, as determined by the nursing program and approved by the Board.
- C. An entity that offers a CRNA program in Arizona shall maintain full national program accreditation with no limitations from the Council on Accreditation of Nurse Anesthesia Educational Programs or an equivalent agency approved by the Board. The program shall notify the Board of all program accreditation actions within 30 days of official notification by the accrediting agency.

**Historical Note**

Former Section IV, Part II; Amended effective February 20, 1980 (Supp. 80-1). Former Section R4-19-54 repealed, new Section R4-19-54 adopted effective July 20, 1981 (Supp. 81-4). Former Section R4-19-54 renumbered as Section R4-19-502 (Supp. 86-1). Section repealed, new Section R4-19-502 renumbered from R4-19-501 and Section heading amended effective November 18, 1994 (Supp. 94-4). Section repealed, new Section

R4-19-502 adopted effective November 25, 1996 (Supp. 96-4). Amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (05-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-503. Application for Approval of an Advanced Practice Registered Nursing Program; Approval by Board; Provisional Approval by Executive Director**

- A. An administrator of an educational institution that proposes to offer a CNS, CNM, or RNP program shall submit an application that includes all of the following information to the Board:
  1. Role, population focus that meets the criteria in R4-19-501 program administrator and lead faculty member as required in R4-19-502(B);
  2. Name, address, and evidence verifying institutional accreditation status of the affiliated educational institution and program accreditation status of current nursing programs offered by the educational institution;
  3. The mission, goals, and objectives of the program consistent with generally accepted standards for advanced practice education in the role and population focus of the program;
  4. List of the required courses, and a description, measurable objectives, and content outline for each required course consistent with curricular requirements in R4-19-502;
  5. A proposed time schedule for implementation of the program and attaining national accreditation;
  6. The total hours allotted for both didactic instruction and supervised clinical practicum in the program;
  7. A program proposal that provides evidence of sufficient financial resources, clinical opportunities and available faculty and preceptors for the proposed enrollment and planned expansion;
  8. A self-study that provides evidence of compliance with R4-19-502;
- B. An entity that wishes to offer a CRNA program shall submit evidence of current accreditation by the Council on Accreditation of Nurse Anesthesia Education Programs or an equivalent organization.
- C. The Board shall approve an advanced practice registered nursing program if approval is in the best interest of the public and the program meets the requirements of this Article. The Board may grant approval for a period of two years or less to an advanced practice nursing program where the program meets all the requirements of this Article except for accreditation by a national nursing accrediting agency, based on the program's presentation of evidence that it has applied for accreditation and meets accreditation standards.
- D. An educational institution or entity that is denied approval of an advanced practice registered nursing program may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying its application for approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
- E. Approval of an advanced practice registered nursing program expires 12 months from the date of approval if a class of students is not admitted within that time.
- F. An advanced practice registered nursing program that has submitted an application according to this Section that meets the threshold requirements of the Nurse Practice Act, may receive

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a 90 day provisional approval from the Board, through Executive Director's delegated authority, prior to application review by the Board, as described in this Section. A program denied provisional approval may request a hearing, as described in subsection (D) of this Section.

**Historical Note**

Former Section IV, Part III; Amended effective Nov. 17, 1978 (Supp. 78-6). Amended effective February 20, 1980 (Supp. 80-1). Amended by adding subsection (F) effective July 20, 1981 (Supp. 81-4). Amended by adding subsection (G) effective September 15, 1982 (Supp. 82-5). Former Section R4-19-55 renumbered as Section R4-19-503 (Supp. 86-1). Former Section R4-19-503 repealed, new Section adopted effective November 18, 1994 (Supp. 94-4). Former Section R4-19-503 renumbered to Section R4-19-504; new Section R4-19-503 adopted effective November 25, 1996 (Supp. 86-1). Amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (05-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-504. Notice of Deficiency; Unprofessional APRN Program Conduct**

- A.** The Board may periodically survey an advanced practice registered nursing program under its jurisdiction to determine whether criteria for approval are being met.
- B.** The Board shall, upon determining that an advanced practice registered nursing program is not in compliance with this Article, provide to the program administrator a written notice of deficiencies that establishes a reasonable time, based upon the number and severity of deficiencies, to correct the deficiencies. The time for correction may not exceed 18 months.
  1. The program administrator shall, within 30 days from the date of service of the notice of deficiencies, consult with the Board or designated Board representative and, after consultation, file a plan to correct each of the identified deficiencies.
  2. The program administrator may, within 30 days from the date of service of the notice of deficiencies, submit a written request for a hearing before the Board to appeal the Board's determination of deficiencies. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
  3. If the Board's determination is not appealed or is upheld upon appeal, the Board may conduct periodic evaluations of the program during the time of correction to determine whether the deficiencies have been corrected.
- C.** The Board shall, following a Board-conducted survey and report, rescind the approval or limit the ability of a program to admit students if the program fails to comply with R4-19-502 within the time set by the Board in the notice of deficiencies provided to the program administrator.
  1. The Board shall serve the program administrator with a written notice of proposed rescission of approval or limitation of admission of students that states the grounds for the rescission or limitation. The program administrator has 30 days to submit a written request for a hearing to show cause why approval should not be rescinded or admissions limited. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

2. Upon the effective date of a decision to rescind program approval, the affected advanced practice registered nursing program shall immediately cease operation and be removed from the official approved-status listing. An advanced practice registered nursing program that is ordered to cease operations shall assist currently enrolled students to transfer to an approved nursing program.
- D.** A disciplinary action, denial of approval, or notice of deficiency may be issued against an RNP or CNS nursing program for any of the following acts of unprofessional conduct:
  1. Failure to maintain minimum standards of acceptable and prevailing educational practice;
  2. For a program that was served with a notice of deficiencies within the preceding three years and timely corrected the noticed deficiencies, subsequent noncompliance with the standards in this Article;
  3. Utilization of students to meet staffing needs in health care facilities;
  4. Non-compliance with the program or parent institution mission or goals, program design, objectives, or policies;
  5. Failure to provide the variety and number of clinical learning opportunities necessary for students to achieve program outcomes or minimal competence;
  6. Student enrollments without adequate faculty, facilities, or clinical experiences;
  7. Ongoing or repetitive employment of unqualified faculty;
  8. Failure to comply with Board requirements within designated time-frames;
  9. Fraud or deceit in advertising, promoting or implementing a nursing program;
  10. Material misrepresentation of fact by the program in any advertisement, application or information submitted to the Board;
  11. Failure to allow Board staff to visit the program or conduct an investigation;
  12. Any other evidence that gives the Board reasonable cause to believe the program's conduct may be a threat to the safety and well-being of students, faculty or potential patients.

**Historical Note**

Former R4-19-504 renumbered to R4-19-505; new R4-19-504 made by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (05-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-505. Requirements for Initial APRN Certification**

- A.** An applicant for certification as an advanced practice registered nurse, shall:
  1. Hold a current Arizona registered nurse (RN) license in good standing or an RN license in good standing from a compact party state with multistate privileges, and not be a participant in an alternative to discipline program in any jurisdiction; and
  2. Submit a verified application to the Board on a form provided by the Board that provides all of the following:
    - a. Full legal name and all former names used by the applicant;
    - b. Current address of record, including primary state of residence and telephone number;
    - c. Place and date of birth;



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- d. RN license number, application for RN license, or copy of a multistate compact RN license;
  - e. Social security number for an applicant who lives or works in the United States;
  - f. Current e-mail address;
  - g. Educational background, including the name and location of basic nursing program, the institution that awarded the highest degree held and any and all advanced practice registered nursing education programs or schools attended including the number of years attended, the length of each program, the date of graduation or completion, and the type of degree or certificate awarded;
  - h. Role and population focus, as applicable for which the applicant is applying;
  - i. Current employer or practice setting, including address, position, and dates of service, if employed or practicing in nursing or health care;
  - j. Evidence of national certification or recertification as an advanced practice registered nurse in the role and population focus, if applicable, of the application and by a certification program that meets the requirements of R4-19-501(C). The applicant shall include the name of the certifying organization, population focus, certification number, date of certification, and expiration date;
  - k. For applicants holding a multistate compact RN license in a state other than Arizona:
    - i. State of original licensure and license number;
    - ii. State of current compact RN license, license number and expiration date;
    - iii. Date of taking RN licensure exam and name of exam;
    - iv. Whether the applicant ever submitted an application for and was granted an Arizona license and, if applicable, the date of Arizona licensure;
    - v. Other information related to the nurse's practice for the purpose of collecting nursing workforce data; and
    - vi. State of licensure and license number of all RN licenses held,
  - l. Responses regarding the applicant's background on the following subjects:
    - i. Current investigation or pending disciplinary action by a nursing regulatory agency in the United States or its territories;
    - ii. Undesignated offense and felony charges, convictions and plea agreements including deferred prosecution;
    - iii. Misdemeanor charges, convictions, and plea agreements, including deferred prosecution, that are required to be reported under A.R.S. § 32-3208;
    - iv. Actions taken on a nursing license by any other state;
    - v. Unprofessional conduct as defined in A.R.S. § 32-1601;
    - vi. Substance use disorder within the last five years;
    - vii. Current participation in an alternative to discipline program in any other state; and
  - m. Information that the applicant meets the criteria in R4-19-506(A) or (C).
3. Submit a fingerprint card on a form provided by the Board or prints if the applicant has not submitted fingerprints to the Board within the last two years.
  4. Submit an official transcript from an institution accredited under A.R.S. § 32-1644 either sent directly from the institution or obtained from a Board-approved database that provides evidence of:
    - a. A graduate degree with a major in nursing for RNP, CNM, and CNS Applicants, or
    - b. A graduate degree associated with a CRNA program for a CRNA applicant.
  5. The applicant shall cause the program to provide the Board with evidence of completion of an APRN program in the role and population focus of the application through submission of an official letter or other official program document sent either directly from the program, or from a Board-approved data base. The APRN program shall meet one of the following criteria during the period of the applicant's attendance in the program:
    - a. The program was part of a graduate degree, or postmasters program at an institution accredited under A.R.S. § 32-1644; or
    - b. The program was approved or recognized in the U.S jurisdiction of program location for the purpose granting APRN licensure or certification.
  6. For an applicant who completed an advanced practice or graduate program in a foreign jurisdiction, submit an evaluation from the Commission on Graduates of Foreign Nursing Schools or a Board-approved credential evaluation service that indicates the applicant's program is comparable to a U.S. graduate nursing or APRN program.
  7. Submit the required fee.
- B.** If the applicant satisfies all other requirements, the Board shall continue to certify:
1. An RNP or CNM without a graduate degree with a major in nursing if the applicant:
    - a. Meets all other requirements for certification; and
    - b. Ensures that the U.S. jurisdiction of an applicant's previous RNP or CNM licensure or certification submits evidence of the applicant's certification or licensure in the nurse practitioner role and population focus that either is current or was current at least six months before the application was received by the Board, and was originally issued:
      - i. Before January 1, 2001, if the RNP or CNM applicant lacks a graduate degree; or
      - ii. Before November 13, 2005 if the RNP's or CNM's graduate degree is in a health-related area other than nursing.
  2. An RNP, CNM, or CNS applicant without evidence of national certification who received initial advanced practice certification or licensure in another state not later than July 1, 2004 and provides evidence, directly from the jurisdiction, that the certification or licensure is current.
  3. A CNS applicant without evidence of completion of a CNS program who received initial certification or advanced practice licensure in this or another state not later than November 13, 2005 and provides evidence, directly from the jurisdiction, that the certificate or license is current.
  4. A CRNA who completed a CRNA program before the effective date of this Section without evidence of a graduate degree.

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5. A CNS applicant who completed a women's health clinical nurse specialist program that was part of a graduate degree in nursing program under subsection (A), without evidence of national certification upon submission of the following:
- A description of the applicant's scope of practice that is consistent with A.R.S. § 32-1601(7);
  - One of the following:
    - A letter from a faculty member who supervised the applicant during the graduate program attesting to the applicant's competence to practice within the defined scope of practice;
    - A letter from a current supervisor verifying the applicant's competence in the defined scope of practice; or
    - A letter from a physician, RNP, CNM, or CNS who has worked with the applicant within the past two years attesting to the applicant's competence in the defined scope of practice; and
  - A form verifying that the applicant has practiced a minimum of 500 hours in the population focus within the past two years, which may include clinical practice time in a CNS program.
- C. The Board shall issue a certificate to practice as an RNP, CNM, or CNS in a population focus, or as a registered nurse anesthetist, to a registered nurse who meets the criteria in this Section. An applicant who is denied a certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective February 20, 1980 (Supp. 80-1). Former Section R4-19-56 repealed, new Section R4-19-56 adopted effective July 16, 1984 (Supp. 84-4). Former Section R4-19-56 renumbered as Section R4-19-504 (Supp. 86-1). Former Section R4-19-504 renumbered to R4-19-505, new Section R4-19-504 adopted effective November 18, 1994 (Supp. 94-4). Former Section R4-19-504 renumbered to Section R4-10-505; new Section R4-19-504 renumbered from R4-19-503 and amended effective November 25, 1996 (Supp. 96-4). Amended effective January 10, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 3911, effective September 28, 1999 (Supp. 99-3). Former R4-19-505 renumbered to R4-19-508; new R4-19-505 renumbered from R4-19-504 and amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citation in subsection (A)(7)(a) was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). A.R.S. Section reference updated under subsection (B)(5)(a), under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2,

2020 (Supp. 20-4).

**R4-19-506. Expiration of APRN Certificate; Practice Requirement; Renewal**

- A. An advanced practice certificate issued after July 1, 2004, expires when the certificate holder's RN license expires, or when national certification expires, whichever occurs first. Certificates issued on or before July 1, 2004, or those issued without proof of national certification under R4-19-505(B)(5) and (B)(2) do not expire unless the RN license expires under A.R.S. § 32-1642 or the nurse has not practiced advanced practice nursing at the applicable level of certification for a minimum of 960 hours in the five years before the date the application is received. This requirement is satisfied if the applicant verifies that the applicant has:
- Completed an advanced practice nursing education program within the past five years; or
  - Practiced for a minimum of 960 hours within the past five years where the nurse:
    - Worked for compensation or as a volunteer, as an APRN and performed one or more acts under A.R.S. § 32-1601(7) for a CNS, A.R.S. § 32-1601(20) for an RNP, A.R.S. § 32-1601(5) for a CNM, or A.R.S. § 32-1634.04 for a CRNA; or
    - Held a position for compensation or as a volunteer that required, preferred or recommended, in the job description, the level of advanced practice certification being sought or renewed.
- B. A registered nurse requesting renewal of an APRN certificate issued after July 1, 2004 shall provide evidence of current national certification or recertification under R4-19-505(A)(2)(j). This provision does not apply to a CNS granted a waiver of certification.
- C. An APRN who does not satisfy the practice requirement of subsection (A) shall complete coursework or continuing education activities at the graduate or advanced practice level that include, at minimum, 45 contact hours of advanced pharmacology and 45 contact hours in a subject or subjects related to the role and population focus of certification. Upon completion of the coursework, the nurse shall engage in a period of precepted clinical practice as specified in this subsection:
- Precepted clinical practice shall be directly supervised by an APRN in the same role and population focus as the certification being renewed or a physician who engages in practice with the same population focus as the certification being renewed.
  - Practice hours completed during the time-frame specified below may be applied to reduce the number of precepted clinical practice hours, except that in no case shall the hours be reduced by more than half the requirement. The nurse shall complete hours according to the following schedule:
    - 300 hours if the applicant has practiced less than 960 hours in only the last five years;
    - 600 hours if the applicant has not practiced 960 hours in the last five years, but has practiced at least 960 hours in the last six years;
    - 1000 hours if the applicant has not practiced at least 960 hours in the last six years, but has practiced 960 hours in the last seven to 10 years; or
    - If the nurse has not practiced 960 hours of advanced practice nursing in the role and population focus being renewed in more than 10 years, complete a program of study as recommended by an approved advanced practice nursing program that includes, at

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minimum, 500 hours of faculty supervised clinical practice in the role and population focus of certification. An applicant who qualifies for any option in subsection (C)(2)(a) through (c) may complete the requirements of this subsection to satisfy the practice requirement.

- D. An applicant who, in addition to not meeting the requirements for continued APRN certification, does not meet the requirements for RN renewal, shall fulfill all RN renewal requirements before satisfying the requirements of this Section.
- E. The Board shall renew a certificate to practice as a registered nurse practitioner in a population focus, a clinical nurse specialist in a population focus, or a registered nurse anesthetist for a registered nurse who meets the criteria in this Section. An applicant who is denied renewal of a certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying renewal of certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Section R4-19-506 renumbered from R4-19-505 effective November 18, 1994 (Supp. 94-4). Former Section R4-19-506 renumbered to R4-19-510, new Section R4-19-506 adopted effective November 25, 1996 (Supp. 96-4). Former R4-19-506 renumbered to R4-19-510; new Section R4-19-506 made by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citations in subsection (A)(2)(a) were updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). A.R.S. Section references updated under subsection (A)(2)(a), under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-507. Temporary Advanced Practice Certificate; Temporary Prescribing and Dispensing Authority**

- A. Based on the registered nurse's qualifications, the Board may issue a temporary certificate to practice as a RNP, CNM, or a CNS in a population focus or a registered nurse anesthetist. A registered nurse who is applying for a temporary certificate shall:
  1. Apply for certification as an APRN;
  2. Submit an application for a temporary certificate;
  3. Demonstrate authorization to practice as a registered nurse in Arizona on either a permanent or temporary Arizona license in good standing or a multistate compact privilege;
  4. Meet all requirements of R4-19-505 or meet the requirements of R4-19-505 with the exception of national certification for RNP, CNM, and CNS applicants unless exempt under R4-19-505(B); and
  5. Submit evidence that the applicant:
    - a. Has applied for and is eligible to take an approved national advanced practice certification exam in the role and population focus of the application;
    - b. Has requested that the certification program transmit all exam results directly to the Board; or
    - c. For a CRNA, holds national certification according to R4-19-501.

- B. If an applicant fails to meet criteria for national advanced practice certification or has failed a certification exam, the applicant is not eligible for a temporary certificate.
- C. The Board may issue temporary prescribing and dispensing authority for RNP, CNM, or CNS applicants, if the applicant:
  1. Meets all application requirements for temporary certification in this Section,
  2. Applies for and meets all requirements for prescribing and dispensing authority under R4-19-511,
  3. Has been certified or licensed as an RNP, CNM, or CNS with prescribing and dispensing authority in the same role and population focus in another state or territory of the United States,
  4. Either holds current national certification as an RNP, CNM, or CNS in the population focus of the application or is exempt from national certification under R4-19-505(B), and
  5. Meets the practice requirement of R4-19-506(A)(2).
- D. Temporary certification as an APRN and temporary prescribing and dispensing authority expire in six months and may be renewed for an additional six months for good cause. Good cause means reasons beyond the control of the temporary certificate holder such as unavoidable delays in obtaining information required for certification.
- E. Notwithstanding subsection (D), the Board shall withdraw a temporary APRN certificate and temporary prescribing and dispensing authority under any one of the following conditions. The temporary certificate holder:
  1. Does not meet requirements for RN licensure in this state or the RN license is suspended or revoked,
  2. Fails to renew the RN license upon expiration,
  3. Loses the multistate compact privilege,
  4. Fails the national certifying examination, fails to maintain current national certification, as required by R4-19-505, or
  5. Violates a statute or rule of the Board.
- F. An applicant who is denied a temporary certificate or temporary prescribing and dispensing authority may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the temporary certification or authority. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

Adopted effective November 25, 1996 (Supp. 96-4). Amended by final rulemaking at 5 A.A.R. 4300, effective October 18, 1999 (Supp. 99-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of

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December 2, 2020 (Supp. 20-4).

#### **R4-19-508. Standards Related to RNP, CNM, and CNS Scope of Practice**

- A.** An RNP, CNM, or CNS shall refer a patient to a physician or another health care provider if the referral will protect the health and welfare of the patient and consult with a physician and other health care providers if a situation or condition occurs in a patient that is beyond the RNP's, CNM's, or CNS's knowledge and experience.
- B.** In addition to the scope of practice permitted a registered nurse, the additional certification of an RNP, CNM, and CNS, under A.R.S. §§ 32-1601 (5), (9), and (20), as applicable, and 32-1606(B)(12), permits the RNP, CNM, and CNS to perform the following acts within the limits of the population focus of certification:
  - 1. Examine a patient and establish a medical diagnosis by client history, physical examination, and other criteria.
  - 2. For a patient who requires the services of a health care facility:
    - a. Admit the patient to the facility,
    - b. Manage the care the patient receives in the facility, and
    - c. Discharge the patient from the facility.
  - 3. Order and interpret laboratory, radiographic, and other diagnostic tests, and perform those tests that the RNP, CNM, or CNS is qualified to perform.
  - 4. Prescribe, order, administer and dispense therapeutic measures including pharmacologic agents and devices if authorized under R4-19-511, and non-pharmacological interventions including, but not limited to, durable medical equipment, nutrition, home health care, hospice, physical therapy and occupational therapy. (For the CNS, all prescribing is restricted according to A.R.S. § 32-1651.)
  - 5. Identify, develop, implement, and evaluate a plan of care for a patient to promote, maintain, and restore health.
  - 6. Perform therapeutic procedures that the RNP, CNM, or CNS is qualified to perform.
  - 7. Delegate therapeutic measures to qualified assistive personnel including medical assistants under R4-19-509.
  - 8. Perform additional acts that the RNP, CNM, or CNS is qualified to perform and that are generally recognized as being within the role and population focus of certification.
- C.** An RNP, CNM, or CNS shall only provide health care services including prescribing and dispensing within the RNP's, CNM's, or CNS's population focus and role and for which the RNP, CNM, or CNS is educationally prepared and for which competency has been established and maintained. Educational preparation means academic coursework or continuing education activities that include both theory and supervised clinical practice.

#### **Historical Note**

Adopted effective February 25, 1987 (Supp. 87-1). Former Section R4-19-505 renumbered to R4-19-506, new Section R4-19-505 renumbered from R4-19-504 effective November 18, 1994 (Supp. 94-4). Former Section R4-19-505 repealed, new Section R4-19-505 renumbered from R4-19-504 and amended effective November 25, 1996 (Supp. 96-4). Amended by final rulemaking at 5 A.A.R. 4300, effective October 18, 1999 (Supp. 99-4). Former R4-19-508 renumbered to R4-19-513; new R4-19-508 renumbered from R4-19-505 and amended by final rulemaking at 11 A.A.R. 3804, effective November 12,

2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 1483, effective June 2, 2007 (Supp. 07-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore one of the A.R.S. citations in subsection (B) was updated.

Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). A.R.S. Section reference updated under subsection (B), under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

#### **R4-19-509. Delegation to Medical Assistants**

- A.** Under A.R.S. §§ 32-1456 and 32-1601(20), an RNP may delegate patient care to a medical assistant in an office or outpatient setting. The RNP shall verify that a medical assistant to whom the RNP delegates meets at least one of the following qualifications:
  - 1. Completed an approved medical assistant training program as defined in A.A.C. R4-16-101(3);
  - 2. If a graduate of an unapproved medical assistant training program, passed the medical assistant examination administered by either the American Association of Medical Assistants or the American Medical Technologists;
  - 3. Completed an unapproved medical assistant training program and was employed as a medical assistant on a continuous basis since completion of the program before February 2, 2000;
  - 4. Was directly supervised by the same registered nurse practitioner for at least 2000 hours before February 2, 2000; or
  - 5. Completed a medical services training program of the Armed Forces of the United States.
- B.** An RNP may delegate the following acts to a medical assistant who is under the direct supervision of the RNP and demonstrates competency in the performance of the act:
  - 1. Obtain vital signs;
  - 2. Perform venipuncture and draw blood;
  - 3. Perform capillary puncture;
  - 4. Perform pulmonary function testing;
  - 5. Perform electrocardiography;
  - 6. Perform patient screening using established protocols;
  - 7. Perform dosage calculations as applicable to written orders;
  - 8. Apply pharmacology principles to prepare and administer oral, inhaled, topical, otic, optic, rectal, vaginal and parenteral medications (excluding intravenous medications);
  - 9. Maintain medication and immunization records;
  - 10. Assist provider with patient care;
  - 11. Perform Clinical Laboratory Improvement Amendments (CLIA) waived hematology, chemistry, urinalysis, microbiological and immunology testing;
  - 12. Screen test results;
  - 13. Obtain specimens for microbiological testing;
  - 14. Obtain patient history;
  - 15. Instruct patients according to their needs to promote health maintenance and disease prevention;
  - 16. Prepare a patient for procedures or treatments;
  - 17. Document patient care and education;
  - 18. Perform first aid procedures;
  - 19. Perform whirlpool treatments;

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20. Perform diathermy treatments;
21. Perform electronic galvation stimulation treatments;
22. Perform ultrasound therapy;
23. Perform massage therapy (subject to regulation by massage therapy board);
24. Apply traction treatments;
25. Apply Transcutaneous Nerve Stimulation unit treatments;
26. Apply hot and cold pack treatments; and
27. Administer small volume nebulizer treatments.

**Historical Note**

Adopted effective November 25, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 4300, effective October 18, 1999 (Supp. 99-4). New Section made by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009

(Supp. 08-4). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore one of the A.R.S. citations in subsection (A) was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). A.R.S. Section reference updated under subsection (A), under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3).

**R4-19-510. Expired****Historical Note**

Section renumbered from R4-19-506 and amended effective November 25, 1996 (Supp. 96-4). Section repealed made by final rulemaking at 10 A.A.R. 792, effective April 3, 2004 (Supp. 04-1). Section R4-19-510 renumbered from R4-19-506 and amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1093, effective March 24, 2011 (Supp. 11-2).

**R4-19-511. Prescribing and Dispensing Authority; Prohibited Acts**

- A. The Board shall authorize an RNP, CNM, or CNS to prescribe and dispense (P&D) drugs and devices within the RNP's, CNM's, or CNS's population focus only if the RNP, CNM, or CNS does all of the following:
1. Obtains authorization by the Board to practice as an RNP, CNM, or CNS;
  2. Applies for prescribing and dispensing privileges on the application for RNP, CNM, or CNS certification;
  3. Submits a completed verified application on a form provided by the Board that contains all of the following information:
    - a. Name, address, e-mail address and home telephone number;
    - b. Arizona registered nurse license number, or copy of compact license;
    - c. RNP, CNM, or CNS population focus;
    - d. RNP, CNM, or CNS certification number issued by the Board; and
    - e. Business address and telephone number;
  4. Submits evidence of a minimum of 45 contact hours of education within the three years immediately preceding the application, covering one or both of the following

topics consistent with the population focus of education and certification:

- a. Pharmacology, or
  - b. Clinical management of drug therapy, and
5. Submits the required fee.
- B. An applicant who is denied P & D authority may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the P & D authority. Board hearings shall comply with A.R.S. Title 41, Chapter 6, Article 10, and 4 A.A.C. 19, Article 6, of this Chapter.
- C. An RNP, CNM, or CNS shall not prescribe or dispense drugs or devices without Board authority or in a manner inconsistent with law. The Board may impose an administrative or civil penalty for each violation, suspend the RNP's, CNM's, or CNS's P & D authority, or impose other sanctions under A.R.S. § 32-1606(C). In determining the appropriate sanction, the Board shall consider factors such as the number of violations, the severity of each violation, and the potential for or existence of patient harm.
- D. In addition to acts listed under R4-19-403, for an RNP, CNM, or CNS who prescribes or dispenses a drug or device, a practice that is or might be harmful to the health of a patient or the public, includes one or more of the following:
1. Prescribing a controlled substance to oneself, a member of the RNP's, CNM's, or CNS's family or any other person with whom the RNP, CNM, or CNS has a relationship that may affect the RNP's, CNM's, or CNS's ability to use independent, objective and sound judgment when prescribing;
  2. Providing any controlled substance or prescription-only drug or device for other than accepted therapeutic purposes;
  3. Delegating the prescribing and dispensing of drugs or devices to any other person;
  4. Prescribing for a patient that is not in the RNP's, CNM's, or CNS's population focus of education and certification except as authorized in subsection (D)(5)(d); and
  5. Prescribing, dispensing, or furnishing a prescription drug or a prescription-only device to a person unless the RNP, CNM, or CNS has examined the person and established a professional relationship, except when engaging in one or more of the following:
    - a. Providing temporary patient care on behalf of the patient's regular treating and licensed health care professional;
    - b. Providing care in an emergency medical situation where immediate medical care or hospitalization is required by a person for the preservation or health, life, or limb;
    - c. Furnishing a prescription drug to prepare a patient for a medical examination; or
    - d. Prescribing antimicrobials to a person who is believed to be at substantial risk as a contact of a patient who has been examined and diagnosed with a communicable disease by the prescribing RNP, CNM, or CNS even if the contact is not in the population focus of the RNP's, CNM's, or CNS's certification.
  6. Prescribing or dispensing any controlled substance or prescription-only drug or device in a manner that is inconsistent with other state or federal requirements.
- E. An RNP, CNM, or CNS shall not dispense a Schedule II Controlled Substance that is an opioid, except for an opioid that is for medication assisted treatment for substance use disorders.

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- F. A CNS's prescribing is additionally limited according to A.R.S. § 32-1651.
- G. A CRNA may apply for and obtain a prescribing-only certificate upon successful completion of all application requirements that are applicable to prescribing, as listed for other APRNs, and follow the same prescribing restrictions and administrative processes, as described in subsections (A) through (D), of this Section; and consistent with A.R.S. § 32-1634.04, and all other applicable laws.

**Historical Note**

Adopted effective November 25, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by emergency rulemaking at 24 A.A.R. 1678, filed and effective May 23, 2018, valid for 180 days, A.R.S. 41-1026(D) (Supp. 18-2). Emergency renewed with amendments at 24 A.A.R. 3335, filed and effective November 9, 2018, valid for an additional 180 days (Supp. 18-4). Emergency expired. Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-512. Prescribing Drugs and Devices**

- A. An RNP, CNM, or CNS granted P & D authority by the Board may, within restrictions provided by law and applicable to each certificate:
1. Prescribe drugs and devices;
  2. Provide for refill of prescription-only drugs and devices for one year from the date of the prescription.
- B. An RNP, CNM, or CNS with P & D authority who wishes to prescribe a controlled substance shall obtain a DEA registration number before prescribing a controlled substance, and shall file the DEA registration number with the Board.
- C. An RNP, CNM, or CNS with a DEA registration number may prescribe, but may not exceed the limitations of each certification:
1. A Schedule II controlled substance as defined in the federal Controlled Substances Act, 21 U.S.C. § 801 et seq., or Arizona's Uniform Controlled Substances Act, A.R.S. Title 36, Chapter 27, but shall not prescribe refills of the prescription, and shall follow all other restrictions provided by law;
  2. A Schedule III or IV controlled substance, as defined in the federal Controlled Substances Act or Arizona's Uniform Controlled Substances Act, and may prescribe a maximum of five refills in six months; and
  3. A Schedule V controlled substance, as defined in the federal Controlled Substances Act or Arizona's Uniform Controlled Substances Act, and may prescribe refills for a maximum of one year.
- D. An RNP, CNM, or CNS whose DEA registration is revoked or expires shall not prescribe controlled substances. An RNP, CNM, or CNS whose DEA registration is revoked or limited shall report the action to the Board within 10 days of the revocation or limitation.
- E. In all outpatient settings or at the time of hospital discharge, an RNP, CNM, or CNS with P & D authority, who prescribed medication to a patient, shall personally provide the patient or the patient's representative with the name of the drug, direc-

tions for use, and any special instructions, precautions, or storage requirements necessary for safe and effective use of the drug if any of the following occurs:

1. A new drug is prescribed or there is a change in the dose, form, or direction for use in a previously prescribed drug;
  2. In the RNP's, CNM's, or CNS's professional judgment, these instructions are warranted; or
  3. The patient or patient's representative requests instruction.
- F. An RNP, CNM, or CNS with P & D authority shall ensure that all prescription orders contain the following:
1. The RNP's, CNM's, or CNS's name, address, telephone number, and population focus;
  2. The prescription date;
  3. The name of the patient and either the address of the patient or a blank for the address if the prescription is not being dispensed by the RNP, CNM, or CNS;
  4. The full name of the drug, strength, dosage form, and directions for use;
  5. The letters "DAW", "dispense as written", "do not substitute", "medically necessary" or any similar statement on the face of the prescription form if intending to prevent substitution of the drug;
  6. The RNP's, CNM's, or CNS's DEA registration number, if applicable; and
  7. The RNP's, CNM's, or CNS's signature.

**Historical Note**

Former R4-19-512 renumbered to R4-19-514; new R4-19-512 made by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (05-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-513. Dispensing Drugs and Devices**

- A. An RNP, CNM, or CNS granted prescribing and dispensing authority by the Board may, within restrictions provided by law and applicable to each certificate:
1. Dispense drugs and devices to patients;
  2. Dispense samples of drugs packaged for individual use without a prescription order or additional labeling;
  3. Only dispense drugs and devices obtained directly from a pharmacy, manufacturer, wholesaler, or distributor; and
  4. Allow other personnel to assist in the delivery of medications provided that the RNP, CNM, or CNS retains responsibility and accountability for the dispensing process.
- B. If dispensing a drug or device, an RNP, CNM, or CNS with dispensing authority shall:
1. Ensure that the patient has a written prescription that complies with R4-19-512(F) and contains the address of the patient and inform the patient that the prescription may be filled by the prescribing RNP, CNM, or CNS or by a pharmacy of the patient's choice;
  2. Affix a prescription number to each prescription that is dispensed;
  3. Ensure that all original prescriptions are preserved for a minimum of seven years and make the original prescriptions available at all times for inspection by the Board of Nursing, Board of Pharmacy, and law enforcement officers in performance of their duties; and

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4. Report the dispensing of controlled substances to the Board of Pharmacy's Controlled Substance Prescription Monitoring Program according to A.R.S. § 36-2608.
- C. An RNP, CNM, or CNS practicing in a public health facility operated by this state or a county or in a qualifying community health center under A.R.S. § 32-1921(D) and (F) may dispense drugs or devices to patients without a written prescription if the public health facility or the qualifying community health center adheres to all storage, labeling, safety, and recordkeeping rules of the Board of Pharmacy.
- D. An RNP, CNM, or CNS who dispenses a drug shall ensure that a label is affixed that contains all of the following information:
  1. Dispensing RNP's, CNM's, or CNS's name and population focus;
  2. Address and telephone number of the location from which the drug is dispensed;
  3. Date dispensed;
  4. Patient's name and address;
  5. Name and strength of the drug, quantity in the container, directions for use, and any cautionary statements necessary for the safe and effective use of the drug;
  6. Manufacturer and lot number; and
  7. Prescription order number.
- E. An RNP, CNM, or CNS who dispenses a drug or device shall ensure that the following information about the drug or device is entered into the patient's medical record:
  1. Name of the drug, strength, quantity, directions for use, and number of refills;
  2. Date dispensed;
  3. Therapeutic reason;
  4. Manufacturer and lot number; and
  5. Prescription order number.
- F. An RNP, CNM, or CNS with dispensing authority shall:
  1. Keep all drugs in a locked cabinet or room in an area that is not accessible to patients;
  2. If dispensing a controlled substance:
    - a. Control access by a written policy that specifies:
      - i. Those persons allowed access, and
      - ii. Procedures to report immediately the discovery of a shortage or illegal removal of drugs to a local law enforcement agency and provide that agency and the DEA with a written report within seven days of the discovery.
    - b. Maintain and make available to the Board upon request an ongoing inventory and record of:
      - i. A Schedule II controlled substance, as defined in the federal Controlled Substances Act or Arizona's Uniform Controlled Substances Act, separately from all other records, and a prescription for a Schedule II controlled substance in a separate prescription file; and
      - ii. A Schedule III, IV, or V controlled substance, as defined in the federal Controlled Substances Act or Arizona's Uniform Controlled Substances Act, in a form that is readily retrievable from other records.
- G. If a prescription order is refilled, an RNP, CNM, or CNS with P & D authority shall record the following information on the back of the prescription order or in the patient's medical record:
  1. Date refilled,
  2. Quantity dispensed if different from the full amount of the original prescription,
  3. RNP's, CNM's, or CNS's name or identifiable initials, and
  4. Manufacturer and lot number.
- H. Under the supervision of an RNP, CNM, or CNS with P & D authority, other personnel may:
  1. Receive and record a prescription refill request from a patient or a patient's representative;
  2. Receive and record a verbal refill authorization from the RNP including:
    - a. The RNP's, CNM's, or CNS's name;
    - b. Date of refill;
    - c. Name, directions for use, and quantity of drug; and
    - d. Manufacturer and lot number;
  3. Prepare and affix a prescription label; and
  4. Prepare a drug or device for delivery, provided that the dispensing RNP, CNM, or CNS:
    - a. Inspects the drug or device and initials the label before issuing to the patient to ensure compliance with the prescription; and
    - b. Ensures that the patient is informed of the name of the drug or device, directions for use, precautions, and storage requirements.

**Historical Note**

Adopted effective November 25, 1996 (Supp. 96-4).  
 Amended by final rulemaking at 5 A.A.R. 4300, effective October 18, 1999 (Supp. 99-4). Former R4-19-513 renumbered to R4-19-515; new R4-19-513 renumbered from R4-19-508 and amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3).  
 Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-514. Standards Related to Clinical Nurse Specialist Scope of Practice**

In addition to the functions of a registered nurse, a CNS, according to A.R.S. § 32-1601(7), may perform one or more of the following for an individual, family, or group within the population focus of certification and for which competency has been maintained:

1. Conduct an advanced assessment, analysis, and evaluation of a patient's complex health needs;
2. Establish primary and differential health status diagnoses;
3. Direct health care as an advanced clinician;
4. Develop, implement, and evaluate a treatment plan according to a patient's need for specialized nursing care;
5. Establish nursing standing orders, algorithms, and practice guidelines related to interventions and specific plans of care;
6. Manage health care according to written protocols;
7. Facilitate system changes on a multidisciplinary level to assist a health care facility and improve patient outcomes cost-effectively;
8. Consult with the public and professionals in health care, business, and industry in the areas of research, case management, education, and administration;
9. Perform psychotherapy if certified as a clinical nurse specialist in psychiatric and mental health nursing;
10. Prescribe, order, administer, and dispense therapeutic measures including pharmacologic agents and devices if authorized under R4-19-511, and within the limitations of A.R.S. § 32-1651; and
11. Perform additional acts that the clinical nurse specialist is qualified to perform.

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**Historical Note**

Adopted effective November 25, 1996 (Supp. 96-4). Section R4-19-514 renumbered from R4-19-512 and amended by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of definitions. Therefore the A.R.S. citation in the opening subsection was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 1438, effective July 6, 2013 (Supp. 13-2). A.R.S. Section reference updated under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-515. Repealed****Historical Note**

Section adopted by final rulemaking at 6 A.A.R. 335, effective December 20, 1999 (Supp. 99-4). Section R4-19-515 renumbered from R4-19-513 by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Repealed by final rulemaking at 18 A.A.R. 2140, effective August 8, 2012 (Supp. 12-3).

**R4-19-516. Repealed****Historical Note**

New Section made by final rulemaking at 11 A.A.R. 3804, effective November 12, 2005 (Supp. 05-3). Repealed by final rulemaking at 18 A.A.R. 2140, effective August 8, 2012 (Supp. 12-3).

**ARTICLE 6. RULES OF PRACTICE AND PROCEDURE****R4-19-601. Expired****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 618, effective December 31, 2001 (Supp. 02-1). Section R4-19-601 renumbered from R4-19-602 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2692, effective August 31, 2011 (Supp. 11-4).

**R4-19-602. Letter of Concern**

A letter of concern issued by the Board is not an appealable agency action as defined in A.R.S. § 41-1092.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-602 renumbered to R4-19-601; new Section R4-19-602 made by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-603. Representation**

Any person subject to a hearing may participate in the hearing and may be represented by legal counsel. The Board shall not pay for the person's legal counsel.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-603 repealed; new Section R4-19-603 renumbered from R4-19-604 and amended by final

rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-604. Notice of Hearing; Response**

- A. The Board, in consultation with the Office of Administrative Hearings, as necessary shall prepare and serve a written notice of hearing on all parties under A.R.S. § 41-1092.05.
- B. In addition to the notice requirements in A.R.S. § 41-1092.05(D), the Board shall include the following in the notice:
  1. The full name, address, and license number, if any, of the licensee, certificate holder, program, or applicant;
  2. The name, address of record, and telephone number of the Board's executive director or Board designee if the hearing is to be conducted by the Board;
  3. A statement that a hearing will proceed without a party's presence if a party fails to attend or participate in the hearing;
  4. The names and addresses of record of persons to whom notice is being given, including the Attorney General representing the state at the hearing; and
  5. Any other matters relevant to the proceedings.
- C. The party named in the notice of hearing shall file a written response under A.R.S. § 32-1664 within 30 days after service of the notice of hearing. The response shall contain:
  1. The party's name, address, and telephone number;
  2. Whether the party has legal representation and, if so, the name and address of the attorney;
  3. A response to the allegations contained in the notice of hearing; and
  4. Any other matters relevant to the proceedings.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-604 renumbered to R4-19-603; new Section R4-19-604 renumbered from R4-19-605 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-605. Expired****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-605 renumbered to R4-19-604; new Section R4-19-605 renumbered from R4-19-606 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2692, effective August 31, 2011 (Supp. 11-4).

**R4-19-606. Expired****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-606 renumbered to R4-19-605; new Section R4-19-606 renumbered from R4-19-607 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2692, effective August 31, 2011 (Supp. 11-4).

**R4-19-607. Recommended Decision**

The Administrative Law Judge who conducts the hearing shall make a recommended decision under A.R.S. § 41-1092.08. The Board shall immediately transmit a copy of the recommended deci-



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sion to each party. Each party may file a memorandum of objections for consideration at the next Board meeting that contains the reasons why the recommended decision is in error or requires correction, and includes appropriate citations to the record, statutes, or rules in support of each objection.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-607 renumbered to R4-19-606; new Section R4-19-607 renumbered from R4-19-612 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-608. Rehearing or Review of Decision**

- A. A party may file a motion for rehearing or review of a decision under A.R.S. §§ 41-1092.09 and 32-1665.
- B. The Board may grant a rehearing or review of the decision for any of the following causes materially affecting the moving party's rights:
  1. Irregularity in the administrative proceedings of the Board or the administrative law judge, or any order, or abuse of discretion, which deprived the moving party of a fair hearing;
  2. Misconduct of the Board, the administrative law judge, or the prevailing party;
  3. Accident or surprise that could not have been prevented by ordinary prudence;
  4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the original hearing;
  5. Excessive or insufficient penalties;
  6. Error in the admission or exclusion of evidence or other errors of law occurring during the pendency of the proceeding or at the administrative hearing; or
  7. The decision is not justified by the evidence or is contrary to law.
- C. Upon the Board's receipt of a motion for rehearing or review, the Board may affirm or modify the decision or grant a rehearing to all or any of the parties on all or part of the issues for any of the reasons in subsection (B). An order granting a rehearing shall specify with particularity the grounds for the order. Any rehearing shall cover only those specified matters.
- D. Within the time limits of A.R.S. § 41-1092.09, the Board may order a rehearing or review on its own initiative for any of the reasons in subsection (B). The Board shall specify the grounds for the rehearing or review in the order.
- E. When a motion for rehearing is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days of such service, serve opposing affidavits.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective December 31, 2001 (Supp. 02-1). Section R4-19-608 renumbered from R4-19-614 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-609. Effectiveness of Orders**

- A. Except as provided in subsection (B), a decision is final upon expiration of the time for filing a request for rehearing or review or upon denial of such a request, whichever is later. If the Board grants a rehearing or review, the decision is stayed until another order is issued.
- B. If it finds that the public health, safety, or welfare imperatively requires emergency action, the Board may proceed under

A.R.S. § 41-1092.11(B), ordering summary suspension of a license while other proceedings are pending. If the Board orders a summary suspension, a party shall exhaust the party's administrative remedies by filing a motion for rehearing or review under A.R.S. § 41-1092.09(B) before seeking judicial review of the decision.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective December 31, 2001 (Supp. 02-1). Section R4-19-609 renumbered from R4-19-615 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-610. Expired****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective December 31, 2001 (Supp. 02-1).

**R4-19-611. Expired****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective December 31, 2001 (Supp. 02-1).

**R4-19-612. Renumbered****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section renumbered to R4-19-607 by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-613. Expired****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective December 31, 2001 (Supp. 02-1).

**R4-19-614. Renumbered****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section renumbered to R4-19-608 by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-615. Renumbered****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Section renumbered to R4-19-609 by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**ARTICLE 7. PUBLIC PARTICIPATION PROCEDURES****R4-19-701. Expired****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2692, effective August 31, 2011 (Supp. 11-4).

**R4-19-702. Petition for Rulemaking; Review of Agency Practice or Substantive Policy Statement; Objection to Rule Based Upon Economic, Small Business, or Consumer Impact**

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A person may petition the Board, requesting the making of a final rule, or a review of an existing agency practice or substantive policy statement that the petitioner alleges to constitute a rule under A.R.S. § 41-1033, or objecting to a rule under A.R.S. § 41-1056.01, by filing a petition which contains the following:

1. The name, current address, and telephone number of the person submitting the petition.
2. For the making of a new rule, the specific language of the proposed rule.
3. For amendment of a current rule, the *Arizona Administrative Code* (A.A.C.) Section number, the Section heading, and the specific language of the current rule, with any language to be deleted stricken through but legible, and any new language underlined.
4. For repeal of a current rule, the A.A.C. Section number and Section heading proposed for repeal.
5. The reasons the rule should be made, specifically stating in reference to an existing rule, why the rule is inadequate, unreasonable, unduly burdensome, or otherwise not acceptable. The petitioner may provide additional supporting information including:
  - a. Any statistical data or other justification, with clear references to attached exhibits;
  - b. An identification of any person or segment of the public that would be affected and how they would be affected; and
  - c. If the petitioner is a public agency, a summary of relevant issues raised in any public hearing, or written comments offered by the public.
6. For a review of an existing agency practice or substantive policy statement alleged to constitute a rule, the reasons the existing agency practice or substantive policy statement constitutes a rule and the proposed action requested of the Board.
7. For an objection to a rule based upon the economic, small business, or consumer impact, evidence of any of the following grounds:
  - a. The actual economic, small business, or consumer impact significantly exceeded the impact estimated in the economic, small business, and consumer impact statement submitted during the making of the rule.
  - b. The actual economic, small business, or consumer impact was not estimated in the economic, small business, and consumer impact statement submitted during the making of the rule and that actual impact imposes a significant burden on persons subject to the rule.
  - c. The Board did not select the alternative that imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.
8. The signature of the person submitting the petition.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2). Amended by final rulemaking at 19 A.A.R. 1419, effective July 6, 2013 (Supp. 13-2).

**R4-19-703. Oral Proceedings**

- A.** The Board shall schedule an oral proceeding on all rulemakings and publish the notice as prescribed in A.R.S. § 41-1023.

A Board member, the executive director, or a Board staff member shall serve as presiding officer at an oral proceeding.

- B.** The Board shall record all oral proceedings either by an electronic recording device or stenographically, and any resulting cassette tapes or transcripts, registers, and all written comments received shall become part of the official record.
- C.** The presiding officer shall conduct an oral proceeding according to A.R.S. § 41-1023; and
1. Request each person in attendance register;
  2. Obtain the following information from any person who intends to speak:
    - a. Name and whether the person represents another;
    - b. Position with regard to the proposed rule; and
    - c. Approximate length of time needed to speak;
  3. Open the proceeding by identifying the subject matter of the rules under consideration and the purpose of the proceeding;
  4. Present the agenda;
  5. Ensure that a Board representative explains the background and general content of the proposed rules;
  6. Limit comments to a reasonable period, and prevent undue repetition of comments;
  7. Announce the address for written public comments and the date and time for the close of record; and
  8. Close the proceeding if there are no persons in attendance within 15 minutes after the posted meeting time.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-703 repealed; new Section R4-19-703 renumbered from R4-19-704 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-704. Petition for Altered Effective Date**

- A.** A person wishing to alter the effective date of a rule shall file a written petition that contains:
1. The name, current address, and telephone number of the person submitting the petition;
  2. Identification of the proposed rule;
  3. If the person is petitioning for an immediate effective date, a demonstration that the immediate date is necessary for one or more of the reasons in A.R.S. § 41-1032(A);
  4. If the person is petitioning for a later effective date, more than 60 days after filing of the rule, a demonstration under A.R.S. § 41-1032(B) that good cause exists for, and the public interest will not be harmed by, the later effective date; and
  5. The signature of the person submitting the petition.
- B.** The Board shall make a decision and notify the petitioner of the decision within 60 days of receipt of the petition.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-704 renumbered to R4-19-703; new Section R4-19-704 renumbered from R4-19-705 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-705. Written Criticism of an Existing Rule**

- A.** Any person may file with the Board a written criticism of an existing rule that contains:
1. The rule addressed, and
  2. The reason the existing rule is inadequate, unduly burdensome, unreasonable, or improper.

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- B. The Board shall acknowledge receipt of any criticism within 10 working days and shall place the criticism in the official record for review by the Board under A.R.S. § 41-1056.

**Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Former Section R4-19-705 renumbered to R4-19-704; new Section R4-19-705 renumbered from R4-19-706 and amended by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**R4-19-706. Renumbered****Historical Note**

Adopted effective October 10, 1996 (Supp. 96-4). Renumbered to R4-19-705 by final rulemaking at 9 A.A.R. 1288, effective June 3, 2003 (Supp. 03-2).

**ARTICLE 8. CERTIFIED AND LICENSED NURSING ASSISTANTS AND CERTIFIED MEDICATION ASSISTANTS**

**R4-19-801. Common Standards for Nursing Assistant (NA) and Certified Medication Assistant (CMA) Training Programs**

**A. Program Administrative Responsibilities**

1. Any person or entity offering a training program under this Article shall, before accepting tuition from prospective students, and at all times thereafter, provide program personnel including a coordinator and instructors, as applicable, who meet the requirements of this Article.
2. If at any time, a person or entity offering a training program cannot provide a qualified instructor for its students, it shall immediately cease instruction and, if the training program cannot provide a qualified instructor within 5 business days, the training program shall offer all enrolled students a refund of all tuition and fees the students have paid to the program.
3. A training program shall obtain and maintain Board approval or re-approval as specified in this Article and A.R.S. § 32-1650.01 (B) before advertising the program, accepting any tuition, fees, or other funds from prospective students, or enrolling students.
4. A training program that uses external clinical facilities shall execute a written agreement with each external clinical facility.
5. A training program that requires students to pay tuition for the program shall:
  - a. Make all program costs readily accessible on the school's website with effective dates,
  - b. Publicly post any increases in costs on the school's website 30 days in advance of the increase;
  - c. Include in the cost calculation and public posting, all fees directly paid to the program including but not limited to tuition, lab fee, clinical fee, enrollment fee, insurance, books, uniform, health screening, credit card fee and state competency exam fee; and
  - d. Provide a description of all program costs to the student that are not directly paid to the program.
6. Before collecting any tuition or fees from a student, a training program shall notify each prospective student of Board requirements for certification and licensure including:
  - a. Legal presence in the United States; and
  - b. For licensure, criminal background check requirements, and ineligibility under A.R.S. § 32-1606(B)(15) and (16).

7. Within the first 14 days of the program and before 50% of program instruction occurs, a training program shall transmit to the Board-approved test vendor, accurate and complete information regarding each enrolled student for the purposes of tracking program enrollment, attrition and completion. Upon receipt of accurate completion information, the vendor shall issue a certificate of completion to the program for each successful graduate.
8. A training program shall provide the Board, or its designee, access to all training program records, students and staff at any time, including during an announced or unannounced visit. A program's refusal to provide such access is grounds for withdrawal of Board approval.
9. A training program shall provide each student with an opportunity to anonymously and confidentially evaluate the course instructor, curriculum, classroom environment, clinical instructor, clinical setting, textbook and resources of the program;
10. A training program shall provide and implement a plan to evaluate the program that includes the frequency of evaluation, the person responsible, the evaluative criteria, the results of the evaluation and actions taken to improve the program. The program shall evaluate the following elements at a minimum every two years:
  - a. Student evaluations consistent with subsection (A)(9);
  - b. First-time pass rates on the written and manual skills certification exams for each admission cohort;
  - c. Student attrition rates for each admission cohort;
  - d. Resolution of student complaints and grievances in the past two years; and
  - e. Review and revision of program policies.
11. A training program shall submit written documentation and information to the Board regarding the following program changes within 30 days of instituting the change:
  - a. For a change or addition of an instructor or coordinator, the name, RN license number, and documentation that the coordinator or instructor meets the applicable requirements of R4-19-802(B) and (C) for NA programs and R4-19-803 (B) for CMA programs;
  - b. For a change in classroom location, the previous and new location, and a description of the new classroom;
  - c. For a change in a clinical facility, the name and address of the new facility and a copy of the signed clinical contract;
  - d. For a change in the name or ownership of the training program, the former name or owners and the new name or owners; and
  - e. For a decrease in hours of the program, a written revised curriculum document that clearly highlights new content, strikes out deleted content and includes revised hours of instruction, as applicable.

**B. Policies and Procedures**

1. A training program shall promulgate and enforce written policies and procedures that comply with state and federal requirements, and are consistent with the policies and procedures of the parent institution, if any. The program shall provide effective and review dates for each policy or procedure.
2. A training program shall provide a copy of its policies and procedures to each student on or before the first day the student begins the program.

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3. The program shall promulgate and enforce the following policies with accompanying procedures:
  - a. Admission requirements including:
    - i. Criminal background, health and drug screening either required by the program or necessary to place a student in a clinical agency; and
    - ii. English language, reading and math skills necessary to comprehend course materials and perform duties safely.
  - b. Student attendance policy, ensuring that a student receives the hours and types of instruction as reported to the Board in the program's most recent application to the Board and as required in this Article. If absences are permitted, the program shall ensure that each absence is remediated by providing and requiring the student to complete learning activities that are equivalent to the missed curriculum topics, clinical experience or skill both in substance and in classroom or clinical time.
  - c. A final examination policy that includes the following provisions:
    - i. Require that its students score a minimum 75% correct answers on a comprehensive secure final examination with no more than one retake. The program may allow an additional retake following documented, focused remediation based on past test performance. Any retake examination must contain different items than the failed exam, address all course competencies, and be documented with score, date administered and proctor in the student record; and
    - ii. Require that each student demonstrate, to program faculty, satisfactory performance of each practical skill as prescribed in the curriculum before performance of that skill on patients or residents without the instructor's presence, direct observation, and supervision.
  - d. Student record maintenance policies consistent with subsection (D) including the retention period, the location of records and the procedure for students to access to their records.
  - e. Clinical supervision policies consistent with clinical supervision provisions of this Section, and:
    - i. R4-19-802(C) and (D) for NA programs, or
    - ii. R4-19-803(B) and (C) for CMA programs;
  - f. Student conduct policies for expected and unacceptable conduct in both classroom and clinical settings;
  - g. Dismissal and withdrawal policies;
  - h. Student grievance policy that includes a chain of command for grade disputes and ensures that students have the right to contest program actions and provide evidence in support of their best interests including the right to a third party review by a person or committee that has no stake in the outcome of the grievance;
    - i. Program progression and completion criteria.
- C. Classroom and clinical instruction
  1. During clinical training sessions, a training program shall ensure that each student is identified as a student by a name badge or another means readily observable to staff, patients, and residents.
  2. A training program shall not utilize, or allow the clinical facility to utilize, students as staff during clinical training sessions.
  3. A training program shall provide a clean, comfortable, distraction-free learning environment for didactic teaching and skill practice.
  4. A training program shall provide, in either electronic or paper format, a written curriculum to each student on or before the first day of class that includes a course description, course hours including times of instruction and total course hours, instructor information, passing requirements, course goals, and a topical schedule containing date, time and topic for each class session.
  5. For each unit or class session the program shall provide, to its students, written:
    - a. Measurable learner-centered objectives,
    - b. An outline of the material to be taught, and
    - c. The learning activities or reading assignment.
  6. A training program shall utilize an electronic or paper textbook corresponding to the course curriculum that has been published within the previous five years. Unless granted specific permission by the publisher, a training program shall not utilize copies of published materials in lieu of an actual textbook.
  7. A training program shall provide, to all program instructors and enrolled students, access to the following instructional and educational resources:
    - a. Reference materials, corresponding to the level of the curriculum; and
    - b. Equipment and supplies necessary to practice skills.
  8. A training program instructor shall:
    - a. Plan each learning experience;
    - b. Ensure that the curriculum meets the requirements of this Section;
    - c. Prepare written course goals, lesson objectives, class content and learning activities;
    - d. Schedule and achieve course goals and objectives by the end of the course; and
    - e. Require satisfactory performance of all critical elements of each skill under R4-19-802(H) for nursing assistant and R4-19-803(D)(4) for medication assistant before allowing a student to perform the skill on a patient or resident without the instructor's presence at the bedside.
  9. A qualified RN instructor shall be present at all times and during all scheduled classroom, skills laboratory and clinical sessions. In no instance shall a nursing assistant or other unqualified person provide any instruction, reinforcement, evaluation or independent activities in the classroom or skills laboratory.
  10. A qualified RN instructor shall supervise any student who provides care to patients or residents by:
    - a. Remaining in the clinical facility and focusing attention on student learning needs during all student clinical experiences;
    - b. Providing the instructor's current and valid contact information to students and facility staff during the instructor's scheduled teaching periods;
    - c. Observing each student performing tasks taught in the training program;
    - d. Documenting each student's performance each day, consistent with course skills and clinical objectives;
    - e. During the clinical session, engaging exclusively in activities related to the supervision of students; and

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f. Reviewing all student documentation.

**D. Records**

1. A training program shall maintain the following program records either electronically or in paper form for a minimum of three years for NA programs and five years for CMA programs:
  - a. Curriculum and course schedule for each admission cohort;
  - b. Results of state-approved written and manual skills testing;
  - c. Documentation of program evaluation under subsection (A)(10);
  - d. A copy of any Board reports, applications, or correspondence, related to the program; and
  - e. A copy of all clinical contracts, if using outside clinical agencies.
2. A training program shall maintain the following student records either electronically or in paper form for a minimum of three years for NA programs and five years for CMA programs:
  - a. A record of each student's legal name, date of birth, address, telephone number, e-mail address and Social Security number, if available;
  - b. A completed skill checklist containing documentation of student level of competency performing the skills in R4-19-802(F) for nursing assistant, and in R4-19-803(D)(4) for medication assistants;
  - c. An accurate attendance record, which describes any make-up class sessions and reflects whether the student completed the required number of hours in the course;
  - d. Scores for each test, quiz, or exam and whether such test, quiz, or exam was retaken; and
  - e. For NA programs only, a copy of a document providing proof of legal presence in the United States as specified in A.R.S. § 41-1080 to be remitted to the Board's designated testing vendor in order to facilitate timely placement of program graduates on a nursing assistant registry.

**E. Certifying Exam Passing Standard:** A training program and each site of a consolidated program under R4-19-802(E) shall attain, at a minimum, an annual first-time passing rate on the manual skill and written certifying examinations that is equal to the Arizona average pass rate for all candidates on each examination minus 20 percentage points. The Board may waive this requirement for programs with less than five students taking the exam during the year. The Board shall issue a notice of deficiency under R4-19-805 to any program with five or more students taking the exam that fails to achieve the minimum passing standard in any calendar year.

**F. Distance Learning; Innovative Programs**

1. A training program may be offered using real-time interactive distance technologies such as interactive television and web based conferencing if the program meets the requirements of this Article.
2. Before a training program may offer, advertise, or recruit students for an on-line, innovative or other non-traditional program, the program shall submit an application for innovative applications in education under R4-19-214 and receive Board approval.

**G. Site visits:** A training program shall permit the Board, and its designee, including another state agency, to conduct an onsite scheduled evaluation for initial Board approval and renewal of approval in accordance with R4-19-804 and announced or

unannounced site visits at any other time the Board deems necessary.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). A.R.S. Section reference updated under subsection (A)(6), under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-802. Nursing Assistant (NA) Program Requirements****A. Organization and Administration**

1. A nursing assistant program may be offered by:
  - a. An educational institution licensed by the State Board for Private Postsecondary Education,
  - b. A public educational institution or a program funded by a local, state or federal governmental agency,
  - c. A health care institution licensed by the Arizona Department of Health Services or a federally authorized health care institution,
  - d. A private business that meets the requirements of this Article and all other legal requirements to operate a business in Arizona.
2. If a nursing assistant program is offered by a private business, the program shall meet the following requirements.
  - a. Hold insurance covering any potential or future claims for damages resulting from any aspect of the program or a hold a surety bond from a surety company with a financial strength rating of "A minus" or better by Best's Credit Ratings, Moody's Investors Service, Standard and Poor's rating service or another comparable rating service as determined by the Board in the amount of a minimum of \$15,000. The program shall ensure that:
    - i. Bond or insurance distributions are limited to students or former students with a valid claim for instructional or program deficiencies;
    - ii. The amount of the bond or insurance is sufficient to reimburse the full amount of collected tuition and fees for all students during all enrollment periods of the program; and
    - iii. The bond or insurance is maintained for an additional 24 months after program closure; and
  - b. Upon initial use and remodeling, provide the Board with a fire inspection report from the Office of the State Fire Marshall or the local authority with jurisdiction, indicating that each program classroom and skill lab location is in compliance with the applicable fire code.
3. Programs approved by the Board before the effective date of this Section shall comply with subsection (A)(2) within one year of the effective date. If a program does not charge tuition or fees, the bond requirement is waived.

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4. A Medicare or Medicaid certified long-term care facility-based nursing assistant program shall not require a student to pay a fee for any portion of the program including the initial attempt on the state competency exam.
  5. In addition to the policies required in R4-19-801(B), the Board may approve a nursing assistant program to offer an advanced placement option to a student with a background in health care. A nursing assistant program wishing to offer an advance placement option shall submit their advanced placement policy to the Board and receive approval before implementing the policy. The program shall include, at a minimum, the following provisions in its policy:
    - a. Advanced placement is limited to students with at least one year full-time employment in the direct provision of health care within the past five years or students who have successfully completed course work that included direct patient care experiences in allied health, medicine or nursing in the past five years.
    - b. The program, at a minimum, shall require an advanced placement student to meet the same outcomes as regular students on all examinations and skill performance demonstrations.
    - c. The program shall require an advanced placement student to successfully accomplish all clinical objectives during a minimum of 16 hours of clinical practice under the direct supervision and observation of a qualified instructor and in a long-term care facility.
    - d. Upon successful completion of advanced placement and any other program requirements, the program shall credit the graduate with the same number of didactic, laboratory and clinical hours as the regular graduate.
- B. Program coordinator qualifications and responsibilities**
1. Program coordinator qualifications include:
    - a. Holding a current, registered nurse license that is active and in good standing or multistate privilege to practice as an RN under A.R.S. Title 32, Chapter 15; and
    - b. Possessing at least two years of nursing experience at least one year of which is in the provision of long-term care facility services.
  2. A director of nursing in a health care facility may assume the role of a program coordinator for a nursing assistant training program that is housed in the facility but shall not function as a program instructor.
  3. A program coordinator's responsibilities include:
    - a. Supervising and evaluating the program;
    - b. Ensuring that instructors meet Board qualifications and there are sufficient instructors to provide for a clinical ratio not to exceed 10 students per instructor;
    - c. Ensuring that the program meets the requirements of this Article; and
    - d. Ensuring that the program meets federal requirements regarding clinical facilities under 42 CFR 483.151.
  4. Other than the director of nursing in a long-term care facility, a program coordinator may also serve as a program instructor.
- C. Program instructor qualifications and duties**
1. Program instructor qualifications include:
    - a. Holding a current, registered nurse license that is active and in good standing under A.R.S. Title 32, Chapter 15 and provide documentation of a minimum of one year full time or 1500 hours employment providing direct care as a registered nurse in any setting; and
    - b. At a minimum, one of the following:
      - i. Successful completion of a three semester credit course on adult teaching and learning concepts offered by an accredited post-secondary educational institution,
      - ii. Completion of a 40 hour continuing education program in adult teaching and learning concepts that was awarded continuing education credit by an accredited organization,
      - iii. One year of full-time or 1500 hours experience teaching adults as a faculty member or clinical educator, or
      - iv. One year of full time or 1500 hours experience supervising nursing assistants, either in addition to or concurrent with the one year of experience required in subsection (C)(1)(a).
  2. In addition to the program instruction requirements in R4-19-801(C), a nursing assistant program instructor shall provide on-site supervision for each student placed in a health care facility not to exceed 10 students per instructor;
- D. Clinical and classroom hour requirements and resources**
1. A nursing assistant training program shall ensure each graduate receives a minimum of 120 hours of total instruction consisting of:
    - a. Instructor-led teaching in a classroom setting for a minimum of 40 hours;
    - b. Instructor-supervised skills practice and testing in a laboratory setting for a minimum of 20 hours; and
    - c. Instructor-supervised clinical experiences for a minimum of 40 hours, consistent with the goals of the program. Clinical requirements include the following:
      - i. The program shall provide students with clinical orientation to any clinical setting utilized.
      - ii. The program shall provide a minimum of 20 hours of direct resident care in a long-term care facility licensed by the Department of Health Services, except as provided in subsection (iv). Direct resident care does not include orientation and clinical pre and post conferences.
      - iii. If another health care facility is used for additional required hours, the program shall ensure that the facility provides opportunities for students to apply nursing assistant skills similar to those provided to long-term care residents.
      - iv. If a long-term care facility licensed by the Department of Health Services is not available within 50 miles of the training program's classroom, the program may provide the required clinical hours in a facility or unit that cares for residents or patients similar to those residing in a long-term care facility.
  - d. To meet the 120 hour minimum program hour requirement, a NA program shall designate an additional 20 hours to classroom, skill or clinical instruction based upon the educational needs of the program's students and program resources.

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2. A nursing assistant training program shall ensure that equipment and supplies are in functional condition and sufficient in number for each enrolled student to practice required skills. At a minimum, the program shall provide:
  - a. Hospital-type bed, over-bed table, linens, linen protectors, pillows, privacy curtain, call-light and night-stand;
  - b. Thermometers, stethoscopes, including a teaching stethoscope, aneroid blood pressure cuffs, and a scale;
  - c. Realistic skill training equipment, such as a manikin or model, that provides opportunity for practice and demonstration of perineal care;
  - d. Personal care supplies including wash basin, towels, washcloths, emesis basin, rinse-free wash, tooth brushes, disposable toothettes, dentures, razor, shaving cream, emery board, orange stick, comb, shampoo, hair brush, and lotion;
  - e. Clothes for dressing residents including undergarments, socks, hospital gowns, shirts, pants and shoes or non-skid slippers;
  - f. Elimination equipment including fracture bed pans, bed pans, urinals, ostomy supplies, adult briefs, specimen cups, graduate cylinder, and catheter supplies;
  - g. Aseptic and protective equipment including running water, sink, soap, paper towels, clean disposable gloves, surgical masks, particulate respirator mask for demonstration purposes, gowns, hair protectors and shoe protectors;
  - h. Restorative equipment including wheelchair, gait belt, walker, anti-embolic hose, adaptive equipment, and cane;
  - i. Feeding supplies including cups, glasses, dishes, straws, standard utensils, adaptive utensils and clothing protectors;
  - j. Clean dressings, bandages and binders; and
  - k. Documentation forms.
- E. Consolidated Programs
  1. A nursing assistant program may request, in writing, to consolidate more than one site of a program under one program approval for convenience of administration. The site of a program is where didactic instruction occurs. The Board may approve the request for a consolidated program if all the following conditions are met:
    - a. The program is not based in a long-term care facility;
    - b. The program does not offer an innovative program as defined in R4-19-214 at any consolidated site;
    - c. A single RN administrator has authority and responsibility for all sites including hiring, retention and evaluation of all program personnel;
    - d. Curriculum and policies are identical for all sites;
    - e. Instructional delivery methods are substantially similar at all sites;
    - f. Didactic, lab practice and clinical hours are identical for all sites;
    - g. The program presents sufficient evidence that all sites have comparable resources, including classroom, skill lab, clinical facilities and staff. Evidence may include pictures, videos, documentation of equipment purchase and instructor resumes;
    - h. The program provides an application to the Board a minimum of 30 days before consolidation of the program or use of the new site;
    - i. The site is fully staffed before accepting students;
    - j. The program evaluates each site separately under R4-19-801(A)(9);
    - k. The program arranges for the test vendor to provide a separate program number for each site;
  2. There have been no substantiated complaints against the program or failure to follow the provisions of this Article in the past two years.
  3. The program shall notify the Board if a site is closed or has not been used in two years.
  4. A program that has been Board-approved as a consolidated program may request to add additional sites 30 days in advance of site utilization. The Board may approve the new site if the site meets the criteria in subsection (E)(1).
  5. The Board may deny a request to consolidate programs or add a site if the requirements of this section are not met. Denial of such a request is not a disciplinary action and does not affect the program's approval status.
  6. The Board shall not renew or visit any site that was not used in the previous approval period.
- F. Curriculum: a nursing assistant training program shall provide classroom and clinical instruction regarding each of the following subjects:
  1. Communication, interpersonal skills, and documentation;
  2. Infection control;
  3. Safety and emergency procedures, including abdominal thrusts for foreign body airway obstruction and cardio-pulmonary resuscitation;
  4. Patient or resident independence;
  5. Patient or resident rights, including the right to:
    - a. Confidentiality;
    - b. Privacy;
    - c. Be free from abuse, mistreatment, and neglect;
    - d. Make personal choices;
    - e. Obtain assistance in resolving grievances and disputes;
    - f. Security of a patient's or resident's personal property; and
    - g. Be free from restraints;
  6. Recognizing and reporting abuse, mistreatment or neglect to a supervisor;
  7. Basic nursing assistant skills, including:
    - a. Taking vital signs, height, and weight using standing, wheelchair and bed scales;
    - b. Maintaining a patient's or resident's environment;
    - c. Observing and reporting pain;
    - d. Assisting with diagnostic tests including obtaining specimens;
    - e. Providing care for patients or residents with drains and tubes including catheters and feeding tubes;
    - f. Recognizing and reporting abnormal patient or resident physical, psychological, or mental changes to a supervisor;
    - g. Applying clean bandages;
    - h. Providing peri-operative care; and
    - i. Assisting in admitting, transferring, or discharging patients or residents.
  8. Personal care skills, including:
    - a. Bathing, skin care, and dressing;
    - b. Oral and denture care;
    - c. Shampoo and hair care;

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- d. Fingernail care;
  - e. Toileting, perineal, and ostomy care;
  - f. Feeding and hydration, including proper feeding techniques and use of assistive devices in feeding; and
9. Age specific, mental health, and social service needs, including:
- a. Modifying the nursing assistant's behavior in response to patient or resident behavior,
  - b. Demonstrating an awareness of the developmental tasks and physiologic changes associated with the aging process,
  - c. Responding to patient or resident behavior,
  - d. Allowing the resident or patient to make personal choices and providing and reinforcing other behavior consistent with the individual's dignity,
  - e. Providing culturally sensitive care,
  - f. Caring for the dying patient or resident, and
  - g. Using the patient's or resident's family as a source of emotional support for the resident or patient;
10. Care of the cognitively impaired patient or resident including:
- a. Understanding and addressing the unique needs and behaviors of patients or residents with dementia or other cognitive impairment,
  - b. Communicating with cognitively impaired patients or residents,
  - c. Reducing the effects of cognitive impairment, and
  - d. Appropriate responses to the behavior of cognitively impaired individuals.
11. Skills for basic restorative services, including:
- a. Body mechanics;
  - b. Resident self-care;
  - c. Assistive devices used in transferring, ambulating and dressing;
  - d. Range of motion exercises;
  - e. Bowel and bladder training;
  - f. Care and use of prosthetic and orthotic devices; and
  - g. Turning and positioning a resident in bed, transferring a resident between bed and chair and positioning a resident in a chair.
12. Health care team member skills including the role of the nursing assistant and others on the health care team, time management and prioritizing work; and
13. Legal aspects of nursing assistant practice, including:
- a. Requirements for licensure and registry placement and renewal.
  - b. Delegation of nursing tasks,
  - c. Ethics,
  - d. Advance directives and do-not-resuscitate orders, and
  - e. Standards of conduct under R4-19-814.
14. Body structure and function, together with common diseases and conditions.
- G.** Curriculum sequence: A nursing assistant training program shall provide a student with a minimum of 16 hours instruction in the subjects identified in subsections (F)(1) through (F)(6) before allowing a student to care for patients or residents.
- H.** Skills: A nursing assistant instructor shall verify and document that the following skills are satisfactorily performed by each student before allowing the student to perform the skill on a patient or resident without the instructor present:
- 1. Hand hygiene, gloving and gowning; and

- 2. Skills in subsection (F)(7), (8) and (11)(a), (c), (d), (f), and (g).

**I.** One-year approval: following receipt and review of a complete initial application as specified in R4-19-804 the Board may approve the program for a period that does not exceed one year, if requirements are met, without a site visit.

**J.** A Medicare or Medicaid certified long-term care facility-based program shall provide in its initial and each renewal application, a signed, sworn, and notarized document, executed by the program coordinator, affirming that the program does not require a nursing assistant student to pay a fee for any portion of the program including the initial attempt on the state competency exam.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Amended by final rulemaking at 23 A.A.R. 1420, effective July 1, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-803. Certified Medication Assistant Program Requirements**

**A.** Organization and Administration: A certified medication assistant (CMA) program may only be offered by those entities identified in A.R.S. § 32-1650.01(A).

**B.** Instructor qualifications and duties

- 1. A medication assistant program instructor shall:

- a. Hold a current, registered nurse license that is active and in good standing or multistate privilege to practice as an RN under A.R.S. Title 32, Chapter 15;
- b. Possess at least two years or 3,000 hours of direct care nursing experience; and
- c. Have administered medications to residents of a long-term care facility for a minimum of 40 hours.

- 2. Duties of a medication assistant instructor include, but are not limited to:

- a. Ensuring that the program meets the requirements of this Article;
- b. Planning each learning experience;
- c. Teaching a curriculum that meets the requirements of this Section;
- d. Implementing student and program evaluation policies that meet or exceed the requirements R4-19-801(A)(9) and (10);
- e. Administering not less than three secure unit examinations and one comprehensive final exam consistent with the course curriculum and the requirements of R4-19-801(B)(3)(c) and;
- f. Requiring each student to demonstrate satisfactory performance of all critical elements of each skill in subsection (D)(4) before allowing a student to perform the skill on a patient or resident without the instructor's presence and direct observation;
- g. Being physically present and attentive to students in the classroom and clinical setting at all times during all sessions;

- 3. A program instructor shall supervise only one student for the first 12 hours of each student's clinical experience; no



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more than three students for the next 12 hours of each student's clinical experience; and no more than five students for the next 16 hours of each student's clinical experience;

**C. Clinical and classroom hour requirements and resources**

1. A medication assistant training program shall ensure each graduate received a minimum of 100 hours of total instruction consisting of:
  - a. Instructor-led didactic instruction for a minimum of 45 hours;
  - b. Instructor supervised skill practice and testing for a minimum of 15 hours;
  - c. Instructor supervised medication administration for a minimum of 40 hours in a long-term care facility licensed by the Department of Health Services.
2. A medication assistant program shall ensure that equipment and supplies are in functional condition and sufficient in number for each enrolled student to practice required skills in subsection (D)(3) and (D)(4). At a minimum, the program shall provide the following:
  - a. A medication cart similar to one used in the clinical practice facility;
  - b. Simulated medications and packaging consistent with resident medications;
  - c. Pill crushers, pill splitters, medication cups and hand hygiene supplies;
  - d. Medication administration record forms; and
  - e. Current drug references, calculator and any other equipment used to administer medications safely.

**D. Curriculum: a medication assistant training program shall provide classroom and clinical instruction in each of the following subjects.**

1. Role of certified medication assistant (CMA) in Arizona including allowable acts, conditions, delegation and restrictions;
2. Principles of medication administration including:
  - a. Terminology,
  - b. Laws affecting drug administration,
  - c. Drug references,
  - d. Medication action,
  - e. Medication administration across the human life-span,
  - f. Dosage calculation,
  - g. Medication safety,
  - h. Asepsis, and
  - i. Documentation.
3. Medication properties, uses, adverse effects, administration and care implications for the following types of medications:
  - a. Vitamins, minerals, and herbs,
  - b. Antimicrobials,
  - c. Eye and ear medications,
  - d. Skin medications,
  - e. Cardiovascular medications,
  - f. Respiratory medications,
  - g. Gastrointestinal medications,
  - h. Urinary system medications and medications to attain fluid balance,
  - i. Endocrine/reproductive medications,
  - j. Musculoskeletal medications,
  - k. Nervous system/sensory system medications and
  - l. Psychotropic medications.
4. Medication administration theory and skill practice in administration of:

- a. Oral tablets, capsules, and solutions;
- b. Ear drops, eye drops and eye ointments;
- c. Topical lotions, ointments and solutions;
- d. Rectal suppositories; and
- e. Nasal drops and sprays.

5. Any other topics deemed by the program or the Board as necessary and pertinent to the safe administration of medications.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3).

**R4-19-804. Initial Approval and Re-Approval of Training Programs**

- A.** An applicant for initial training program approval shall submit an application packet to the Board at least 90 days before the expected starting date of the program. An applicant shall submit application documents in an electronic format.
- B.** The Board may impose disciplinary action including denial on any training program that has advertised, conducted classes, recruited or collected money from potential students before receiving Board approval or after expiration of approval except for completing instruction to students who enrolled before the expiration date.
- C.** A program applying for initial approval shall include all of the following in their application packet:
  1. Name, address, web address, telephone number, e-mail address and fax number of the program;
  2. Identity of all program owners or sponsoring institutions;
  3. Name, license number, telephone number, e-mail address and qualifications of the program coordinator as required in R4-19-802;
  4. Name, license number, telephone number, e-mail address and qualifications of each program instructor including clinical instructors as required in either R4-19-802 for NA programs or R4-19-803 for CMA programs;
  5. Name, telephone number, e-mail address and qualifications any person with administrative oversight of the training program, such as an owner, supervisor or director;
  6. Accreditation status of the training program, if any, including the name of the accrediting body and date of last review;
  7. Name, address, telephone number and contact person, for all health care institutions which will be clinical sites for the program;
  8. Medicare certification status of all clinical sites, if any;
  9. Evidence of program compliance with this Article including all of the following:
    - a. Program description that includes the length of the program, number of hours of clinical, laboratory and classroom instruction, and program goals consistent with federal, state, and if applicable, private postsecondary requirements;
    - b. A list and description of classroom facilities, equipment, and instructional tools the program will provide;
    - c. Written curriculum and course schedule according to the provisions of this Article;

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- d. A copy of the documentation that the program will use to verify student attendance, instructor presence and skills;
  - e. Copy of signed, current clinical contracts;
  - f. The title, author, name, year of publication, and publisher of all textbooks the program will require students to use;
  - g. A copy of course policies and any other materials that demonstrate compliance with this Article and the statutory requirements in Title 32, Chapter 15;
  - h. A plan to evaluate the program that meets requirements in R4-19-801(A)(10);
  - i. An implementation plan including start date and a description of how the program will provide oversight to ensure all requirements of this Article are met;
  - j. A self-assessment checklist of the application contents and their location in the application, on a form provided by the Board; and
  - k. Other requirements as requested consistent with R4-19-802 for nursing assistant programs and R4-19-803 for medication assistant programs.
- D. Re-approval of Training Programs**
- 1. A training program applying for re-approval shall submit an electronic application and accompanying materials to the Board before expiration of the current approval. A program or site of a consolidated program that did not hold any classes in the previous approval period is not eligible for renewal of approval.
  - 2. The program shall include the following with the renewal application:
    - a. A program description and course goals;
    - b. Name, license number, and qualifications of current program personnel;
    - c. A copy of the current curriculum which meets the applicable requirements in either R4-19-802 or R4-19-803;
    - d. The dates of each program offering, number of students who have completed the program, and the results of the state-approved written and manual skills tests, including first-time pass rates since the last program review;
    - e. A copy of current program policies, consistent with R4-19-801;
    - f. Any change in resources, contracts, or clinical facilities since the previous approval or changes that were not previously reported to the Board;
    - g. The program evaluation plan with findings regarding required evaluation elements under R4-19-801(A)(10);
    - h. The title, author, year of publication, and publisher of the textbook used by the program;
    - i. Copies of the redacted records of one program graduate;
    - j. The total number of enrolled students and graduates for each year since the last approval;
    - k. The total number of persons taking the state-approved exam in the past two years; if the number is less than 10, a comprehensive plan to increase program enrollment;
    - l. A self-assessment checklist of the application contents and their location in the application, on a form provided by the Board; and
    - m. Other requirements as requested consistent with R4-19-802 for nursing assistant programs and R4-19-803 for medication assistant programs.
- E.** Upon determination of administrative completeness of either an initial or renewal application, the Board, through its authorized representative, shall schedule and conduct a site visit of a NA program, unless one year only approval is granted on an initial application. The Board may conduct a site visit of a CMA program. Site visits are for the purpose of verifying compliance with this Article. Site visits may be conducted in person or through the use of distance technology.
- F.** Following an evaluation of the program application and a site visit, if applicable, the Board may approve or renew the approval of the program for two years for a nursing assistant program and up to four years for a medication assistant program, if the program renewal application and site visit findings, as applicable, meet the requirements of this Article, and A.R.S. Title 32, Chapter 15 and renewal is in the best interest of the public. If the program does not meet these requirements, the Board may issue a notice of deficiency under R4-19-805 or take disciplinary action.
- G.** A program may request an administrative hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for program approval or renewal of approval. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
- H.** The owner, operator, administrator or coordinator of a program that is denied approval or renewal of approval shall not be eligible to conduct, own or operate a new or existing program for a period of two years from the date of denial.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-805. Deficiencies and Rescission of Program Approval, Unprofessional Program Conduct, Voluntary Termination, Disciplinary Action, and Reinstatement**

**A. Deficiencies**

- 1. Upon determining that a training program has not complied with this Article, the Board s may issue a written notice of deficiency to the program. The Board shall establish a reasonable period of time, based upon the number and severity of deficiencies, for correction of the deficiencies. Under no circumstances, however, shall the period for correction of deficiencies exceed six months.
  - a. Within ten days from the date that the notice of deficiency is served, the program shall submit a plan of correction to the Board.
  - b. The Board, through its authorized representative, may approve the plan of correction or require modifications to the plan if the plan does not adequately address the deficiencies.
  - c. The Board may conduct periodic evaluations and site visits during the period of correction to ascertain

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- the program's progress toward correcting the deficiencies.
- d. The Board shall evaluate the program's compliance, at a regularly scheduled Board meeting following the period of correction to determine whether the program has corrected the deficiencies.
2. The Board may rescind the approval of a training program or take other disciplinary action under A.R.S. § 32-1663, based on the number and severity of violations if the program engages in any of the following:
    - a. Failure to submit a plan of correction to the Board within ten days of service of a notice of deficiency.
    - b. Failure to comply with the requirements of this Article within the period set by the Board in the notice of deficiency;
    - c. Noncompliance with federal, state, or, if applicable, private postsecondary requirements;
    - d. Failure to permit a scheduled or unannounced Board site visit or failure to allow a Board representative access to program documents, staff or students during a site visit or investigation;
    - e. Loaning or transferring Board program approval to another entity or facility, including a facility with the same ownership;
    - f. Offering, advertising, recruiting, or enrolling students in a training program before Board approval is granted;
    - g. Conducting a training program after expiration of Board approval without filing an application for renewal of approval before the expiration date;
    - h. For a long-term care based nursing assistant program, charging for any portion of the program;
    - i. Committing an act of unprofessional program conduct.
- B. Unprofessional program conduct.** A notice of deficiency or a disciplinary action including denial of approval or rescission of approval may be issued against a training program for any of the following acts of unprofessional conduct:
1. Failing to maintain minimum standards of acceptable and prevailing educational practice;
  2. Any violation of this Article;
  3. Utilization of students as labor rather than for educational purposes in a health care facility;
  4. Failing to follow the program's or parent institution's mission or goals, program design, objectives, or policies;
  5. Failing to provide the classroom, laboratory or clinical teaching hours required by this Article or described in the program description;
  6. Enrolling students in a program without adequate faculty, facilities, or clinical experiences, as required by this Article;
  7. Permitting unqualified persons to supervise teaching-learning experiences in any portion of the program;
  8. Failing to comply with Board requirements within designated timeframes;
  9. Engaging in fraud, misrepresentation or deceit in advertising, recruiting, promoting or implementing the program;
  10. Making a false, inaccurate or misleading statement to the Board or the Board's designee in the course of an investigation, or on any application or information submitted to the Board or on the program's public website;
  11. Failing to supervise students in the clinical setting in accordance with this Article or allowing more than the maximum students per clinical instructor prescribed in this Article;
12. Engaging in any other conduct that gives the Board reasonable cause to believe the program's conduct may be a threat to the safety or welfare of students, faculty, patients or the public.
13. Failing to:
    - a. Furnish in writing a full and complete explanation of a matter reported pursuant to A.R.S. § 32-1664, or
    - b. Respond to a subpoena issued by the Board;
  14. Failing to take appropriate action to safeguard a patient's or resident's welfare or follow policies and procedures of the program or clinical site designed to safeguard the patient or resident;
  15. Failing to promptly provide make-up classroom, laboratory, or clinical hours, with adequate notice to students, equivalent educational content, and reasonable scheduling, when shortages of hours were caused by the program or program instructors;
  16. Failing to promptly remove, or adequately discipline or train, program instructors whose conduct violates this Article or may be a threat to the safety or welfare of students, patients, residents, or the public.
  17. Engaging in retaliatory, threatening, or intimidating conduct toward current, prospective or former program students, instructors, other staff, or the public, who make complaints about any aspect of the program to program staff or the Board.
- C. Disciplinary Action.** If the Board issues disciplinary action against the approval of a nursing assistant or medication assistant training program, the program may request a hearing by filing a written request with the Board within 30 days of service of the Board's order. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10, and 4 A.A.C. 19, Article 6.
- D. Voluntary termination**
1. If a training program is voluntarily terminating before renewal, the program shall submit a written notice of termination to the Board.
  2. The program coordinator shall continue the training program, including retaining necessary instructors, until the last student is transferred or has completed the training program.
  3. Within 15 days after the termination of a training program, the administrator or a program representative shall notify the Board in writing of the permanent location and availability of all program records.
  4. A program that fails to renew its approval with the Board shall be considered voluntarily terminated unless there is a complaint against the program.
- E. Re-issuance of approval**
1. If the Board revokes the approval of a training program, the owner, administrator or coordinator of the revoked program may apply for re-issuance of program approval after a period of two years by complying with the requirements of this Article. The owner, administrator and coordinator of a program that had its approval revoked shall not own, administer or coordinate a training program for a period of two years from the date of program revocation.
  2. If the Board, in lieu of revocation, accepts a voluntarily surrender of a program's approval, the program's owner, administrator or coordinator may apply for reissuance of the program's approval after a period of two years. The

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owner, administrator and coordinator of a program that voluntarily surrendered its approval shall not own, administer or coordinate a training program for a period of two years from the date of the surrender of approval.

3. A training program owner, administrator or coordinator whose program approval was voluntarily surrendered or that had its approval rescinded or revoked shall submit a complete reissuance application packet in writing that contains all of the information and documentation required of programs applying for initial approval. In addition, the program shall provide substantial evidence that the basis for revocation or voluntary surrender no longer exist and that reissuance of program approval is in the best interest of the public.
4. The Board may reissue approval to a training program that meets the requirements of this Article. A program that is denied reissuance of approval may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying reissuance. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3).

**R4-19-806. Initial Nursing Assistant Licensure (LNA) and Medication Assistant Certification**

A. An applicant for initial licensed nursing assistant (LNA) licensure or CMA certification shall submit the following to the Board:

1. A verified application on a form furnished by the Board that provides the following information about the applicant:
  - a. Full legal name and any and all former names used by the applicant;
  - b. Current address of record, including county of residence, e-mail address and telephone number;
  - c. Place and date of birth;
  - d. Social Security number;
  - e. Ethnic category and marital status at the applicant's discretion;
  - f. Educational background, including the name of the training program attended, and date of graduation and for medication assistant, proof of high school or equivalent education completion as required in A.R.S. § 32-1650-02(A)(4);
  - g. Current employer, including address and telephone number, type of position, and dates of employment, if employed in health care;
  - h. A list of all states in which the applicant is or has been included on a nursing assistant registry or been licensed or certified as a nursing or medication assistant and the license or certificate number, if any;
  - i. For medication assistant, proof of LNA licensure and 960 hours or 6 months full time employment as a CNA or LNA in the past year, as required in A.R.S. § 32-1650.02;
  - j. Responses to questions regarding the applicant's background on the following subjects:
    - i. Current investigation or pending disciplinary action by a nursing, nursing assistant or medication assistant regulatory agency in the United States or its territories;
    - ii. Action taken on a nursing assistant or medication assistant license, certification or registry designation in any other state;
    - iii. Felony conviction or conviction of an undesignated or other similar offense and the date of absolute discharge of sentence;
    - iv. Unprofessional conduct as defined in A.R.S. § 32-1601;
    - v. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;

2. Proof of satisfactory completion of a nursing assistant or medication assistant training program that meets the requirements of this Article;
3. Proof of United States citizenship or alien status as specified in A.R.S. § 41-1080;
4. For LNA applicants, one or more fingerprint cards or fingerprints;
5. For CMA applicants, one or more fingerprint cards or fingerprints, as required by A.R.S. § 32-1606(B)(15) if a fingerprint background report has not been received by the Board in the past two years; and
6. Applicable fees under A.R.S. § 32-1643 and R4-19-808.

B. An applicant for licensure as a nursing assistant shall submit a passing score on a Board-approved nursing assistant examination and provide one of the following criteria:

1. Proof that the applicant has completed a Board-approved nursing assistant training program within the past two years;
2. Proof that the applicant has completed a nursing assistant training program approved in another state or territory of the United States consisting of at least 120 hours within the past two years;
3. Proof that the applicant has completed a nursing assistant program approved in another state or territory of the United States of at least 75 hours of instruction in the past two years and proof of working as a nursing assistant for an additional number of hours in the past two years that together with the hours of instruction, equal at least 120 hours;
4. Proof that the applicant either holds a nursing license in good standing in the U.S. or territories, has graduated from an approved nursing program, or otherwise meets educational requirements for a registered or practical nursing license in Arizona;
5. Documentation sent directly from the program that the applicant successfully completed a nursing course or courses as part of an RN or LPN program approved in either this or another state in the last 2 years that included:
  - a. Didactic content regarding long-term care clients; and
  - b. Forty hours of instructor-supervised direct patient care in a long-term care or comparable facility; or
6. Documentation of a minimum of 100 hours of military health care training, as evidenced by military records, and proof of working in health care within the past 2 years.

C. An applicant for medication assistant shall meet the qualifications of A.R.S. §§ 32-1650.02 and 32-1650.03. An applicant who wishes to use part of a nursing program in lieu of comple-

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tion of a Board approved medication assistant training program under A.R.S. § 32-1650.02 shall submit the following:

1. An official transcript from a Board approved nursing program showing a grade of C or higher in a 45 hour or 3 semester credit, or equivalent, pharmacology course; and
2. A document signed by both the applicant's clinical instructor and the nursing program administrator verifying that the applicant completed 40 hours of supervised medication administration in a long-term care facility.

**D. Certifying Exam**

1. A LNA applicant shall take and pass both portions of the certifying exam within 2 years:
  - a. Of program completion for graduates of nursing assistant programs approved in Arizona or another state, or
  - b. Of the date of the first test for all other applicants.
2. A CMA applicant shall take and pass both portions of the certifying exam within one year:
  - a. Of program completion for graduates of Board-approved programs, or
  - b. Of the date of the first test for all other applicants.
3. An applicant may re-take the failed portion or portions of a certifying exam, under conditions prescribed in written policy by the exam vendor, until a passing score is achieved or their time expires under subsections (D)(1) or (2).

**E.** An applicant who does not take or pass an examination within the time period specified in subsection (D) shall enroll in and successfully complete a Board approved training program in the certification category before being permitted to retake an examination.

**F.** The Board may license a nursing assistant or certify a medication assistant applicant who meets the applicable criteria in this Article and A.R.S. Title 32, Chapter 15 if licensure or certification is in the best interest of the public.

**G.** An applicant who is denied licensure or certification may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

**H.** Medication assistant certification expires when nursing assistant licensure expires.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-807. Nursing Assistant Licensure and Medication Assistant Certification by Endorsement**

- A.** An applicant for LNA or CMA by endorsement shall submit all of the information, documentation, and fees required in R4-19-806.
- B.** An applicant who has been employed for less than one year shall list all employers during the past two years.
- C.** An applicant for nursing assistant licensure by endorsement shall meet the training program criteria in R4-19-806(B). An applicant for medication assistant endorsement shall, in addition,

provide evidence satisfactory completion of a training program that meets the requirements of A.R.S. § 32-1650.04 and pass a competency examination as prescribed in A.R.S. § 32-1650.03.

**D.** In addition to the other requirements of this Section, an applicant for licensure or certification by endorsement shall provide evidence that the applicant:

1. Is or has been, within the last 2 years, listed as active on a nursing assistant register or a substantially equivalent register by another state or territory of the United States with no substantiated complaints or discipline; and
2. For nursing assistant, meets one or more of the following criteria:
  - a. Regardless of job title or description, performed nursing assistant activities for a minimum of 160 hours for an employer or as part of a nursing or allied health program in the past two years; or
  - b. Has completed a nursing assistant training program and passed the required examination within the past two years.
3. In addition to the above requirements, for medication assistant certification, meets the practice requirements of A.R.S. § 32-1650.04 and pays applicable fees under R4-19-808.

**E.** The Board may license a nursing assistant or certify a medication assistant applicant who meets the applicable criteria in this Article if certification is in the best interest of the public.

**F.** An applicant who is denied licensure or certification may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for licensure or certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

**R4-19-808. Fees Related to Certified Medication Assistant**

- A.** The Board shall collect the following fees related medication assistant certification:
  1. Initial application for certification by exam, \$50.00.
  2. Fingerprint processing, \$50.00.
  3. Application for certification by endorsement, \$50.00.
- B.** If an individual or entity submits a dishonored check, draft order or note, the Board may collect, from the provider of the instrument, the amount allowed under A.R.S. § 44-6852.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 5004, effective November 15, 2002 (Supp. 02-4). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

**R4-19-809. Nursing Assistant Licensure and Medication Assistant Certificate Renewal**

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- A.** An applicant for renewal of a LNA license or a CMA certificate shall:
1. Submit a verified application to the Board on a form furnished by the Board that provides all of the following information about the applicant:
    - a. Full legal name, address of record including county of residence, e-mail address and telephone number;
    - b. Marital status and ethnicity at the applicant's discretion;
    - c. Current health care employer including name, address, telephone number, dates of employment and type of setting;
    - d. If the applicant fails to meet the practice requirements in subsections (A)(2) for nursing assistant or (A)(3) for medication assistant renewal, documentation that the applicant has completed a Board-approved training program for the licensure or certification sought and passed both the written and manual skills portions of the competency examination within the past two years;
    - e. Responses to questions that address the applicant's background:
      - i. Any investigation or disciplinary action by a nursing regulatory agency or nursing assistant regulatory agency in the United States or its territories not previously disclosed by the applicant to the Board;
      - ii. Felony conviction or conviction of undesignated offense and date of absolute discharge of sentence since licensed, certified or last renewed, and
      - iii. Unprofessional conduct committed by the applicant as defined in A.R.S. § 32-1601 since the time of last renewal and not previously disclosed by the applicant to the Board;
      - iv. Any disciplinary action or investigation related to the applicant's nursing or nursing assistant license or medication assistant certificate, nursing assistant certificate or registry listing by any other state regulatory agency since issuance of the license or certificate, or since last renewal and not previously disclosed to the Board.
      - v. Explanation and supporting documentation for each affirmative answer to questions regarding the applicant's background;
    - f. For LNA renewal, employment as a nursing assistant, performing nursing assistant tasks for an employer or the applicant's performance of nursing assistant activities as part of a nursing or allied health program for a minimum of 160 hours every two years since the last license or certificate was issued, or
    - g. For CMA renewal, employment as a medication assistant for a minimum of 160 hours within the last 2 years, and
    - h. Pay applicable fees according to A.R.S. § 32-1643 and R4-19-808.
- B.** An applicant's license or certificate expires every two years on the last day of the applicant's birth month. If an applicant fails to timely renew the license or certificate, the applicant shall:
1. Not work or practice as an LNA or CMA until the Board issues a renewal license or certificate; and
  2. Pay any late fee imposed by the Board.
- C.** If an applicant's license or certificate was, or is currently, revoked, surrendered, denied, suspended or placed on probation in another jurisdiction, the applicant is not eligible to renew or reactivate the applicant's Arizona license or certificate until a review or investigation has been completed and a decision made by the Board.
- D.** The Board may renew an LNA license and CMA certificate of an applicant who meets the criteria established in statute and this Article. An applicant who is denied renewal of a license or certificate may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying renewal of the license or certificate. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6 of this Chapter.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**R4-19-810. Certified Nursing Assistant Registry; Licensed Nursing Assistant Registry**

- A.** The Board shall maintain a Certified Nursing Assistant (CNA) Registry and a Licensed Nursing Assistant (LNA) Registry. All individuals listed in either Registry shall provide proof to the Board, either directly or through the Board's test vendor, of legal presence in the United States as specified in A.R.S. § 41-1080. Both Registries meet the requirements of A.R.S. § 32-1606(B)(11).
1. To be placed on the CNA Registry, an applicant shall either:
    - a. Have successfully completed an approved nursing assistant training program and passed the nursing assistant written and manual skills competency evaluation within the past two years; or
    - b. For endorsement, be listed on another state's nursing assistant registry.
  2. To renew CNA Registry status under A.R.S. § 32-1642(E), an applicant shall submit an application that includes verified statements establishing:
    - a. Whether applicant has performed nursing assistant or nursing related services for at least eight hours within the past 24 months. An applicant must complete this work requirement to be eligible for renewal.
    - b. Whether the applicant's listing on any registry in any other state includes documented findings of abuse, neglect or misappropriation of property.
  3. The Executive Director shall include the following information in the CNA Registry for each registered individual:
    - a. Full legal name and any other names used;
    - b. Address of record;
    - c. County of residence;
    - d. The date of initial placement on the registry;

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- e. Dates and results of both the written and manual skills portions of the nursing assistant competency examination;
  - f. Date of expiration of current registration, if applicable;
  - g. Any substantiated complaints of abuse, neglect or misappropriation of property; and
  - h. Registry status such as active or expired as applicable.
- B.** An LNA applicant who meets the qualifications under subsection (A)(1) and the licensure requirements of this Article shall be placed on an LNA Registry. The Executive Director shall include the following information in the LNA Registry for each licensed individual:
- 1. Information contained in subsection (A)(3);
  - 2. Status of the license and any Board actions on the license, such as active, denied, expired, or revoked, as applicable.
- C.** The Executive Director shall include the following information in the applicable Registry for an individual if the Board, or the United States Department of Health and Human Services (HHS) finds that the individual has violated relevant law. For a finding by the Board or HHS, the Executive Director shall include:
- 1. The finding, including the date of the decision, and a reference to each statute, rule, or regulation violated; and
  - 2. The sanction, if any, including the date of action and the duration of action, if time-limited.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-811. Repealed****Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Repealed by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2).

**R4-19-812. Change of Name or Address**

- A.** An applicant, CNA, LNA, or CMA certificate holder shall notify the Board, in writing or electronically through the Board's website of any legal name change within 30 days of the change, and submit a copy of the official document verifying the name change.
- B.** An applicant, CNA, LNA, or CMA certificate holder shall notify the Board in writing or electronically through the Board's website of any change of address within 30 days of the address change.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp.

14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

**R4-19-813. Performance of Nursing Assistant Tasks; Performance of Medication Assistant Tasks**

- A.** A CNA or LNA may perform the following tasks as delegated by a licensed nurse:
- 1. Tasks for which the nursing assistant has been trained through the curriculum identified in R4-19-802, and
  - 2. Tasks learned through inservice or educational training if the task meets the following criteria and the nursing assistant has demonstrated competence performing the task:
    - a. The task can be safely performed according to clear, exact, and unchanging directions;
    - b. The task poses minimal risk to the patient or resident and the consequences of performing the task improperly are not life-threatening or irreversible;
    - c. The results of the task are reasonably predictable; and
    - d. Assessment, interpretation, or decision-making is not required during the performance or at the completion of the task.
- B.** A licensed nursing assistant who is also certified as a medication assistant under A.R.S. § 32-1650.02 may administer medications under the conditions imposed by A.R.S. § § 32-1650 through 32-1650.07.
- C.** A licensed nursing assistant under this Article shall:
- 1. Recognize the limits of the licensee's personal knowledge, skills, and abilities;
  - 2. No change
  - 3. Inform the registered nurse, licensed practical nurse, or another person authorized to delegate the task about the licensee's ability to perform the task before accepting the assignment;
  - 4. Accept delegation, instruction, and supervision from a licensed nurse or another person authorized to delegate a task;
  - 5. Not perform any task that requires a judgment based on nursing knowledge;
  - 6. Acknowledge responsibility for personal actions necessary to complete an accepted assigned task;
  - 7. Follow the plan of care, if available;
  - 8. Observe, report, and record signs, symptoms, and changes in the patient or resident's condition in an ongoing and timely manner; and
  - 9. Retain responsibility for all assigned tasks without delegating any tasks to another person.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2).

**R4-19-814. Standards of Conduct for Licensed Nursing Assistants and Certified Medication Assistants**

For purposes of A.R.S. § 32-1601(24)(d), a practice or conduct that is or might be harmful or dangerous to the health of a patient or the public and constitutes a basis for disciplinary action on a LNA license and a CMA certificate includes the following:

- 1. Failing to maintain professional boundaries or engaging in a dual relationship with a patient, resident, or any member of the patient's or resident's family;

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2. Engaging in sexual conduct with a patient, resident, or any member of the patient's or resident's family who does not have a pre-existing relationship with the licensee or any conduct while on duty or in the presence of a patient or resident that a reasonable person would interpret as sexual;
3. Leaving an assignment or abandoning a patient or resident who requires care without properly notifying the immediate supervisor;
4. Failing to accurately and timely document care and treatment provided to a patient or resident, including, for a CMA, medications administered or not administered;
5. Falsifying or making a materially incorrect entry in a health care record;
6. Failing to follow an employer's policies and procedures, designed to safeguard the patient or resident;
7. Failing to take action to protect a patient or resident whose safety or welfare is at risk from potential or actual incompetent health care practice, or to report the practice to the immediate supervisor or a facility administrator;
8. Failing to report signs, symptoms, and changes in patient or resident conditions to the immediate supervisor in an ongoing and timely manner;
9. Violating the rights or dignity of a patient or resident;
10. Violating a patient or resident's right of privacy by disclosing confidential information or knowledge concerning the patient or resident, unless disclosure is otherwise required by law;
11. Neglecting or abusing a patient or resident physically, verbally, emotionally, or financially;
12. Failing to immediately report to a supervisor and the Board any observed or suspected abuse or neglect, including a resident or patient's report of abuse or neglect;
13. Soliciting, or borrowing, property or money from a patient or resident, or any member of the patient's or resident's family, or the patient's or resident's guardian;
14. Soliciting or engaging in the sale of goods or services unrelated to the licensee's health care assignment with a patient or resident, or any member of the patient or resident's immediate family, or guardians;
15. Removing, without authorization, any money, property, or personal possessions, or requesting payment for services not performed from a patient, resident, employer, co-worker, or member of the public.
16. Repeated use or being under the influence of alcohol, medication, or any other substance to the extent that judgment may be impaired and practice detrimentally affected or while on duty in any work setting;
17. Accepting or performing patient or resident care tasks that the licensee lacks the education, competence or legal authority to perform;
18. Removing, without authorization, narcotics, drugs, supplies, equipment, or medical records from any work setting;
19. Obtaining, possessing, using, or selling any narcotic, controlled substance, or illegal drug in violation of any employer policy or any federal or state law;
20. Permitting or assisting another person to use the licensee's license or CMA certificate holder's certificate or identity for any purpose;
21. Making untruthful or misleading statements in advertisements of the individual's practice as a licensed nursing assistant or certified medication assistant;
22. Offering or providing licensed nursing assistant or certified medication assistant services for compensation without a designated registered nurse supervisor;
23. Threatening, harassing, or exploiting an individual;
24. Using violent or abusive behavior in any work setting;
25. Failing to cooperate with the Board during an investigation by:
  - a. Not furnishing in writing a complete explanation of a matter reported under A.R.S. § 32-1664;
  - b. Not responding to a subpoena or written request for information issued by the Board;
  - c. Not completing and returning a Board-issued questionnaire within 30 days; or
  - d. Not informing the Board of a change of address or phone number within 10 days of each change;
26. Cheating on the competency exam or providing false information on an initial or renewal application for licensure or certification;
27. Making a false or inaccurate statement to the Board or the Board's designee during the course of an investigation;
28. Making a false or misleading statement on a nursing assistant, medication assistant or health care related employment or credential application;
29. If an applicant, licensee or CMA certificate holder is charged with a felony or a misdemeanor, involving conduct that may affect patient safety, failing to notify the Board, in writing, within 10 working days of being charged under A.R.S. § 32-3208. The applicant, licensee or CMA certificate holder shall include the following in the notification:
  - a. Name, current address, telephone number, Social Security number, and license and certificate number, if applicable;
  - b. Date of the charge; and
  - c. Nature of the offense;
30. Failing to notify the Board, in writing, of a conviction for a felony or an undesignated offense within 10 days of the conviction. The applicant, licensee or CMA certificate holder shall include the following in the notification:
  - a. Name, current address, telephone number, Social Security number, and license and CMA certificate number, if applicable;
  - b. Date of the conviction;
  - c. Nature of the offense;
31. For a medication assistant, performance of any acts associated with medication administration not specifically authorized by A.R.S. § 32-1650 et seq; and
32. Practicing in any other manner that gives the Board reasonable cause to believe that the health of a patient, resident, or the public may be harmed.
33. Violation of any other state or federal laws, rules or regulations.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 4254, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4621, effective January 31, 2009 (Supp. 08-4). Antiquated statute reference in opening subsection revised at the request of Board under A.R.S. § 41-1011(C), Office File No. M11-189, filed May 16, 2011 (Supp. 11-2). Pursuant to authority of A.R.S. § 41-1011(C), Laws 2012, Ch. 152, § 1, provides for A.R.S. references to be corrected to reflect the renumbering of



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definitions. Therefore the A.R.S. citation in the opening subsection was updated. Agency request filed July 12, 2012, Office File No. M12-242 (Supp. 12-3). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). A.R.S. Section reference updated under subsection under Laws 2015, Ch. 262, effective July 1, 2016 (Laws 2015, Ch. 262, § 23) at file number R16-186 (Supp. 16-3).

**R4-19-815. Reissuance or Subsequent Issuance of a Nursing Assistant License or Medication Assistant Certificate**

- A.** A person whose LNA license or CMA certificate was denied, revoked, or voluntarily surrendered according to A.R.S. § 32-1663 may apply to the Board to issue or re-issue the license or certificate:
  - 1. Five years from the date of denial or revocation, or
  - 2. In accordance with the terms of a voluntary surrender agreement.
- B.** A person who applies for issuance or re-issuance of a license or certificate under the conditions of subsection (A) is subject to the following terms and conditions:
  - 1. The applicant shall submit a written application for issuance or re-issuance of the license or certificate that contains substantial evidence that the basis for surrendering, denying, or revoking the license or certificate has been removed and that the issuance or re-issuance of the license or certificate will not be a threat to public health or safety.
  - 2. Safe practice:
    - a. According to A.R.S. § 32-1664(F), the Board for reasonable cause may require a combination of mental, physical, nursing competency, psychological, or psychiatric evaluations, or any combination of evaluations, reports, and affidavits that the Board considers necessary to determine the person's competence and conduct to safely practice as an LNA or CMA.
    - b. The Board may require the applicant to be tested for competency, or retake and successfully complete a Board approved training program and pass the required examination, all at the applicant's expense.
- C.** The Board shall consider the application, and may designate a time for the applicant to address the Board at a regularly scheduled meeting.
- D.** After considering the application, the Board may:
  - 1. Grant certification or licensure, with or without conditions or limitations, or
  - 2. Deny the application.
- E.** An applicant who is denied issuance or re-issuance of LNA licensure or CMA certification may request a hearing by filing a written request with the Board within 30 days of service of the Board's order. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6, of this Chapter.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 757, effective February 4, 2000 (Supp. 00-1). Amended by final rulemaking at 20 A.A.R. 1859, effective September 8, 2014 (Supp. 14-3). Amended by exempt rulemaking at 22 A.A.R. 1900, effective July 1, 2016 (Supp. 16-2). Amended by final rulemaking at 25 A.A.R. 919, effective June 3, 2019 (Supp. 19-2). Amended by final

rulemaking at 26 A.A.R. 3289, with an immediate effective date of December 2, 2020 (Supp. 20-4).

**ARTICLE 9. LICENSED HEALTH AIDE****R4-19-901. Standards for Licensed Health Aide (LHA) Training Programs**

- A.** Organization and Administration: An LHA program may be offered only by an entity:
  - 1. Approved by Board;
  - 2. Approved by the Arizona Department of Health Services as a Medicare-certified home health agency service provider; and
  - 3. That meets the requirements of A.R.S. § 36-2939.
- B.** Instructor qualifications. An LHA instructor shall:
  - 1. Hold a current, registered nurse license that is active and in good standing or multistate privilege to practice as an RN under A.R.S. Title 32, Chapter 15;
  - 2. Possess at least two years of direct care nursing experience in pediatrics or medical/surgical care including medication administration, tracheostomy care, and enteral care and therapy for persons under 21 years of age.
- C.** Curriculum: An LHA program shall provide a basic curriculum that includes: nursing assistant skills, medication administration, tracheostomy care; and enteral care and therapy for persons under 21 years of age.
- D.** Competency Examination: An LHA program shall provide to the Board for approval a competency examination that includes a written portion and successful performance of the following skills for persons under 21 years of age, and specific to the LHA's singular patient:
  - 1. Nursing assistant skills,
  - 2. Medication administration,
  - 3. Tracheostomy care, and
  - 4. Enteral care and therapy.
- E.** Training requirements: The LHA program shall train and evaluate the LHA, both in writing and performance of LHA skills, as to the applicable, required competencies related to the healthcare needs of the individual patient for whom the LHA provides care; and provide ongoing assessments as to safety of LHA when performing LHA tasks.
- F.** Program Certificate Requirements: Upon satisfactory completion of the basic curriculum, the LHA program shall issue a program certificate to those students who demonstrate the skills and ability to safely administer care to the individual patient for whom they provide care.

**Historical Note**

New Section made by final exempt rulemaking (the Board solicited comments on draft rules) at 28 A.A.R. 111 (January 7, 2022), with an effective date of January 2, 2022 (Supp. 21-4).

**R4-19-902. Initial Approval and Renewal of Approval of LHA Training Programs**

- A.** An applicant for initial training program approval shall submit an electronic application packet to the Board at least 90 days before the expected starting date of the program.
- B.** A program applying for initial approval shall include all of the following in its application packet:
  - 1. Name, address, web address, telephone number, e-mail address and fax number of the program;
  - 2. Identity of all program owners or sponsoring institutions;
  - 3. Evidence of program compliance with all of the following:

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## CHAPTER 19. BOARD OF NURSING

- a. Program description that includes the length of the program, number of hours of instruction;
- b. A copy of the documentation that the program will use to verify student knowledge and skills;
- c. A copy of course policies and any other materials that demonstrate compliance with R4-19-901;
- C. A program seeking renewal of its approval shall submit an application for renewal containing the information required in this Section at least 90 days prior to the expiration of its current approval.
- D. LHA program approvals and renewals shall be for a period of four years.

**Historical Note**

New Section made by final exempt rulemaking (the Board solicited comments on draft rules) at 28 A.A.R. 111 (January 7, 2022), with an effective date of January 2, 2022 (Supp. 21-4).

**R4-19-903. Rescission of Program Approval, Unprofessional Program Conduct, Voluntary Termination, Disciplinary Action, and Reinstatement**

- A. The Board may take disciplinary action against an LHA program, including rescinding program approval, for any of the following acts of unprofessional conduct:
  - 1. Failing to comply with Board requirements within designated timeframes;
  - 2. Making a false, inaccurate or misleading statement to the Board or the Board's designee in the course of an investigation, or on any application or information submitted to the Board or on the program's public website;
  - 3. Engaging in any other conduct that gives the Board reasonable cause to believe the program's conduct may be a threat to the safety or welfare of students, instructors, patients or the public.
  - 4. Failing to:
    - a. Furnish in writing a full and complete explanation of a matter reported pursuant to A.R.S. § 32-1664, or
    - b. Respond to a subpoena issued by the Board;
  - 5. Failing to promptly remove, or adequately discipline or train, program instructors whose conduct violates this Article or may be a threat to the safety or welfare of students, patients, or the public.
- B. Disciplinary Action. An LHA program may request a hearing prior to the imposition of any disciplinary action by the Board by filing a written request with the Board within 30 days of service of the Board's notice of charges. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10, and 4 A.A.C. 19, Article 6.
- C. Voluntary termination.
  - 1. An LHA program that seeks to voluntarily terminate the program before its next renewal shall submit a written notice of termination to the Board.
  - 2. The program shall continue the training program, including retaining necessary instructors, until the last enrolled student has transferred or completed the training program.
  - 3. Within 15 days after the termination of a training program, a program representative shall notify the Board in writing of the permanent location and availability of all program records.
  - 4. A program that fails to renew its approval with the Board shall be considered voluntarily terminated unless there is a complaint against the program.

**Historical Note**

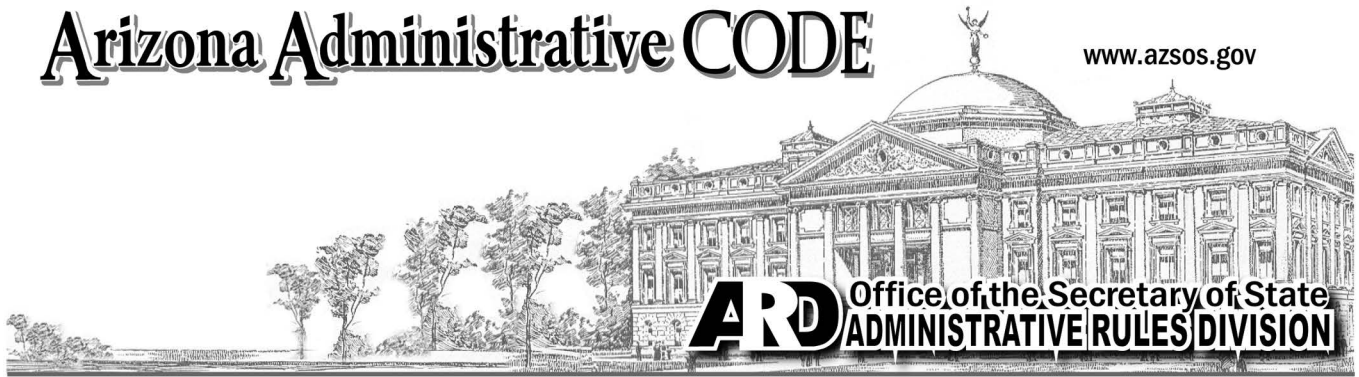
New Section made by final exempt rulemaking (the Board solicited comments on draft rules) at 28 A.A.R. 111 (January 7, 2022), with an effective date of January 2, 2022 (Supp. 21-4).

**R4-19-904. Licensed Health Aide (LHA) Licensure, Renewals, and Patient Safety Referral**

- A. An applicant for initial licensed health aide (LHA) licensure shall submit the following to the Board:
  - 1. A verified application on a form furnished by the Board that provides the following information about the applicant:
    - a. Full legal name and any and all former names used by the applicant;
    - b. Current address of record, including county of residence, e-mail address and telephone number;
    - c. Place and date of birth;
    - d. Social Security number;
    - e. Relationship to the patient that meets the definition of "family member" in R4-19-101;
    - f. Patient age and enrollment status in Arizona Long Term Care System ("ALTCS").
  - 2. Proof of satisfactory completion of an LHA training program that meets the requirements of this Article within the past two years;
  - 3. Proof the applicant has satisfactorily completed an LHA competency examination approved by the Board.
  - 4. Proof of United States citizenship or alien status as specified in A.R.S. § 41-1080; and
  - 5. Applicable fees under A.R.S. § 32-1643.
- B. An applicant who is denied licensure or certification may request a hearing by filing a written request with the Board within 30 days of service of the Board's order denying the application for certification. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 10 and 4 A.A.C. 19, Article 6.
- C. An applicant's license expires every four years. If an applicant fails to timely renew the license, the applicant shall not work as an LHA until the board issues a renewal license. To renew LHA licensure, an applicant shall:
  - 1. Pay applicable fees pursuant to A.R.S. § 32-1643;
  - 2. Submit proof that applicant's patient still meets the age and eligibility requirements of A.R.S. § 36-2939;
  - 3. Submit a statement on a form provided by the Board and completed by the applicant's home health agency employer or support coordinator confirming that applicant has adequately maintained the skills and knowledge required for safe LHA care of the applicant's patient.
- D. The Board shall maintain a list, published on its website, of all LHA licensees.
- E. The Board shall submit a safety referral for any LHA for whom the Board has concerns regarding potential patient neglect or abuse to the Arizona Department of Economic Security.

**Historical Note**

New Section made by final exempt rulemaking (the Board solicited comments on draft rules) at 28 A.A.R. 111 (January 7, 2022), with an effective date of January 2, 2022 (Supp. 21-4).



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Supp. 24-4

## TITLE 4. PROFESSIONS AND OCCUPATIONS

### CHAPTER 23. BOARD OF PHARMACY

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

<a href="#">R4-23-1101.</a>	<a href="#">Repealed .....</a>	<a href="#">78</a>	<a href="#">R4-23-1104.01</a>	<a href="#">Repealed .....</a>	<a href="#">80</a>
<a href="#">R4-23-1102.</a>	<a href="#">Pharmacy Technician Licensure .....</a>	<a href="#">78</a>	<a href="#">R4-23-1105.</a>	<a href="#">Pharmacy Technician Trainee Training Program:</a>	
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#### Questions about these rules? Contact:

Board: Board of Pharmacy  
Address: 1110 W. Washington St., Suite 260  
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[Website:](#) [www.azpharmacy.gov](http://www.azpharmacy.gov)  
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[Email:](#) [kgandhi@azpharmacy.gov](mailto:kgandhi@azpharmacy.gov)

**The release of this Chapter in Supp. 24-4 replaces Supp. 24-1, 1-84 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

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### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 23. BOARD OF PHARMACY

Authority: A.R.S. § 32-1904 et seq.

## Supp. 24-4

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*Article 5, consisting of Sections R4-23-501 through R4-23-505, expired effective August 30, 2013 (Supp. 14-1).*

*Article 5, consisting of Sections R4-23-501 and R4-23-502, recodified to Article 8 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).*

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*Article 8, consisting of Sections R4-23-801 through R4-23-804, repealed effective November 4, 1998 (Supp. 98-4).*

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## CHAPTER 23. BOARD OF PHARMACY

**ARTICLE 1. ADMINISTRATION****R4-23-101. General**

- A. This Chapter applies to all actions and proceedings of the Board and shall be deemed part of the record in any Board action or proceeding without formal introduction of, or reference to the rules. A party to a Board action is deemed to have knowledge of the rules.
- B. The Board, within its jurisdiction, may, in the interest of justice, excuse the failure of any person to comply with the rules.
- C. The Board, within its jurisdiction, may grant an extension of time within which to comply with any rule when it deems the extension to be in the interest of justice.

**Historical Note**

Former Rules 1.1000, 1.1200, and 1.1300; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-102. Meetings**

- A. The Board shall hold not less than four meetings per fiscal year to conduct general business and interview permit and license applicants.
- B. A special meeting of the Board may be held at any time subject to the call of the President or a majority of the Board members and in compliance with the notification requirements of A.R.S. § 38-431.02.

**Historical Note**

Former Rules 1.2100, 1.2200, 1.2300, and 1.2400. Amended by final rulemaking at 7 A.A.R. 2143, effective May 1, 2001 (Supp. 01-2).

**R4-23-103. Repealed****Historical Note**

Former Rules 1.3100, 1.3200, 1.3300, and 1.3400; Amended subsection (C) effective August 9, 1983 (Supp. 83-4). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-104. Repealed****Historical Note**

Former Rules 1.4011, 1.4110, 1.4120, 1.4200, 1.4210, 1.4220, 1.4300, 1.4400, 1.5500, 1.5600, 1.5700, and 1.4500; Amended effective August 23, 1978 (Supp. 78-5); Amended by deleting subsection (B) and renumbering subsections (C) through (J) as subsections (B) through (I) effective August 9, 1983 (Supp. 83-4). Amended effective February 8, 1991 (Supp. 91-1). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-105. Repealed****Historical Note**

Former Rules 1.5100, 1.5200, 1.5300, and 1.5400; Amended subsection (B) effective August 9, 1983 (Supp. 83-4). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-106. Repealed****Historical Note**

Former Rules 1.5800 and 1.5900. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-107. Repealed****Historical Note**

Former Rules 1.5910, 1.5920, 1.5921, and 1.5922. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-108. Repealed****Historical Note**

Former Rule 1.5930. Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-109. Repealed****Historical Note**

Former Rules 1.7100, 1.7200, and 1.7300. Amended effective July 14, 1977 (Supp. 77-4). Amended effective February 8, 1991 (Supp. 91-1). Section repealed by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1); Historical Note updated (Supp. 06-2).

**R4-23-110. Definitions**

In addition to definitions in A.R.S. § 32-1901, the following definitions apply to this Chapter:

“Active ingredient” means any component that furnishes pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease or that affects the structure or any function of the body of man or other animals. The term includes those components that may undergo chemical change in the manufacture of the drug, that are present in the finished drug product in a modified form, and that furnish the specified activity or effect.

“AHCCCS” means the Arizona Health Care Cost Containment System.

“Annual family income” means the combined yearly gross earned income and unearned income of all adult individuals within a family unit.

“Approved course in pharmacy law” means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations.

“Approved Provider” means an individual, institution, organization, association, corporation, or agency that is approved by the Accreditation Council for Pharmacy Education (ACPE) in accordance with ACPE’s policy and procedures or by the Board as meeting criteria indicative of the ability to provide quality continuing education.

“Assisted living facility” means a residential care institution as defined in A.R.S. § 36-401.

“Authentication of product history” means identifying the purchasing source, the ultimate fate, and any intermediate handling of any component of a radiopharmaceutical or other drug.

“Automated dispensing system” means a mechanical system in a long-term care facility that performs operations or activities, other than compounding or administration, relative to the storage, packaging, counting, labeling, and dispensing of med-



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ications, and which collects, controls, and maintains all transaction information.

“Automated storage and distribution system” means a mechanical system that performs operations or activities other than counting, compounding, or administration, relative to the storage, packaging, or distributing of drugs or devices and that collects, controls, and maintains all transaction information.

“Batch” means a specific quantity of drug that has uniform character and quality, within specified limits, and is produced according to a single manufacturing order during the same cycle of manufacture.

“Beyond-use date” means:

A date determined by a pharmacist and placed on a prescription label at the time of dispensing to indicate a time beyond which the contents of the prescription are not recommended to be used; or

A date determined by a pharmacist and placed on a compounded pharmaceutical product’s label at the time of preparation as specified in R4-23-410(B)(3)(d), R4-23-410(I)(6)(e), or R4-23-410(J)(1)(d) to indicate a time beyond which the compounded pharmaceutical product is not recommended to be used.

“Biological safety cabinet” means a containment unit suitable for the preparation of low to moderate risk agents when there is a need for protection of the product, personnel, and environment, consistent with National Sanitation Foundation (NSF) standards, published in the National Sanitation Foundation Standard 49, Class II (Laminar Flow) Biohazard Cabinetry, NSF International P. O. Box 130140, Ann Arbor, MI, revised June 1987 edition, (and no future amendments or editions), incorporated by reference and on file with the Board.

“Care-giver” means a person who cares for someone who is sick or disabled or an adult who cares for an infant or child and includes a patient’s husband, wife, son, daughter, mother, father, sister, brother, legal guardian, nurse, or medical practitioner.

“Change of ownership,” as used in A.R.S. § 32-1901.01(A), means a change of at least 30 percent in voting stock or vested interest that has direct operational oversight.

“Community pharmacy” means any place under the direct supervision of a pharmacist where the practice of pharmacy occurs or where prescription orders are compounded and dispensed other than a hospital pharmacy or a limited service pharmacy.

“Component” means any ingredient used in compounding or manufacturing drugs in dosage form, including an ingredient that may not appear in the finished product.

“Compounding and dispensing counter” means a pharmacy counter working area defined in this Section where a pharmacist, intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist compounds, mixes, combines, counts, pours, or prepares and packages a prescription medication to dispense an individual prescription order or prepackages a drug for future dispensing.

“Computer system” means an automated data-processing system that uses a programmable electronic device to store, retrieve, and process data.

“Computer system audit” means an accounting method, involving multiple single-drug usage reports and audits, used to determine a computer system’s ability to store, retrieve, and process original and refill prescription dispensing information.

“Contact hour” means 50 minutes of participation in a continuing education activity sponsored by an Approved Provider.

“Container” means:

A receptacle, as described in the official compendium or the federal act, that is used in manufacturing or compounding a drug or in distributing, supplying, or dispensing the finished dosage form of a drug; or

A metal receptacle designed to contain liquefied or vaporized compressed medical gas and used in manufacturing, transfilling, distributing, supplying, or dispensing a compressed medical gas.

“Continuing education” means a structured learning process required of a licensee to maintain licensure that includes study in the general areas of socio-economic and legal aspects of health care; the properties and actions of drugs and dosage forms; etiology, characteristics and therapeutics of disease status; or pharmacy practice.

“Continuing education activity” means continuing education obtained through an institute, seminar, lecture, conference, workshop, mediated instruction, programmed learning course, or postgraduate study in an accredited college or school of pharmacy.

“Continuing education unit” or “CEU” means 10 contact hours of participation in a continuing education activity sponsored by an Approved Provider.

“Continuous quality assurance program” or “CQA program” means a planned process designed by a pharmacy permittee to identify, evaluate, and prevent medication errors.

“Correctional facility” has the same meaning as in A.R.S. §§ 13-2501 and 31-341.

“CRT” means a cathode ray tube or other mechanism used to view information produced or stored by a computer system.

“CSPMP” means the Controlled Substances Prescription Monitoring Program established under A.R.S. Title 36, Chapter 28.

“Current good compounding practices” means the minimum standards for methods used in, and facilities or controls used for, compounding a drug to ensure that the drug has the identity and strength and meets the quality and purity characteristics it is represented to possess.

“Current good manufacturing practice” means the minimum standard for methods used in, and facilities or controls used for manufacturing, processing, packing, or holding a drug to ensure that the drug meets the requirements of the federal act as to safety, and has the identity and strength and meets the quality and purity characteristics it is represented to possess.

“Cytotoxic” means a pharmaceutical that is capable of killing living cells.

“Day” means a calendar day unless otherwise specified.

“DEA” means the Drug Enforcement Administration as defined in A.R.S. § 32-1901.

“Declared disaster areas” means areas designated by the governor or by a county, city, or town under A.R.S. § 32-1910 as

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those areas that have been adversely affected by a natural disaster or terrorist attack and require extraordinary measures to provide adequate, safe, and effective health care for the affected population.

“Delinquent license” means a pharmacist, intern, or pharmacy technician license the Board suspends for failure to renew or pay all required fees on or before the date the renewal is due.

“Dietary supplement or food supplement,” as used in A.R.S. § 32-1904(B), means a product (other than tobacco) that:

Is intended to supplement the diet that contains one or more of the following dietary ingredients: a vitamin, mineral, herb or other botanical, amino acid, dietary substance for use by humans to supplement the diet by increasing the total daily intake, or concentrate, metabolite, constituent, extract, or combinations of these ingredients;

Is intended for ingestion in pill, capsule, tablet, or liquid form;

Is not represented for use as a conventional food or as the sole item of a meal or diet; and

Is labeled as a “dietary supplement” or “food supplement.”

“Digital signature” has the same meaning as in A.R.S. § 41-132(E).

“Dispensing pharmacist” means a pharmacist who, in the process of dispensing a prescription medication after the complete preparation of the prescription medication and before delivery of the prescription medication to a patient or patient’s agent, verifies, checks, and initials the prescription medication label, as required in R4-23-402(A).

“Drug sample” means a unit of a prescription drug that a manufacturer provides free of charge to promote the sale of the drug.

“Durable medical equipment” or “DME” means technologically sophisticated medical equipment that may be used by a patient or consumer in a home or residence. DME may be prescription-only devices as defined in A.R.S. § 32-1901. DME includes:

Air-fluidized beds,

Apnea monitors,

Blood glucose monitors and diabetic testing strips,

Continuous Positive Airway Pressure (CPAP) machines,

Electronic and computerized wheelchairs and seating systems,

Feeding pumps,

Home phototherapy devices,

Hospital beds,

Infusion pumps,

Medical oxygen and oxygen delivery systems excluding compressed medical gases,

Nebulizers,

Respiratory disease management devices,

Sequential compression devices,

Transcutaneous electrical nerve stimulation (TENS) unit, and

Ventilators.

“Earned income” means monetary payments received by an individual as a result of work performed or rental property owned or leased by the individual, including:

Wages,

Commissions and fees,

Salaries and tips,

Profit from self-employment,

Profit from rent received from a tenant or boarder, and

Any other monetary payments received by an individual for work performed or rental of property.

“Electronic signature” has the same meaning as in A.R.S. § 44-7002.

“Eligible patient” means a patient who a pharmacist determines is eligible to receive an immunization using professional judgment after consulting with the patient regarding the patient’s current health condition, recent health condition, and allergies.

“Emergency drug supply unit” means those drugs that may be required to meet the immediate and emergency therapeutic needs of long-term care facility residents and hospice inpatient facility patients, and which are not available from any other authorized source in sufficient time to prevent risk of harm to residents or patients.

“Extreme emergency” means the occurrence of a fire, water leak, electrical failure, public disaster, or other catastrophe constituting an imminent threat of physical harm to pharmacy personnel or patrons.

“Family unit” means:

A group of individuals residing together who are related by birth, marriage, or adoption; or

An individual who:

Does not reside with another individual; or

Resides only with another individual or group of individuals to whom the individual is unrelated by birth, marriage, or adoption.

“FDA” means the Food and Drug Administration, a federal agency within the United States Department of Health and Human Services, established to set safety and quality standards for foods, drugs, cosmetics, and other consumer products.

“Health care decision maker” has the same meaning as in A.R.S. § 12-2291.

“Health care institution” has the same meaning as in A.R.S. § 36-401.

“Hospice inpatient facility” means a health care institution licensed under A.R.S. § 36-401 and Article 8 that provides hospice services to a patient requiring inpatient services.

“Immediate notice” means a required notice sent by mail, fax, or electronic mail to the Board Office within 24 hours.

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“Immunizations training program” means an immunization training program for pharmacists and interns that meets the requirements of R4-23-411(E).

“Inactive ingredient” means any component other than an “active ingredient” present in a drug.

“Internal test assessment” means performing quality assurance or other procedures necessary to ensure the integrity of a test.

“ISO Class 5 environment” means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

“ISO Class 7 environment” means an atmospheric environment that complies with the ISO/TC209 International Cleanroom Standards, specifically ANSI/ISO-14644-1:1999: Cleanrooms and associated controlled environments--Part 1: Classification of air cleanliness, first edition dated May 1, 1999, (and no future amendments or editions), incorporated by reference and on file in the Board office.

“Licensed health care professional” means an individual who is licensed and regulated under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 18, 25, 29, or 35.

“Limited-service correctional pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that:

    Holds a current Board permit under A.R.S. § 32-1931;

    Is located in a correctional facility; and

    Uses pharmacists, interns, and support personnel to compound, produce, dispense, and distribute drugs.

“Limited-service long-term care pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board-issued permit and dispenses prescription medication or prescription-only devices to patients in long-term care facilities.

“Limited-service mail-order pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices by mailing or delivering the prescription medication or prescription-only device to an individual by the United States mail, a common or contract carrier, or a delivery service.

“Limited-service nuclear pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and provides radiopharmaceutical services.

“Limited-service pharmacy permittee” means a person who holds a current limited-service pharmacy permit in compliance with A.R.S. §§ 32-1929, 32-1930, 32-1931, and A.A.C. R4-23-606.

“Limited-service sterile pharmaceutical products pharmacy” means a limited-service pharmacy, as defined in A.R.S. § 32-1901, that holds a current Board permit under A.R.S. § 32-1931 and dispenses a majority of its prescription medication or prescription-only devices as sterile pharmaceutical products.

“Long-term care consultant pharmacist” means a pharmacist providing consulting services to a long-term care facility.

“Long-term care facility” or “LTCF” means a nursing care institution as defined in A.R.S. § 36-401.

“Lot” means a batch or any portion of a batch of a drug, or if a drug produced by a continuous process, an amount of drug produced in a unit of time or quantity in a manner that assures its uniformity. In either case, a lot is identified by a distinctive lot number and has uniform character and quality with specified limits.

“Lot number” or “control number” means any distinctive combination of letters or numbers, or both, from which the complete history of the compounding or manufacturing, control, packaging, and distribution of a batch or lot of a drug can be determined.

“Low-income subsidy” means Medicare-provided assistance that may partially or fully cover the costs of drugs and is based on the income of an individual and, if applicable, the individual’s spouse.

“Materials approval unit” means any organizational element having the authority and responsibility to approve or reject components, in-process materials, packaging components, and final products.

“Mechanical counting device for a drug in solid, oral dosage form” means a mechanical device that counts drugs in solid, oral dosage forms for dispensing and includes an electronic balance when used to count drugs.

“Mechanical storage and counting device for a drug in solid, oral dosage form” means a mechanical device that stores and counts and may package or label drugs in solid, oral dosage forms for dispensing.

“Mediated instruction” means information transmitted via intermediate mechanisms such as audio or video tape or telephone transmission.

“Medical practitioner-patient relationship” means that before prescribing, dispensing, or administering a prescription-only drug, prescription-only device, or controlled substance to a person, a medical practitioner, as defined in A.R.S. § 32-1901, shall first conduct a physical examination of that person or have previously conducted a physical examination. This subdivision does not apply to:

    A medical practitioner who provides temporary patient supervision on behalf of the patient’s regular treating medical practitioner;

    Emergency medical situations as defined in A.R.S. § 41-1831;

    Prescriptions written to prepare a patient for a medical examination; or

    Prescriptions written, prescription-only drugs, prescription-only devices, or controlled substances issued for use by a county or tribal public health department for immunization programs, emergency treatment, in response to an infectious disease investigation, public health emergency, infectious disease outbreak or act of bioterrorism. For purposes of this subsection, “bioterrorism” has the same meaning as in A.R.S. § 36-781.

“Medicare” means a federal health insurance program established under Title XVIII of the Social Security Act.

“Medication error” means any unintended variation from a prescription or medication order. Medication error does not

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include any variation that is corrected before the medication is dispensed to the patient or patient's care-giver, or any variation allowed by law.

"Mobile pharmacy" means a pharmacy that is self-propelled or movable by another vehicle that is self-propelled.

"MPJE" means Multistate Pharmacy Jurisprudence Examination, a Board-approved national pharmacy law examination written and administered in cooperation with NABP.

"NABP" means National Association of Boards of Pharmacy.

"NABPLEX" means National Association of Boards of Pharmacy Licensure Examination.

"NAPLEX" means North American Pharmacist Licensure Examination.

"Order" means either of the following:

A prescription order as defined in A.R.S. § 32-1901; or

A medication order as defined in A.A.C. R4-23-651.

"Other designated personnel" means a non-pharmacist individual who is permitted in the pharmacy area, for a limited time, under the direct supervision of a pharmacist, to perform non-pharmacy related duties, such as trash removal, floor maintenance, and telephone or computer repair.

"Outpatient" means an individual who is not a residential patient in a health care institution.

"Outpatient setting" means a location that provides medical treatment to an outpatient.

"Patient profile" means a readily retrievable, centrally located information record that contains patient demographics, allergies, and medication profile.

"Pharmaceutical patient care services" means the provision of drug selection, drug utilization review, drug administration, drug therapy monitoring, and other drug-related patient care services intended to achieve outcomes related to curing or preventing a disease, eliminating or reducing a patient's symptoms, or arresting or slowing a disease process, by identifying and resolving or preventing potential and actual drug-related problems.

"Pharmaceutical product" means a medicinal drug.

"Pharmacy counter working area" means a clear and continuous working area that contains no major obstacles such as a desktop computer, computer monitor, computer keyboard, external computer drive device, printer, fax machine, pharmacy balance, typewriter, or pill-counting machine, but may contain individual documents or prescription labels, pens, prescription blanks, refill log, pill-counting tray, spatula, stapler, or other similar items necessary for the prescription-filling process.

"Pharmacy law continuing education" means a continuing education activity that addresses practice issues related to state or federal pharmacy statutes, rules, or regulations, offered by an Approved Provider.

"Pharmacy permittee" means a person who holds a current pharmacy permit that complies with A.R.S. §§ 32-1929, 32-1930, 32-1931, 32-1934, and R4-23-606 and R4-23-652.

"Physician" means a medical practitioner licensed under A.R.S. Title 32, Chapter 13 or 17.

"Physician-in-charge" means a physician who is responsible to the Board for all aspects of a prescription medication donation program required in A.R.S. § 32-1909 and operated in the physician's office or in a health care institution.

"Poverty level" means the annual family income for a family unit of a particular size, as specified in the poverty guidelines updated annually in the *Federal Register* by the U.S. Department of Health and Human Services.

"Precursor chemical" means a precursor chemical I as defined in A.R.S. § 13-3401(26) and a precursor chemical II as defined in A.R.S. § 13-3401(27).

"Prepackaged drug" means a drug that is packaged in a frequently prescribed quantity, labeled in compliance with A.R.S. §§ 32-1967 and 32-1968, stored, and subsequently dispensed by a pharmacist or intern under the supervision of a pharmacist, who verifies at the time of dispensing that the drug container is properly labeled, in compliance with A.R.S. § 32-1968, for the patient.

"Prep area" means a specified area either within an ISO class 7 environment or adjacent to but outside an ISO class 7 environment that:

Allows the assembling of necessary drugs, supplies, and equipment for compounding sterile pharmaceutical products, but does not allow the use of paper products such as boxes or bulk drug storage;

Allows personnel to don personnel protective clothing, such as gown, gloves, head cover, and booties before entering the clean compounding area; and

Is a room or a specified area within a room, such as an area specified by a line on the floor.

"Primary care provider" means the medical practitioner who is treating an individual for a disease or medical condition.

"Proprietor" means the owner of a business permitted by the Board under A.R.S. §§ 32-1929, 32-1930, 32-1931, and 32-1934.

"Provider pharmacy" means a pharmacy that contracts with a long-term care facility to supply prescription medication or other services for residents of a long-term care facility.

"Radiopharmaceutical" means any drug that emits ionizing radiation and includes:

Any nonradioactive reagent kit, nuclide generator, or ancillary drug intended to be used in the preparation of a radiopharmaceutical, but does not include drugs such as carbon-containing compounds or potassium-containing salts, that contain trace quantities of naturally occurring radionuclides; and

Any biological product that is labeled with a radionuclide or intended to be labeled with a radionuclide.

"Radiopharmaceutical quality assurance" means performing and interpreting appropriate chemical, biological, and physical tests on radiopharmaceuticals to determine the suitability of the radiopharmaceutical for use in humans and animals. Radiopharmaceutical quality assurance includes internal test assessment, authentication of product history, and appropriate record retention.

"Radiopharmaceutical services" means procuring, storing, handling, compounding, preparing, labeling, quality assurance testing, dispensing, distributing, transferring, recordkeeping,

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and disposing of radiochemicals, radiopharmaceuticals, and ancillary drugs. Radiopharmaceutical services include quality assurance procedures, radiological health and safety procedures, consulting activities associated with the use of radiopharmaceuticals, and any other activities required for the provision of pharmaceutical care.

“Red C stamp” means a device used with red ink to imprint an invoice with a red letter C at least one inch high, to make an invoice of a Schedule III through IV controlled substance, as defined in A.R.S. § 36-2501, readily retrievable, as required by state and federal rules.

“Refill” means other than the original dispensing of the prescription order, dispensing a prescription order in the same quantity originally ordered or in multiples of the originally ordered quantity when specifically authorized by the prescriber, if the refill is authorized by the prescriber:

In the original prescription order;

By an electronically transmitted refill order that the pharmacist promptly documents and files; or

By an oral refill order that the pharmacist promptly documents and files.

“Regulated chemical” means the same as in A.R.S. § 13-3401(30).

“Remodel” means to alter structurally the pharmacy area or location.

“Remote drug storage area” means an area that is outside the premises of the pharmacy, used for the storage of drugs, locked to deny access by unauthorized persons, and secured against the use of force.

“Resident” means:

An individual admitted to and living in a long-term care facility or an assisted living facility,

An individual who has a place of habitation in Arizona and lives in Arizona as other than a tourist, or

A person that owns or operates a place of business in Arizona.

“Responsible person” means the owner, manager, or other employee who is responsible to the Board for a permitted establishment’s compliance with the laws and administrative rules of this state and of the federal government pertaining to distribution of drugs, devices, precursor chemicals, and regulated chemicals. Nothing in this definition relieves other individuals from the responsibility to comply with state and federal laws and administrative rules.

“Score transfer” means the process that enables an applicant to take the NAPLEX in a jurisdiction and be eligible for licensure by examination in other jurisdictions.

“Security features” means attributes incorporated into the paper of a prescription order, referenced in A.R.S. § 32-1968(A)(4), that are approved by the Board or its staff and include one or more of the following designed to prevent duplication or aid the authentication of a paper document: laid lines, enhanced laid lines, thermochromic ink, artificial watermark, fluorescent ink, chemical void, persistent void, penetrating numbers, high-resolution border, high-resolution latent images, micro-printing, prismatic printing, embossed images, abrasion ink, holograms, and foil stamping.

“Shared order filling” means the following:

Preparing, packaging, compounding, or labeling an order, or any combination of these functions, that are performed by:

A person with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy; or

A person, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

Returning the filled order to the requesting pharmacy for delivery to the patient or patient’s care-giver or, at the request of this pharmacy, directly delivering the filled order to the patient.

“Shared order processing” means the following:

Interpreting the order, performing order entry verification, drug utilization review, drug compatibility and drug allergy review, final order verification, and when necessary, therapeutic intervention, or any combination of these order processing functions, that are performed by:

A pharmacist or intern, under pharmacist supervision, with a current Arizona Board license, located at an Arizona pharmacy, on behalf of and at the request of another resident or nonresident pharmacy; or

A pharmacist or intern, under pharmacist supervision, located at a nonresident pharmacy, on behalf of and at the request of an Arizona pharmacy; and

After order processing is completed, returning the processed order to the requesting pharmacy for order filling and delivery to the patient or patient’s care-giver or, at the request of this pharmacy, returning the processed order to another pharmacy for order filling and delivery to the patient or patient’s care-giver.

“Shared services” means shared order filling or shared order processing, or both.

“Sight-readable” means that an authorized individual is able to examine a record and read its information from a CRT, microfiche, microfilm, printout, or other method acceptable to the Board or its designee.

“Single-drug audit” means an accounting method that determines the numerical and percentage difference between a drug’s beginning inventory plus purchases and ending inventory plus sales.

“Single-drug usage report” means a computer system printout of original and refill prescription order usage information for a single drug.

“Standard-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded from sterile commercial drugs using sterile commercial devices or a sterile pharmaceutical optic or ophthalmic product compounded from non-sterile ingredients.

“State of emergency” means a governmental declaration issued under A.R.S. § 32-1910 as a result of a natural disaster or terrorist attack that results in individuals being unable to refill existing prescriptions.

“Sterile pharmaceutical product” means a medicinal drug free from living biological organisms.

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“Strength” means:

The concentration of the drug substance (for example, weight/weight, weight/volume, or unit dose/volume basis); or

The potency, that is, the therapeutic activity of a drug substance as indicated by bioavailability tests or by controlled clinical data (expressed, for example, in terms of unity by reference to a standard).

“Substantial-risk sterile pharmaceutical product” means a sterile pharmaceutical product compounded as a parenteral or injectable dosage form from non-sterile ingredients.

“Supervision” means a pharmacist is present, assumes legal responsibility, and has direct oversight of activities relating to acquiring, preparing, distributing, administering, and selling prescription medications by interns, pharmacy technicians, or pharmacy technician trainees and when used in connection with the intern training requirements means that, in a pharmacy where intern training occurs, an intern preceptor assumes the primary responsibility of teaching the intern during the entire period of the training.

“Supplying” means selling, transferring, or delivering to a patient or a patient’s agent one or more doses of:

A nonprescription drug in the manufacturer’s original container for subsequent use by the patient, or

A compressed medical gas in the manufacturer’s or compressed medical gas distributor’s original container for subsequent use by the patient.

“Support personnel” means an individual, working under the supervision of a pharmacist, trained to perform clerical duties associated with the practice of pharmacy, including cashiering, bookkeeping, pricing, stocking, delivering, answering non-professional telephone inquiries, and documenting third-party reimbursement. Support personnel shall not perform the tasks of a pharmacist, intern, pharmacy technician, or pharmacy technician trainee.

“Temporary pharmacy facility” means a facility established as a result of a declared state of emergency to temporarily provide pharmacy services within or adjacent to declared disaster areas.

“Tourist” means an individual who is living in Arizona but maintains a place of habitation outside of Arizona and lives outside of Arizona for more than six months during a calendar year.

“Transfill” means a manufacturing process by which one or more compressed medical gases are transferred from a bulk container to a properly labeled container for subsequent distribution or supply.

“Unearned income” means monetary payment received by an individual that is not compensation for work performed or rental of property owned or leased by the individual, including:

Unemployment insurance,

Workers’ compensation,

Disability payments,

Payments from the Social Security Administration,

Payments from public assistance,

Periodic insurance or annuity payments,

Retirement or pension payments,

Strike benefits from union funds,

Training stipends,

Child support payments,

Alimony payments,

Military family allotments,

Regular support payments from a relative or other individual not residing in the household,

Investment income,

Royalty payments,

Periodic payments from estates or trusts, and

Any other monetary payments received by an individual that are not:

As a result of work performed or rental of property owned by the individual,

Gifts,

Lump-sum capital gains payments,

Lump-sum inheritance payments,

Lump-sum insurance payments, or

Payments made to compensate for personal injury.

“Verified signature” or “signature verifying” means in relation to a Board license or permit application or report, form, or agreement, the hand-written or electronic signature of an individual who, by placing a hand-written or electronic signature on a hard-copy or electronic license or permit application or report, form, or agreement agrees with and verifies that the statements and information within or attached to the license or permit application or report, form, or agreement are true in every respect and that inaccurate reporting can result in denial or loss of a license or permit or report, form, or agreement.

“Veteran” means an individual who has served in the United States Armed Forces.

“Virtual manufacturer” means an entity that contracts for the manufacture of a drug or device for which the entity:

Owns the New Drug Application or Abbreviated New Drug Application number, as defined by the FDA, for a drug;

Owns the Unique Device Identification number, as defined by the FDA, for a prescription device;

Is not involved in the physical manufacture of the drug or device; and

Contracts with an Arizona-permitted manufacturing entity for the physical manufacture of the drug or device; or

If the contracted manufacturing entity is in a location not included in the definition at A.R.S. 32-1901 of other jurisdiction, the virtual manufacturer ensures the facility is inspected every time the virtual manufacturer submits an initial or renewal application and determined to comply with current good manufacturing practices as defined by the federal act and the official compendium.

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Virtual manufacturer includes an entity that may be identified as an own-label distributor, which contracts with a manufacturer to produce a drug or device and with another entity to package and label the drug or device, which is then sold under the distributor's name or another name.

"Virtual wholesaler" means an entity that engages in the wholesale distribution of a drug or device in, into, or out of Arizona but does not take physical possession of the drug or device. A virtual wholesaler distributes a drug or device only from a Board-permitted facility to:

A Board-permitted pharmacy, drug manufacturer, full-service drug wholesaler, or non-prescription drug wholesaler; or

A medical practitioner licensed under A.R.S. Title 32; and

Virtual wholesaler includes an entity that may be identified as a broker that buys and sells goods for others or a person that facilitates distribution of a drug, chemical, or device regulated by the Board.

"Wholesale distribution" means distribution of a drug to a person other than a consumer or patient, but does not include:

Selling, purchasing, or trading a drug or offering to sell, purchase, or trade a drug for emergency medical reasons. For purposes of this Section, "emergency medical reasons" includes transferring a prescription drug by a community or hospital pharmacy to another community or hospital pharmacy to alleviate a temporary shortage;

Selling, purchasing, or trading a drug, offering to sell, purchase, or trade a drug, or dispensing a drug as specified in a prescription;

Distributing a drug sample by a manufacturers' or distributors' representative; or

Selling, purchasing, or trading blood or blood components intended for transfusion.

"Wholesale distributor" means any person engaged in wholesale distribution of drugs, including: manufacturers; repackers; own-label distributors; private-label distributors; jobbers; brokers; warehouses, including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; and retail pharmacies that conduct wholesale distributions in the amount of at least 5% of gross sales.

**Historical Note**

Adopted effective August 24, 1992 (Supp. 92-2).

Amended effective December 18, 1992 (Supp. 92-4).

Amended effective November 1, 1993 (Supp. 93-4).

Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended effective April 5, 1996 (Supp. 96-2). Amended effective July 8, 1997; amended effective August 5, 1997 (Supp. 97-3).

Amended effective January 12, 1998 (Supp. 98-1).

Amended effective July 7, 1998 (Supp. 98-3). Amended by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 4589, effective

November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 7 A.A.R. 646, effective January 11, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R.

409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Amended by final rulemaking at 8 A.A.R. 4898 and 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 3967, effective November 13, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 2258, effective August 6, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 3405, effective October 4, 2008; amended by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009; amended by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 18 A.A.R. 2603, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 2609, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by exempt rulemaking under Laws 2016, Ch. 284, § 3 at 22 A.A.R. 2606, effective August 31, 2016 (Supp. 16-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-111. Notice of Hearing**

**A.** Except as provided in A.R.S. § 32-1928(B), the Board shall revoke, suspend, place on probation, or fine a licensee or permittee only after:

1. Notice is served under this Section, and
2. A hearing is conducted under R4-23-122.

**B.** The Board shall give notice of hearing to a party at least 30 days before the date set for the hearing in the manner described in R4-23-115(E) and (F). The notice shall include:

1. A statement of the date, time, place, and nature of the hearing;
2. A statement of the legal authority and jurisdiction for the hearing;
3. A reference to the particular section or sections of statute and rule involved; and
4. A statement of the violation or issue asserted by the Board.

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**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-112. Ex Parte Communications**

A party shall not communicate, either directly or indirectly, with a Board member about any substantive issue in a pending matter unless:

1. All parties are present;
2. It is during a scheduled proceeding, where an absent party fails to appear after proper notice; or
3. It is by written motion with copies to all parties.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-113. Motions**

- A. Purpose. A party requesting a ruling from the Board shall file a motion. Motions may be made for rulings such as:
  1. Continuing or expediting a hearing under R4-23-116;
  2. Vacating a hearing under R4-23-117;
  3. Scheduling a prehearing conference under R4-23-118;
  4. Quashing a subpoena under R4-23-119;
  5. Requesting telephonic testimony under R4-23-120; and
  6. Reconsidering a previous order under R4-23-121.
- B. Form. Unless made during a prehearing conference or hearing, motions shall be made in writing and shall conform to the requirements of R4-23-115. All motions, whether written or oral, shall state the factual and legal grounds supporting the motion, and the requested action.
- C. Time limits. Absent good cause, or unless otherwise provided by law or these rules, written motions shall be filed with the Board office at least 15 days before the hearing. A party demonstrates good cause by showing that the grounds for the motion could not have been known in time, using reasonable diligence and:
  1. A ruling on the motion will further administrative convenience, expedition or economy; or
  2. A ruling on the motion will avoid undue prejudice to any party.
- D. Response to motion. A party shall file a written response stating any objection to the motion within five days of service, or as directed by the Board.
- E. Oral argument. A party may request oral argument when filing a motion or response. If necessary to develop a complete record, the Board shall grant oral argument.
- F. Rulings. Rulings on motions, other than those made during a prehearing conference or the hearing, shall be in writing and served on all parties.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-114. Computing Time**

In computing any time period, the Board shall exclude the day from which the designated time period begins to run. The Board shall include the last day of the period unless it falls on a Saturday, Sunday, or legal holiday. When the time period is 10 days or less, the Board shall exclude Saturdays, Sundays, and legal holidays.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-115. Filing Documents**

- A. Docket. The Board shall open a docket for each hearing. All documents filed in a matter with the Board shall be date stamped on the day received by the Board office and entered in the docket.
- B. Definition. "Documents" include papers such as complaints, answers, motions, responses, notices, and briefs.
- C. Form. A party shall state on the document the name and address of each party served and how service was made under subsection (E). A document shall contain the Board caption and the Board's docket number.
- D. Signature. A document filed with the Board shall be signed by the party or the party's attorney. A signature constitutes a certification that the signer has read the document, has a good faith basis for submission of the document, and that it is not filed for the purpose of delay or harassment.
- E. Filing and service. A copy of a document filed with the Board shall be served on all parties. Filing with the Board office and service shall be completed by personal delivery; first-class, certified, or express mail; or facsimile.
- F. Date of filing and service. A document is filed with the Board on the date it is received by the Board office, as established by the Board office's date stamp on the face of the document. A copy of a document is served on a party as follows:
  1. On the date it is personally served,
  2. Five days after it is mailed by first-class or express mail,
  3. On the date of the return receipt if it is mailed by certified mail, or
  4. On the date indicated on the facsimile transmission.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-116. Continuing or Expediting a Hearing; Reconvening a Hearing**

- A. Continuing or expediting a hearing. When ruling on a motion to continue or expedite, the Board shall consider such factors as:
  1. The time remaining between the filing of the motion and the hearing date;
  2. The position of other parties;
  3. The reasons for expediting the hearing or for the unavailability of the party, representative, or counsel on the date of the scheduled hearing;
  4. Whether testimony of an unavailable witness can be taken telephonically or by deposition; and
  5. The status of settlement negotiations.
- B. Reconvening a hearing. The Board may recess a hearing and reconvene at a future date by a verbal ruling.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-117. Vacating a Hearing**

The Board shall vacate a calendared hearing and return the matter to the Board office for further action, if:

1. The parties agree to vacate the hearing;
2. The Board dismisses the matter;
3. The non-Board party withdraws the appeal; or
4. Facts demonstrate to the Board that it is appropriate to vacate the hearing for the purpose of informal disposition, or if the action will further administrative convenience, expedition, and economy and does not conflict with law or cause undue prejudice to any party.

**Historical Note**



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New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-118. Prehearing Conference**

- A. Procedure. The Board may hold a prehearing conference. The conference may be held telephonically. The Board may issue a prehearing order outlining the issues to be discussed.
- B. Record. The Board may record any agreements reached during a prehearing conference by electronic or mechanical means, or memorialize them in an order.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-119. Subpoenas**

- A. Form. A party wanting the Board to issue a subpoena shall submit a written request to the Board and include:
  - 1. The caption and docket number of the matter;
  - 2. A list or description of any documents sought;
  - 3. The full name and home or business address of the custodian of the documents sought or all persons to be subpoenaed;
  - 4. The date, time, and place to appear or to produce documents according to the subpoena; and
  - 5. The name, address, and telephone number of the party, or the party's attorney, requesting the subpoena.
- B. The Board may require a brief statement of the relevance of testimony or documents requested.
- C. Service of subpoena. The Board shall serve a subpoena in a manner allowed by law.
- D. Objection to subpoena. If a party or the person served with a subpoena objects to the subpoena or any portion of the subpoena, the party or person may file an objection with the Board within five days after service of the subpoena or at the start of the hearing if the subpoena is served fewer than five days before the hearing.
- E. Quashing or modifying subpoenas. The Board shall quash or modify a subpoena if:
  - 1. It is unreasonable or oppressive, or
  - 2. The desired testimony or evidence may be obtained by an alternative method.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-120. Telephonic Testimony**

The Board may grant a motion for telephonic testimony if:

- 1. Personal attendance by a party or witness at the hearing will present an undue hardship for the party or witness;
- 2. Telephonic testimony will not cause undue prejudice to any party; and
- 3. The proponent of the telephonic testimony pays for any cost of obtaining the testimony telephonically.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-121. Rights and Responsibilities of Parties**

- A. Generally. A party may present testimony and documentary evidence and argument with respect to the contested issue and may examine and cross-examine witnesses.

- B. Preparation. A party shall have all witnesses, documents, and exhibits available on the date of the hearing.
- C. Exhibits. A party shall provide a copy of each exhibit to all other parties at the time the exhibit is offered to the Board, unless the exhibit was previously provided to all other parties.
- D. Responding to orders. A party shall comply with an order issued by the Board concerning the conduct of a hearing. Unless an objection is made orally during a pre-hearing conference or hearing, a party shall file a motion requesting the Board to reconsider the order.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-122. Conduct of Hearing**

- A. Public access. Unless otherwise provided by law, all hearings are open to the public and may be conducted in an informal manner as prescribed in A.R.S. § 41-1092 et seq.
- B. Opening. The Board shall begin the hearing by reading the caption, stating the nature and scope of the hearing, and identifying the parties, counsel, and witnesses for the record.
- C. Stipulations. The Board shall enter into the record any stipulation, settlement agreement, or consent order entered into by any of the parties before or during the hearing.
- D. Opening statements. The party with the burden of proof may make an opening statement at the beginning of a hearing. All other parties may make statements in a sequence determined by the Board.
- E. Order of presentation. After opening statements, the party with the burden of proof shall begin the presentation of evidence, unless the parties agree otherwise or the Board determines that requiring another party to proceed first would be more expeditious or appropriate, and would not prejudice any other party. Copies of documentary evidence may be received in the discretion of the Board. Upon request, parties shall be given an opportunity to compare the copy with the original.
- F. Examination. A party shall conduct direct and cross examination of witnesses in the order and manner determined by the Board to expedite and ensure a fair hearing. The Board shall make rulings necessary to prevent argumentative, repetitive, or irrelevant questioning and to expedite the examination to the extent consistent with the disclosure of all relevant testimony and information. The Board may take notice of judicially cognizable facts. In addition, the Board may take notice of generally recognized technical or scientific facts within the Board's or its staff's specialized knowledge. A party shall be notified either before or during the hearing or by reference in preliminary reports of the material the Board notices. The Board may use the Board's or its staff's experience, technical competence, and specialized knowledge in the evaluation of the evidence.
- G. Closing argument. When all evidence has been received, parties shall have the opportunity to present closing oral argument, in a sequence determined by the Board. The Board may permit or require closing oral argument to be supplemented by written memoranda. The Board may permit or require written memoranda to be submitted simultaneously or sequentially, within time periods the Board may prescribe.
- H. Conclusion of hearing. Unless otherwise provided by the Board, the hearing is concluded upon the submission of all evidence, the making of final argument, and the issuing of a final decision or order of the Board.
- I. Decisions and orders. Unless otherwise provided by law, any final decisions or order adverse to a party in a hearing shall be in writing or stated in the record. Any final decision shall

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include findings of fact and conclusions of law, separately stated. Findings of fact shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Unless otherwise provided by law, each party shall be notified either personally or by mail to the party's last known address of record of any decision or order. Upon request, a copy of the decision or order shall be delivered or mailed to each party and to each party's attorney of record.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-123. Failure of Party to Appear for Hearing**

If a party fails to appear at a hearing, the Board may proceed with the presentation of the evidence of the appearing party, or vacate the hearing and return the matter to the Board office for any further action.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-124. Witnesses; Exclusion from Hearing**

All witnesses at the hearing shall testify under oath or affirmation. At the request of a party, or at the discretion of the Board, the Board may exclude witnesses who are not parties from the hearing room so that they cannot hear the testimony of other witnesses.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-125. Proof**

- A. Standard of proof. Unless otherwise provided by law, the standard of proof is a preponderance of the evidence.
- B. Burden of proof. Unless otherwise provided by law:
  - 1. The party asserting a claim, right, or entitlement has the burden of proof;
  - 2. A party asserting an affirmative defense has the burden of establishing the affirmative defense; and
  - 3. The proponent of a motion shall establish the grounds to support the motion.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-126. Disruptions**

A person shall not interfere with access to or from the hearing room, or interfere, or threaten interference with the hearing. If a person interferes, threatens interference, or disrupts the hearing, the Board may order the disruptive person to leave or be removed.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-127. Hearing Record**

- A. Maintenance. The Board shall maintain the official administrative record of a matter.
- B. Transfer of record. Any party requesting a copy of the administrative record or any portion of the administrative record shall make a request to the Board office and shall pay the reasonable costs of duplication.
- C. Release of exhibits. Exhibits shall be released:
  - 1. Upon the order of a court of competent jurisdiction; or

- 2. Upon motion of the party who submitted the exhibits if the time for judicial appeal has expired and no appeal is pending.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-128. Rehearing or Review and Appeal of Decision**

- A. The Board shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10, and this Section. For purposes of these rules, the terms "contested case" and "party" are defined in A.R.S. § 41-1001.
- B. A party to a contested case shall exhaust the party's administrative remedies by filing a motion for rehearing or review within 30 days after the service of the Board decision that is subject to rehearing or review in order to be eligible for judicial review under A.R.S. Title 12, Chapter 7, Article 6. The Board shall notify a party in its decision, that is subject to rehearing or review, that the party may file a motion for rehearing or review, and that failure to file a motion for rehearing or review within 30 days after service of the decision has the effect of prohibiting the party from seeking judicial review of the Board's decision.
- C. A party may amend a motion for rehearing or review at any time before the Board rules on the motion.
- D. The Board may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
  - 1. Irregularity in the proceedings of the Board, or any order or abuse of discretion, that deprived the moving party of a fair hearing;
  - 2. Misconduct of the Board, its staff, its hearing officer, or the prevailing party;
  - 3. Accident or surprise that could not have been prevented by ordinary prudence;
  - 4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
  - 5. Excessive or insufficient penalty;
  - 6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings;
  - 7. That the Board's decision is a result of passion or prejudice; or
  - 8. That the findings of fact or decision is not justified by the evidence or is contrary to law.
- E. The Board may affirm or modify a decision or grant a rehearing to all or any of the parties on all or part of the issues for any of the reasons in subsection (D). An order modifying a decision or granting a rehearing shall specify with particularity the grounds for the order.
- F. If a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. The Board may extend this period for a maximum of 20 days, for good cause as described in subsection (I).
- G. Not later than 10 days after the date of a decision, after giving parties notice and an opportunity to be heard, the Board may grant a rehearing or review on its own initiative for any reason for which it might have granted relief on the motion of a party. The Board may grant a motion for rehearing or review, timely served, for a reason not stated in the motion.
- H. If a rehearing is granted, the Board shall hold the rehearing within 60 days after the order granting the rehearing is issued.

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- I. The Board may extend all time limits listed in this Section upon a showing of good cause. A party demonstrates good cause by showing that the grounds for the party's motion or other action could not have been known in time, using reasonable diligence, and a ruling on the motion will:
1. Further administrative convenience, expedition, or economy; or
  2. Avoid undue prejudice to any party.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**R4-23-129. Notice of Judicial Appeal; Transmitting the Transcript**

- A. Notification to the Board office. Within 10 days of filing a complaint for judicial review of a final administrative decision of the Board, the party shall file a copy of the complaint with the Board office. The Board office shall then transmit the administrative record to the Superior Court.
- B. Transcript. A party requesting a transcript shall arrange for transcription at the party's expense. The Board office shall make a copy of the audio taped record available to the transcriber. The party arranging for transcription shall deliver the transcript, certified by the transcriber under oath to be a true and accurate transcription of the audio taped record, to the Board office, together with one unbound copy.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1132, effective May 1, 2004 (Supp. 04-1).

**ARTICLE 2. PHARMACIST LICENSURE****R4-23-201. General**

- A. License required. Before practicing as a pharmacist in Arizona, a person shall possess a valid pharmacist license issued by the Board.
- B. Methods of licensure. Licensure as a pharmacist shall be by:
1. Examination using a Board-approved testing method; or
  2. Reciprocity, as provided under A.R.S. § 32-1922(B).
- C. The Board may reinstate the license of a pharmacist who is practicing pharmacy in another jurisdiction and has an Arizona license that lapsed at least five years ago if the pharmacist:
1. Passes the MPJE or other Board-approved jurisprudence examination, and
  2. Pays all fees and penalties specified under A.R.S. § 32-1925(C).
- D. The Board may reinstate the license of a pharmacist who has not practiced pharmacy within the last 12 months before seeking reinstatement and whose Arizona license lapsed at least five years ago if the pharmacist:
1. Completes the requirements in subsection (C), and
  2. Appears before the Board to furnish satisfactory proof of fitness to be licensed as a pharmacist.
- E. Verification of license. A pharmacy permittee or pharmacist-in-charge shall not allow a person to practice as a pharmacist until the pharmacy permittee or pharmacist-in-charge verifies the person is currently licensed by the Board as a pharmacist.

**Historical Note**

Former Rules 2.1100, 2.1310, 2.1320, and 2.1400.  
Amended effective August 23, 1978 (Supp. 78-4).  
Amended by deleting subsection (E) effective April 20, 1982 (Supp. 82-2). Amended subsections (C) and (D) effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective

January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-202. Licensure by Examination**

- A. Eligibility. To be eligible for licensure as a pharmacist by examination, a person shall:
1. Have a degree in pharmacy from an approved school or college of pharmacy; or
  2. Qualify under the requirements of A.R.S. § 32-1922(D).
- B. Application.
1. An applicant for licensure by examination shall:
    - a. Submit a completed application on a form furnished by the Board, and
    - b. Submit with the application form:
      - i. The documents specified in the application form, and
      - ii. The application fee specified in R4-23-205.
  2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.
  3. An applicant for licensure by examination shall register for the NAPLEX and jurisprudence examination through NABP's registration process. When NABP determines the applicant is eligible to test, NABP will issue an authorization to test.
  4. The Board shall deem an application for licensure by examination invalid 12 months after the date the application is received. An applicant whose application form is invalid and who wishes to continue licensure procedures, shall submit a new application form and fee as specified under subsection (B)(1).
- C. Passing grade; notification; re-examination.
1. To pass the required examinations, an applicant shall receive a passing grade on both the NAPLEX and jurisprudence examination.
  2. The Board office shall retrieve an applicant's NAPLEX and jurisprudence examination scores from the NABP database no later than two weeks after the applicant's examination date.
  3. An applicant who fails the NAPLEX or jurisprudence examination may register with the NABP to retake the examination within the 12-month period defined in subsection (B)(4). An applicant who fails the NAPLEX or jurisprudence examination three times shall petition the Executive Director as specified in R4-23-401 for approval before retaking the examination. If the applicant fails the NAPLEX or jurisprudence examination four times, the applicant shall petition the Board as specified in R4-23-401 for Board consideration before taking the examination for a last time.
  4. For the purpose of licensure by examination, the Board office shall deem a passing score on the NAPLEX or jurisprudence examination invalid 24 months after the applicant's examination date. An applicant who fails to complete the licensure process within the 24-month period, and who wishes to continue licensure procedures, shall retake the examination or examinations.
- D. NAPLEX score transfer.
1. The Board office shall deem a score transfer received on the date the NABP transmits the applicant's official score transfer report to the Board office.

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2. An applicant who receives a passing score on the NAPLEX taken in another jurisdiction shall, within 12 months after the date the Board office receives the applicant's official NABP score transfer report, make application for licensure according to subsection (B). After 12 months, an applicant may reapply for licensure in this state under the provisions of subsection (B) or R4-23-203(B).
- E. Licensure.**
1. The Board office shall issue a certificate of licensure and a wall license to a successful applicant.
  2. A licensee shall maintain the certificate of licensure in the practice site for inspection by the Board or its designee or review by the public.
- F. Time frames for licensure by examination.**
1. The Board office shall complete an administrative completeness review within 60 days after the date the application form is received.
    - a. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application form.
    - b. If the application form is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 60-day time frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
    - c. If the Board office does not provide the applicant with written notice regarding administrative completeness, the application form shall be deemed complete 60 days after receipt by the Board office.
  2. An applicant with an incomplete application form shall submit all of the missing information within 90 business days after service of the notice of incompleteness. If an applicant cannot submit all missing information within 90 business days after service of the notice of incompleteness, the applicant may send a written notice of a 30-day extension to the Board office postmarked or delivered no later than 90 business days after service of the notice of incompleteness.
  3. If an applicant fails to submit a complete application form within the time allowed under subsection (F)(2), the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a license shall apply again according to subsection (B).
  4. The Board office shall complete a substantive review of the applicant's qualifications in no more than 120 days after the date on which the administrative completeness review of an application form is complete.
    - a. The Board office shall deem the application invalid 12 months after the date the application for licensure by examination is received.
    - b. If the Board office finds deficiencies during the substantive review of the applicant's qualifications, the Board office shall issue a written request to the applicant for additional documentation.
    - c. The 120-day time frame for a substantive review is suspended from the date of a written request for additional documentation until the date all documentation is received. The applicant shall submit the additional documentation according to subsection (F)(2).
    - d. If the applicant and the Board office agree in writing, the 120-day substantive review time frame may be extended once for no more than 45 days.
  5. For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time frames for licensure by examination.
    - a. Administrative completeness review time frame: 60 days.
    - b. Substantive review time frame: 120 days.
    - c. Overall time frame: 180 days.
- G. License renewal.**
1. To renew a license, a pharmacist shall submit a completed license renewal application on a form furnished by the Board with the biennial renewal fee specified in R4-23-205.
  2. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1925, the pharmacist license is suspended and the licensee shall not practice as a pharmacist. The suspended licensee shall pay a reinstatement penalty as provided in A.R.S. § 32-1925 and R4-23-205 to vacate the suspension.
  3. A licensee shall maintain the renewal certificate of licensure in the practice site for inspection by the Board or its designee or review by the public.
  4. Time frames for license renewals. The Board office shall follow the time frames established in subsection (F) when processing a renewal application.

**Historical Note**

Former Rules 2.2100, 2.2200, 2.2300, 2.2400, 2.2500, 2.2600, 2.2700, 2.2800, 2.2910, 2.2920, 2.2930, 2.3000, 2.3010, 2.3100; Amended effective August 23, 1978 (Supp. 78-5). Amended effective June 10, 1981 (Supp. 81-3). Former Section R4-23-202 repealed, new Section R4-23-202 adopted effective July 24, 1985 (Supp. 85-4). Amended effective March 13, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 12 A.A.R. 4689, effective February 3, 2007 (Supp. 06-4). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1012 and 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-203. Licensure by Reciprocity**

- A.** Eligibility. A person is eligible for licensure by reciprocity if the person is licensed as a pharmacist in another jurisdiction and qualified under A.R.S. § 32-1922(B).
- B.** Application. An applicant for licensure by reciprocity shall comply with R4-23-202(B).
- C.** Passing grade; notification; re-examination. An applicant for licensure by reciprocity shall comply with R4-23-202(C) regarding the jurisprudence examination.
- D.** Licensure. The provisions of R4-23-202(E) apply for an applicant for licensure by reciprocity.
- E.** Time frames for licensure by reciprocity. The Board office shall follow the time frames established in R4-23-202(F).

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- F. License renewal. The procedure specified in R4-23-202(G) applies.

**Historical Note**

Former Rules 2.4100, 2.4200, 2.4310, 2.4320, 2.4330, 2.4340, 2.4350, 2.4360, 2.4400, 2.4510, 2.4520, 2.4522, 2.4523, 2.4530, 2.4540, 2.4550, 2.4560, 2.4610, 2.4620, and 2.4700; Amended effective August 23, 1978 (Supp. 78-4). Amended subsections (H), (L), (O) through (Q) effective June 10, 1981 (Supp. 81-3). Former Section R4-23-203 repealed, new Section R4-23-203 adopted effective July 24, 1985 (Supp. 85-4). Amended effective March 13, 1991 (Supp. 91-1). Amended effective January 12, 1998 (Supp. 98-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-204. Continuing Education Requirements**

- A. Under A.R.S. § 32-1936, continuing professional pharmacy education is mandatory for all licensees.
- General continuing education requirement. In accordance with A.R.S. § 32-1925(F), the Board shall not renew a license unless the licensee has, during the two years preceding the application for renewal, participated in 30 contact hours (3.0 CEUs) of continuing education activity sponsored by an Approved Provider as defined in R4-23-110.
  - Special continuing education requirement. The Board shall not renew a license unless:
    - A licensee certified under R4-23-411 to administer immunizations, vaccines, and emergency medications has participated in at least two contact hours of continuing education activity related to administering immunizations, vaccines, and emergency medications;
    - A licensee authorized to dispense controlled substances has participated in at least three contact hours of opioid-related, substance use disorder-related, or addiction-related continuing education activity; and
    - A licensee who dispenses self-administered hormonal contraceptives under a standing prescription order has participated in at least three contact hours of continuing education activity related to self-administered hormonal contraceptives.
  - A pharmacist is exempt from the continuing education requirement in subsections (A)(1) and (2) between the time of initial licensure and first renewal.
- B. Acceptance of continuing education units CEUs. The Board shall:
- Accept CEUs for continuing education activities sponsored only by an Approved Provider;
  - Accept CEUs accrued only during the two-year period immediately before licensure renewal;

- Not allow CEUs accrued in a biennial renewal period to be carried forward to the succeeding biennial renewal period;
- Allow a pharmacist who leads, instructs, or lectures to a group of health professionals on pharmacy-related topics in a continuing education activity sponsored by an Approved Provider to receive CEUs for a presentation by following the same attendance procedures as any other attendee of the continuing education activity; and
- Not accept as CEUs the performance of normal teaching duties within a learning institution by a pharmacist whose primary responsibility is the education of health professionals.

- C. Continuing education records and reporting CEUs. A pharmacist shall:
- Maintain continuing education records that:
    - Verify the continuing education activities the pharmacist participated in during the preceding five years; and
    - Consist of a statement of credit or a certificate issued by an Approved Provider at the conclusion of a continuing education activity;
  - At the time of licensure renewal, attest to the number of CEUs the pharmacist participated in during the renewal period on the biennial renewal form; and
  - When requested by the Board office, submit proof of continuing education participation within 20 days of the request.
- D. The Board may revoke, suspend, or place on probation the license of a pharmacist who fails to comply with continuing education participation, recording, or reporting requirements of this Section.
- E. A pharmacist who is aggrieved by any decision of the Board or its administrative staff concerning continuing education units may request a hearing before the Board.

**Historical Note**

Adopted effective September 1, 1981 (Supp. 81-5). Amended effective March 13, 1991 (Supp. 91-1). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 29 A.A.R. 1655 (July 28, 2023), with an immediate effective date of July 5, 2023 (Supp. 23-3).

**R4-23-205. Fees and Charges**

- A. The Board establishes and shall collect the full biennial fee for all initial and renewal license and permit applications listed in subsections (B) and (C).
- B. Licensure fees:
- Pharmacist:
    - Initial licensure: \$180.
    - Licensure renewal: \$180.
  - Intern. Initial licensure: \$50.
  - Pharmacy technician:
    - Initial licensure: \$72.
    - Licensure renewal: \$72.
  - Temporary license valid for 30 days:
    - Pharmacist: \$120.
    - Intern: \$50.
    - Pharmacy technician: \$50.
- C. Vendor permit fees (Resident and nonresident):
- Pharmacy: \$480 biennially (Including hospital, and limited service).

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2. Drug wholesaler or manufacturer:
    - a. Manufacturer: \$1000 biennially.
    - b. Full-service drug wholesaler: \$1000 biennially.
    - c. Nonprescription drug wholesaler: \$500 biennially.
  3. Drug packager or repackager: \$1000 biennially.
  4. Compressed medical gas distributor: \$200 biennially.
  5. Durable medical equipment and compressed medical gas supplier: \$100 biennially.
  6. Third-party logistics provider: \$1000 biennially.
  7. Automated prescription-dispensing kiosk: \$480 biennially.
- D.** Pharmacy technician trainee 36-month, non-renewable, registration: \$25.
- E.** Reciprocity fee: \$150.
- F.** Application fee: \$50.
- G.** Certificate fees:
1. Certificate of free sale: \$200 per certificate.
  2. Certificate of good manufacturing practice: \$200 per certificate.
- H.** Charges for services:
1. Wall license.
    - a. Pharmacist: \$20.
    - b. Intern: \$10.
    - c. Pharmacy technician: \$10.
  2. Duplicate of any Board-issued certificate: \$10.
  3. License, permit, or certificate verification: \$15.
- I.** Fees are not refunded under any circumstances except for the Board's failure to comply with its established licensure or permit time frames under R4-23-202 or R4-23-602.
- J.** Penalty. A renewal application submitted after the expiration date is subject to a penalty as provided in A.R.S. §§ 32-1925 and 32-1931.
1. Licensee: A penalty equal to half the licensee's biennial licensure renewal fee under subsection (B) and not to exceed \$350.
  2. Permittee: A penalty equal to half the permittee's biennial permit fee under subsection (C) and not to exceed \$350.

**Historical Note**

Adopted effective July 24, 1985 (Supp. 84-5). Amended subsection (A) paragraph (1) effective May 20, 1988 (Supp. 88-2). Amended effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 409 and 8 A.A.R. 646, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 15 A.A.R. 173, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by exempt rulemaking under Laws 2016, Ch. 284, § 3 at 22 A.A.R. 2606, effective August 31, 2016 (Supp. 16-3). Amended by final exempt rulemaking at 23 A.A.R. 2058, effective August 9, 2017; amended by final exempt rulemaking with amendments to subsection (D), at 23 A.A.R. 2383 (Supp. 17-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final

rulemaking at 25 A.A.R. 1012, and 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**ARTICLE 3. INTERN TRAINING; INTERN PRECEPTORS****R4-23-301. Intern Licensure**

- A.** Licensure as an intern is for the purpose of complementing an individual's academic or experiential education in preparation for licensure as a pharmacist. An applicant may request a waiver of intern licensure requirements by submitting a written request as specified in R4-23-401 and appearing in person at a Board meeting.
- B.** The prerequisite for licensure as an intern is one of the following:
1. Current enrollment, in good standing, in an approved college or school of pharmacy;
  2. Graduation from a college or school of pharmacy along with:
    - a. Proof the applicant is certified by the Foreign Pharmacy Graduate Examination Committee (FPGEC), if applicable; or
    - b. Application for licensure as a pharmacist by examination or reciprocity; or
  3. By order of the Board if the Board determines the applicant needs intern training.
- C.** If an intern licensee stops attending pharmacy school classes without graduating, the licensee shall immediately stop practicing as an intern and surrender the intern license to the Board or the Board's designee no later than 30 days after the date of the last attended class, unless the licensee petitions the Board as specified in R4-23-401 and receives Board approval to continue working as an intern. A student re-entering a pharmacy program who wishes to continue internship training shall reapply for intern licensure.
- D.** Experiential training. The preceptor supervising an intern shall ensure the training received by the intern includes the activities and services encompassed by the term "practice of pharmacy" as defined in A.R.S. § 32-1901.
- E.** Out-of-state experiential training. The Board shall credit an intern for experiential training received outside this state if the Board determines the experiential training requirements of the jurisdiction in which the training was received are equal to the minimum requirements for experiential training in this state. An applicant seeking credit for experiential training received outside this state shall furnish a certified copy of the training records from:
1. The Board of Pharmacy or the intern licensing agency of the jurisdiction where the training was received; or
  2. In a jurisdiction without an intern licensing agency, the director of the applicant's approved college or school of pharmacy's experiential training program.
- F.** Verification of license. A pharmacy permittee or pharmacist-in-charge shall not allow an individual to practice as an intern until the pharmacy permittee or pharmacist-in-charge verifies the individual is currently licensed by the Board as an intern.
- G.** Intern application.
1. An applicant for licensure as an intern shall:
    - a. Submit a completed application on a form furnished by the Board, and
    - b. Submit with the application form:

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- i. The documents specified in the application form, and
  - ii. The initial licensure fee specified in R4-23-205.
- 2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.
- H. Licensure.**
  - 1. If an applicant is found to be ineligible for intern licensure under statute and rule, the Board office shall issue a written notice of denial to the applicant.
  - 2. If an applicant is found to be eligible for intern licensure under statute and rule, the Board office shall issue a certificate of licensure and a wall license. An applicant who is assigned a license number and has been granted “open” status on the Board’s license verification site may begin practice as an intern before receiving the certificate of licensure.
  - 3. An applicant who is assigned a license number and has a “pending” status on the Board’s license verification site shall not practice as an intern until the Board office issues a certificate of licensure as specified in subsection (H)(2).
  - 4. A licensee shall maintain the certificate of licensure in the practice site for inspection by the Board or its designee or review by the public.
- I. Time frames for intern licensure.** The Board office shall follow the time frames established in R4-23-202(F).
- J. License renewal.**
  - 1. An intern whose license expires before the intern completes the education or training required for licensure as a pharmacist but fewer than six years after issuance of the initial intern license may renew the intern license for a period equal to the difference between the expiration date of the initial intern license and six years from the issue date of the initial intern license by paying a prorated renewal fee based on the intern initial license fee specified in R4-23-205.
  - 2. If an intern fails to graduate from an approved college or school of pharmacy within six years from the date the Board issues the initial intern license, the intern is not eligible for relicensure as an intern unless the intern obtains Board approval as specified in A.R.S. § 32-1923(E) and R4-23-401. To remain in good standing, an intern who receives Board approval for relicensure shall pay a prorated renewal fee for the number of months of licensure approved by the Board based on the intern initial license fee specified in R4-23-205 before the license expires.
  - 3. If an intern receives Board approval for relicensure and does not pay the renewal fee specified in subsection (J)(2) before the license expires, the intern license is suspended and the suspended licensee shall not practice as an intern until the suspended licensee pays a penalty as provided in A.R.S. § 32-1925 and R4-23-205 to vacate the suspension.
- K. Notification of training.** An intern who is employed as an intern outside the experiential training program of an approved college or school of pharmacy shall notify the Board within 10 days of starting or terminating training or changing training site.
- L. Change of address.** An intern shall notify the Board within 10 days after the intern’s employment or mailing address changes.

**Historical Note**

Former Rules 3.1000, 3.1100, 3.1200, 3.2000, 3.2100,

and 3.2200; Amended effective August 23, 1978 (Supp. 78-4). Amended effective April 20, 1982 (Supp. 82-2). Amended subsections (A), (F) and (G) effective August 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3565, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-302. Training Site; Intern Preceptors; Training Time**

- A.** To receive credit for intern training hours, an intern shall train in a site that:
  - 1. Holds a valid Arizona pharmacy permit; or
  - 2. Is an alternative training site. For purposes of this Section, the term alternative training site is a non-pharmacy training site established and monitored by an approved college or school of pharmacy or other non-pharmacy site where pharmacy-related activities are performed and where an intern gains experience as specified in R4-23-301(D).
- B.** Intern preceptor. To be an intern preceptor, a pharmacist shall:
  - 1. Hold a current unrestricted pharmacist license;
  - 2. Have at least one year of experience as an actively practicing pharmacist; and
  - 3. If found guilty of violating any federal or state law relating to the practice of pharmacy, drug or device distribution, or recordkeeping or unprofessional conduct, enter into an agreement satisfactory to the Board that places restrictions on the pharmacist’s license.
- C.** Preceptor responsibilities. A preceptor is responsible for the actions of an intern during the training period. A preceptor shall give an intern the opportunity for skill development and provide the intern with timely and realistic feedback regarding the intern’s progress.
- D.** Training hours. An intern preceptor shall ensure the intern receives hours of experiential training consistent with the requirements of the ACPE.

**Historical Note**

Former Rules 3.3000, 3.3100, 3.3200, 3.3300, 3.3310, 3.3320, 3.3330, 3.3340, 3.3400, 3.4000, 3.4100, 3.4200, 3.4300, and 3.4400; Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-303. Repealed****Historical Note**

Former Rules 3.5000 and 3.5200; Amended effective August 23, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8

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A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2619, effective December 2, 2012 (Supp. 12-4). Repealed by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-304. Repealed****Historical Note**

Former Rules 3.6100, 3.6200, 3.6300, and 3.6400; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 4356, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 18 A.A.R. 2619, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Repealed by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**R4-23-305. Repealed****Historical Note**

Former Rule 3.7000; Amended effective August 23, 1978 (Supp. 78-4). Amended by final rulemaking at 8 A.A.R. 416, effective January 10, 2002 (Supp. 02-1). Repealed by final rulemaking at 30 A.A.R. 155 (January 26, 2024), effective March 4, 2024 (Supp. 24-1).

**ARTICLE 4. PROFESSIONAL PRACTICES****R4-23-401. Time-frames for Board Approvals and Special Requests**

- A. To request a Board approval required by this Chapter or a special request to deviate from or waive compliance with a requirement of this Chapter, a person shall send a letter by regular mail, e-mail, or facsimile to the Board office, detailing the nature of the approval or special request, including the applicable Arizona Revised Statute or administrative code citation. This Section does not apply to a request from a person regarding the probation, suspension, or revocation of a license or permit.
- B. The Board office shall complete an administrative completeness review within 15 days from the date of receipt of a written request and immediately open a request file for the applicant.
  1. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the request.
  2. If the request is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 15-day time-frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
  3. If the Board office does not provide the applicant with notice regarding administrative completeness, the request is deemed complete 15 days after receipt by the Board office.
- C. An applicant with an incomplete request shall submit all of the missing information within 30 days of service of the notice of incompleteness.
  1. If an applicant cannot submit all missing information within 30 days of service of the notice of incompleteness, the applicant may send a written request for an extension

to the Board office post-marked or delivered no later than 30 days from service of the notice of incompleteness.

2. The written request for an extension shall document the reasons the applicant cannot meet the 30-day deadline.
3. The Board office shall review the request for an extension of the 30-day deadline and grant the request if the Board office determines that an extension of the deadline will enable the applicant to assemble and submit the missing information. An extension shall be for no more than 30 days. The Board office shall notify the applicant in writing of its decision to grant or deny the request for an extension. An applicant who requires an additional extension shall submit an additional written request according to subsections (C)(1) and (C)(2).
- D. If an applicant fails to submit a complete request within the time allowed, the Board office shall close the applicant's request file. An applicant whose request file is closed and who later wishes to obtain an approval or special request shall apply again according to subsection (A).
- E. From the date on which the administrative completeness review of a request is finished, the Board shall complete a substantive review of the applicant's request in no more than 120 days.
  1. The Board shall:
    - a. Approve the request,
    - b. Deny the request, or
    - c. If the Board determines deficiencies exist, request that the applicant produce additional documentation.
  2. If the Board approves or denies, the Board office shall issue a written approval or denial.
  3. If the Board finds deficiencies during the substantive review of a request, the Board office shall issue a written request to the applicant for additional documentation.
  4. The 120-day time-frame for a substantive review of a request for approval or special request is suspended from the date of a written request for additional documentation until the date of the next Board meeting after all documentation is received. The applicant shall submit the additional documentation according to subsection (C).
  5. If the applicant and the Board office mutually agree in writing, the 120-day substantive review time-frame may be extended once for no more than 30 days.
- F. If the applicant fails to submit the additional information requested within the time allowed, the Board office shall close the applicant's request file. An applicant whose request file is closed and who later wishes to obtain an approval or special request shall apply again according to subsection (A).
- G. For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time-frames for a Board approval required by this Chapter or a special request to deviate from or waive compliance with a requirement of this Chapter:
  1. Administrative completeness review time-frame: 15 days;
  2. Substantive review time-frame: 120 days; and
  3. Overall time-frame: 135 days.

**Historical Note**

Former Rule 4.1000; Former Section R4-23-401 repealed, new Section R4-23-401 adopted effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Repealed effective August 24, 1992 (Supp. 92-3). New Section made by final rulemaking at 9 A.A.R. 3184, effective August 30, 2003 (Supp. 03-3).

**R4-23-402. Pharmacist, Graduate Intern, and Pharmacy**



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**Intern**

- A.** A pharmacist or a graduate intern or pharmacy intern under the supervision of a pharmacist shall perform the following professional practices in dispensing a prescription medication from a prescription order:
1. Receive, reduce to written form, and manually initial oral prescription orders;
  2. Obtain and record the name of the individual who communicates an oral prescription order;
  3. Obtain, or assume responsibility to obtain, from the patient, patient's agent, or medical practitioner and record, or assume responsibility to record, in the patient's profile, the following information:
    - a. Name, address, telephone number, date of birth (or age), and gender;
    - b. Individual history including known diseases and medical conditions, known drug allergies or drug reactions, and if available a comprehensive list of medications currently taken and medical devices currently used;
  4. Record, or assume responsibility to record, in the patient's profile, a pharmacist's, graduate intern's, or pharmacy intern's comments relevant to the patient's drug therapy, including other information specific to the patient or drug;
  5. Verify the legality and pharmaceutical feasibility of dispensing a drug based upon:
    - a. The patient's allergies,
    - b. Incompatibilities with medications the patient currently takes,
    - c. The patient's use of unusual quantities of dangerous drugs or narcotics,
    - d. A medical practitioner's signature, and
    - e. The frequency of refills;
  6. Verify that a dosage is within proper limits;
  7. Interpret the prescription order, which includes exercising professional judgment in determining whether to dispense a particular prescription;
  8. Compound, mix, combine, or otherwise prepare and package the prescription medication needed to dispense individual prescription orders;
  9. Prepackage or supervise the prepackaging of drugs by a pharmacy technician or pharmacy technician trainee under R4-23-1104. For drugs prepackaged by a pharmacy technician or pharmacy technician trainee, a pharmacist shall:
    - a. Verify the drug to be prepackaged;
    - b. Verify that the label meets the official compendium's standards;
    - c. Check the completed prepackaging procedure and product; and
    - d. Manually initial the completed label; or
    - e. For automated packaging systems, manually initial the completed label or a written log or initial a computer-stored log;
  10. Check prescription order data entry to ensure that the data input:
    - a. Is for the correct patient by verifying the patient's name, address, telephone number, gender, and date of birth or age;
    - b. Is for the correct drug by verifying the drug name, strength, and dosage form;
  - c. Communicates the prescriber's directions precisely by verifying dose, dosage form, route of administration, dosing frequency, and quantity; and
  - d. Is for the correct medical practitioner by verifying the medical practitioner's name, address, and telephone number;
  11. Except as provided in subsection (A)(12), make a final accuracy check of the completed prescription label including verification of medication, accuracy of patient's name, consistency with prescription order, and drug utilization review and initial in handwriting or by another method approved by the Board or its designee the finished label;
  12. If a technology-assisted verification of product program is used, make a final accuracy check of the completed prescription label including accuracy of patient's name, consistency with prescription order, and drug utilization review and initial in handwriting or by another method approved by the Board or its designee the finished label. If a technology-assisted verification of product program is used, verification of product is not required.
  13. Record, or assume responsibility to record, a prescription serial number and date dispensed on the original prescription order;
  14. Obtain, or assume responsibility to obtain, permission to refill a prescription order and record, or assume responsibility to record on the original prescription order:
    - a. Date dispensed,
    - b. Quantity dispensed, and
    - c. Name of medical practitioner or medical practitioner's agent who communicates permission to refill the prescription order;
  15. Reduce to written or printed form, or assume responsibility to reduce to written or printed form, a new prescription order received by:
    - a. Fax,
    - b. E-mail, or
    - c. Other means of communication;
  16. Verify, or assume responsibility to verify, that a completed prescription medication is sold only to the correct patient, patient's care-giver, or authorized agent;
  17. Record on the original prescription order the name or initials of the pharmacist, graduate intern, or pharmacy intern who originally dispenses the prescription order; and
  18. Record on the original prescription order the name or initials of the pharmacist, graduate intern, or pharmacy intern who dispenses each refill.
- B.** Only a pharmacist, graduate intern, or pharmacy intern shall provide oral consultation about a prescription medication to a patient or patient's care-giver in an outpatient setting, including a patient discharged from a hospital. The oral consultation is required whenever the following occurs:
1. The prescription medication has not been previously dispensed to the patient in the same strength or dosage form or with the same directions;
  2. The pharmacist, through the exercise of professional judgment, determines that oral consultation is warranted; or
  3. The patient or patient's care-giver requests oral consultation.
- C.** Oral consultation shall include:
1. Reviewing the name and strength of a prescription medication or name of a prescription-only device and the

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- labeled indication of use for the prescription medication or prescription-only device;
2. Reviewing the prescription's directions for use;
  3. Reviewing the route of administration; and
  4. Providing oral information regarding special instructions and written information regarding side effects, procedure for missed doses, or storage requirements.
- D.** When, in the professional judgment of the pharmacist or graduate intern or pharmacy intern under the supervision of a pharmacist, or when circumstance precludes it, oral consultation may be omitted if the pharmacist, graduate intern, or pharmacy intern:
1. Personally provides written information to the patient or patient's care-giver that summarizes the information that would normally be orally communicated;
  2. Documents, or assumes responsibility to document, both the circumstance and reason for not providing oral consultation by a method approved by the Board or its designee; and
  3. Offers the patient or patient's care-giver the opportunity to communicate with a pharmacist, graduate intern, or pharmacy intern at a later time and provides a method for the patient or patient's care-giver to contact a pharmacist, graduate intern, or pharmacy intern at the pharmacy.
- E.** The pharmacist or graduate intern or pharmacy intern under the supervision of a pharmacist, through the exercise of professional judgment, may provide oral consultation that includes:
1. Common severe adverse effects, interactions, or therapeutic contraindications, and the action required if they occur;
  2. Techniques of self-monitoring drug therapy;
  3. The duration of the drug therapy; and
  4. Prescription refill information.
- F.** Nothing in subsection (B) requires a pharmacist, graduate intern, or pharmacy intern to provide oral consultation if a patient or patient's care-giver refuses the consultation.
- G.** Using a method approved by the Board or its designee, a pharmacist, graduate intern, or pharmacy intern shall document, or assume responsibility to document, that oral consultation is or is not provided.
- H.** Oral consultation documentation. When oral consultation is required as specified in subsection (B), a pharmacist, graduate intern, or pharmacy intern shall:
1. Document, or assume responsibility to document, that oral consultation is provided; or
  2. When a patient refuses oral consultation or a person other than the patient or patient's care-giver picks up a prescription and oral consultation is not provided, document, or assume responsibility to document, that oral consultation is not provided; or
  3. When a pharmacist, graduate intern, or pharmacy intern determines to omit oral consultation under subsection (D) and oral consultation is not provided, document, or assume responsibility to document, both the circumstance and reason that oral consultation is not provided; and
  4. Document, or assume responsibility to document, the name, initials, or identification code of the pharmacist, graduate intern, or pharmacy intern who did or did not provide oral consultation.
- I.** When a prescription is delivered to the patient or patient's care-giver outside the immediate area of a pharmacy and a pharmacist is not present, the prescription shall be accompanied by written or printed patient medication information that, in addition to the requirements in subsection (C), includes:
1. Approved use for the prescription medication;
  2. Possible adverse reactions;
  3. Drug-drug, food-drug, or disease-drug interactions;
  4. Missed dose information; and
  5. Telephone number of the dispensing pharmacy or another method approved by the Board or its designee that allows a patient or patient's care-giver to consult with a pharmacist.
- J.** A prescription medication or prescription-only device, delivered to a patient at a location where a licensed health care professional is responsible for administering the prescription medication to the patient, is exempt from the requirement of subsection (C).
- K.** A pharmacist, graduate intern, or pharmacy intern shall wear a badge indicating name and title while on duty.
- L.** Nothing in this Section prevents a hospital pharmacist from accepting a prescription order according to rules pertaining specifically to hospital pharmacies.

**Historical Note**

Former Rule 4.1100; Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Amended effective July 7, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 4656, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 2258, effective August 6, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 274, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 12 A.A.R. 4691, effective February 3, 2007 (Supp. 06-4). Amended by final rulemaking at 23 A.A.R. 3257, effective January 8, 2018 (Supp. 17-4).

**R4-23-403. Repealed****Historical Note**

Former Rule 4.1200; Amended effective August 10, 1978 (Supp. 78-4). Amended effective March 28, 1980 (Supp. 80-2). Amended effective August 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective May 16, 1990 (Supp. 90-2). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Section repealed by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).

**R4-23-404. Unethical Practices**

- A.** Rebates prohibited. A pharmacist or pharmacy permittee shall not offer, deliver, receive, or accept any unearned rebate, refund, commission, preference, patronage dividend, discount, or other unearned consideration, whether in the form of money or otherwise, as compensation or inducement to refer a patient, client, or customer to any person, except for a rebate or premium paid completely and directly to a patient. A pharmacist or pharmacy permittee shall not:
1. Make payment to a medical practitioner in money or other consideration for a prescription order prescribed by the medical practitioner; or
  2. Make payment to a long-term care or assisted living facility or other health care institution in money, discount,

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rental, or other consideration in an amount above the prevailing rate for:

- a. Prescription medication or devices dispensed or sold for a patient or resident of the facility or institution; or
- b. Drug selection or drug utilization review services, drug therapy management services, or other pharmacy consultation services provided for a patient or resident of the facility or institution.

**B.** Prescription order-blank advertising prohibited. A pharmacist or pharmacy permittee shall not:

1. Directly or indirectly furnish to a medical practitioner a prescription order-blank that refers to a specific pharmacist or pharmacy in any manner; or
2. Actively or passively participate in any arrangement or agreement where a prescription order-blank is prepared, written, or issued in a manner that refers to a specific pharmacist or pharmacy.

**C.** Fraudulent claim for service. A pharmacist or pharmacy permittee shall not claim the performance of a service that the pharmacist or pharmacy permittee knows or should know was not performed, such as, claiming to dispense a prescription medication that is not dispensed.

**D.** Fraudulent claim for a fee. A pharmacist or pharmacy permittee:

1. Shall not claim a fee for a service that is not performed or earned;
2. May divide a prescription order into two or more portions of prescription medication at the request of a patient, or for some other ethical reason, and charge a dispensing fee for the additional service; and
3. Shall not divide a prescription order merely to obtain an additional fee.

**E.** Prohibiting a prescription-only drug or device from being dispensed over the counter. A pharmacist shall ensure that:

1. A prescription-only drug or device is dispensed only after receipt of a valid prescription order from a licensed medical practitioner;
2. The dispensed prescription-only drug or device is properly prepared, packaged, and labeled according to this Chapter; and
3. The prescription order is filed according to this Chapter.

**F.** Drugs dispensed in the course of the conduct of a business of dispensing drugs through diagnosis by mail or the internet.

1. A pharmacist shall not dispense a drug from a prescription order if the pharmacist has knowledge, or reasonably should know under the circumstances, that the prescription order was issued on the basis of an internet-based questionnaire or an internet-based consultation without a medical practitioner-patient relationship as defined in R4-23-110.
2. A pharmacist who dispenses a prescription-only drug, prescription-only device, or controlled substance in violation of this Section is engaging in unethical conduct in violation of A.R.S. § 32-1901.01.

**Historical Note**

Former Rules 4.2110, 4.2120, 4.2130, 4.2210, 4.2230, 4.2400, 4.2500, 4.2600, 4.4100, 4.4200, 4.4310, 4.4320, 4.4400, and 4.4500; Amended effective August 10, 1978 (Supp. 78-4); Amended subsection (I) effective August 9, 1983 (Supp. 83-4). Amended by deleting subsections (H) through (M) effective November 18, 1983 (Supp. 83-6). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemak-

ing at 14 A.A.R. 3405, effective October 4, 2008 (Supp. 08-3).

**R4-23-405. Change of Responsibility**

A pharmacist designated as the pharmacist-in-charge for a pharmacy, manufacturer, or other establishment shall give immediate notice, as defined in R4-23-110, when:

1. The pharmacist's responsibility as a pharmacist-in-charge is terminated; or
2. The pharmacist knows of a pending termination of the pharmacist's responsibility as the pharmacist-in-charge.

**Historical Note**

Former Rules 4.5100 and 4.5200; Amended effective August 9, 1983 (Supp. 83-4). Amended effective February 8, 1991 (Supp. 91-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1).

**R4-23-406. Repealed****Historical Note**

Adopted as an emergency effective January 10, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 79-1). Amended as an emergency effective April 2, 1979, pursuant to A.R.S. § 41-1003, valid for only 90 days. Adopted effective April 10, 1979 (Supp. 79-1). Former Section R4-23-406 repealed, new Section R4-23-406 adopted effective August 9, 1983 (Supp. 83-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Section repealed by final rulemaking at 10 A.A.R. 230, effective March 6, 2004 (Supp. 04-1).

**R4-23-407. Prescription Requirements**

**A.** Prescription orders. A pharmacist shall ensure that:

1. A prescription order the pharmacist uses to dispense a drug or device includes the following information:
  - a. Date of issuance;
  - b. Name and address of the patient for whom or the owner of the animal for which the drug or device is dispensed;
  - c. Drug name, strength, and dosage form or device name;
  - d. Name of the manufacturer or distributor of the drug or device if the prescription order is written generically or a substitution is made;
  - e. Prescribing medical practitioner's directions for use;
  - f. Date of dispensing;
  - g. Quantity prescribed and if different, quantity dispensed;
  - h. For a prescription order for a controlled substance, the medical practitioner's address and DEA number;
  - i. For a written prescription order, the medical practitioner's signature;
  - j. For an electronically transmitted prescription order, the medical practitioner's digital or electronic signature;
  - k. For an oral prescription order, the medical practitioner's name and telephone number; and
  - l. Name or initials of the dispensing pharmacist;
2. A prescription order is kept by the pharmacist or pharmacy permittee as a record of the dispensing of a drug or device for seven years from the date the drug or device is dispensed;

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3. The dispensing of a drug or device complies with the packaging requirements of the official compendium and state and federal law; and
4. If the drug dispensed is a schedule II controlled substance that is an opioid, the drug is placed in a container that has a red cap and a warning label stating "CAUTION: OPIOID, Risk of Overdose and Addiction" or other similarly clear language indicating the possibility of overdose and addiction. Under delegation from the Board, the Executive Director may waive the red-cap requirement if implementing the requirement is not feasible because of the specific dosage form or packaging type.
- B.** Prescription refills. A pharmacist shall ensure that the following information is recorded on the back of a prescription order when it is refilled:
  1. Date refilled,
  2. Quantity dispensed,
  3. Name or approved abbreviation of the manufacturer or distributor if the prescription order is written generically or a substitution is made, and
  4. The name or initials of the dispensing pharmacist.
- C.** Prescription order adaptation. Except for a prescription order for a controlled substance, a pharmacist, using professional judgment, may make the following adaptations to a prescription order if the pharmacist documents the adaptation in the patient's record:
  1. Change the prescribed quantity if the prescribed quantity is not a package size commercially available from the manufacturer;
  2. Change the prescribed dosage form or directions for use if the change achieves the intent of the prescribing medical practitioner;
  3. Complete missing information on the prescription order if there is sufficient evidence to support the change; and
  4. Extend the quantity of a maintenance drug for the limited quantity necessary to achieve medication refill synchronization for the patient.
- D.** A pharmacist may furnish a copy of a prescription order to the patient for whom it is prescribed or to the authorized representative of the patient if the copy is clearly marked "COPY FOR REFERENCE PURPOSES ONLY" or other similar statement. A copy of a prescription order is not a valid prescription order and a pharmacist shall not dispense a drug or device from the information on a copy.
- E.** Transfer of prescription order information. For a transfer of prescription order information to be valid, a pharmacy permittee or pharmacist-in-charge shall ensure that:
  1. Both the original and the transferred prescription order are maintained for seven years after the last dispensing date;
  2. The original prescription order information for a Schedule III, IV, or V controlled substance is transferred only as specified in 21 CFR 1306.25;
  3. The original prescription order information for a non-controlled substance drug is transferred without limitation only up to the number of originally authorized refills;
  4. For a transfer within Arizona:
    - a. The transfer of original prescription order information for a non-controlled substance drug meets the following conditions:
      - i. The transfer of information is communicated electronically, verbally, or by fax directly between:
        - (1) Two licensed pharmacists,
        - (2) A licensed pharmacist and a licensed intern, or
        - (3) Two licensed interns;
      - ii. The following information is recorded by the transferring pharmacist or intern:
        - (1) The word "void" is written on the face of the invalidated original prescription unless it is an electronic or oral transfer and the transferred prescription order information is invalidated in the transferring pharmacy's computer system; and
        - (2) The name and identification code, number, or address and telephone number of the pharmacy to which the prescription is transferred, the name of the receiving pharmacist or intern, the date of transfer, and the name of the transferring pharmacist or intern is written on the back of the prescription or entered into the transferring pharmacy's computer system; and
      - iii. The following information is recorded by the receiving pharmacist or intern on the transferred prescription order:
        - (1) The word "transfer;"
        - (2) Date of issuance of the original prescription order;
        - (3) Original number of refills authorized on the original prescription order;
        - (4) Date of original dispensing;
        - (5) Number of valid refills remaining and the date of the last refill;
        - (6) Name and identification code, number, or address, telephone number, and original prescription number of the pharmacy from which the prescription is transferred;
        - (7) Name of the transferring pharmacist or intern; and
        - (8) Name of the receiving pharmacist or intern;
    - b. The transfer of original prescription order information for a Schedule III, IV, or V controlled substance meets the following conditions:
      - i. The transfer of information is communicated directly between two licensed pharmacists or interns electronically or verbally;
      - ii. The following information is recorded by the transferring pharmacist or intern:
        - (1) The word "void" is written on the face of the invalidated original prescription order unless it is an electronic or oral transfer and the transferred prescription order information is invalidated in the transferring pharmacy's computer system; and
        - (2) The name, address, and DEA number of the pharmacy to which the prescription is transferred, the name of the receiving pharmacist, the date of transfer, and the name of the transferring pharmacist is written on the back of the prescription order or entered into the transferring pharmacy's computer system; and
      - iii. The following information is recorded by the receiving pharmacist on the transferred prescription order:

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- (1) The word “transfer;”
  - (2) Date of issuance of original prescription order;
  - (3) Original number of refills authorized on the original prescription order;
  - (4) Date of original dispensing;
  - (5) Number of valid refills remaining and the date of the last refill;
  - (6) Name, address, DEA number, and original prescription number of the pharmacy from which the prescription is transferred;
  - (7) Name of the transferring pharmacist; and
  - (8) Name of the receiving pharmacist;
5. For a transfer from out-of-state:
  - a. The transfer of original prescription order information for a non-controlled substance drug meets the conditions in subsections (E)(4)(a)(i) and (E)(4)(a)(iii); and
  - b. The transfer of original prescription order information for a Schedule III, IV, or V controlled substance meets the conditions in subsections (E)(4)(b)(i) and (E)(4)(b)(iii); and
6. For an electronic transfer, the electronic transfer of original prescription order information meets the following conditions:
  - a. The electronic transfer is between pharmacies owned by the same company using a common or shared database;
  - b. The electronic transfer of original prescription order information for a non-controlled substance drug is performed by a pharmacist or intern, pharmacy technician trainee, or pharmacy technician under the supervision of a pharmacist;
  - c. The electronic transfer of original prescription order information for a controlled substance is performed between two licensed pharmacists;
  - d. The electronic transfer of original prescription order information for a non-controlled substance drug meets the following conditions:
    - i. The transferring pharmacy’s computer system:
      - (1) Invalidates the transferred original prescription order information;
      - (2) Records the identification code, number, or address of the pharmacy to which the prescription order information is transferred;
      - (3) Records the name or identification code of the receiving pharmacist, intern, pharmacy technician trainee, or pharmacy technician; and
      - (4) Records the date of transfer; and
    - ii. The receiving pharmacy’s computer system:
      - (1) Records that a prescription transfer occurred;
      - (2) Records the date of issuance of the original prescription order;
      - (3) Records the original number of refills authorized on the original prescription order;
      - (4) Records the date of original dispensing;
      - (5) Records the number of valid refills remaining and the date of the last refill;
      - (6) Records the identification code, number, or address and original prescription number of the pharmacy from which the prescription is transferred;
  - e. The electronic transfer of original prescription order information for a controlled substance meets the following conditions:
    - i. The transferring pharmacy’s computer system:
      - (1) Invalidates the transferred original prescription order information;
      - (2) Records the identification code, number, or address, and DEA number of the pharmacy to which the prescription order information is transferred;
      - (3) Records the name or identification code of the receiving pharmacist;
      - (4) Records the date of transfer; and
      - (5) Records the name or identification code of the transferring pharmacist; and
    - ii. The electronic prescription order information received by the computer system of the receiving pharmacy includes the information required in subsection (E)(4)(b)(iii); and
  - f. In addition to electronic documentation of a transferred prescription order in the computer system, an original prescription order containing the requirements of this Section is filed in compliance with A.R.S. § 32-1964.
- F. Transmission of a prescription order from a medical practitioner to a pharmacy by fax.
  1. A medical practitioner or medical practitioner’s agent may transmit a prescription order for a Schedule III, IV, or V controlled substance, prescription-only drug, or non-prescription drug to a pharmacy by fax under the following conditions:
    - a. The prescription order is faxed only to the pharmacy of the patient’s choice;
    - b. The faxed prescription order:
      - i. Contains all the information required for a prescription order in A.R.S. §§ 32-1968 and 36-2525; and
      - ii. Is only faxed from the medical practitioner’s practice location, except that a nurse in a hospital, long-term care facility, or inpatient hospice may send a fax of a prescription order for a patient of the facility; and
    - c. The faxed prescription order shall contain the following additional information:
      - i. The date the prescription order is faxed;
      - ii. The fax number of the prescribing medical practitioner or the facility from which the prescription order is faxed, and the telephone number of the facility; and
      - iii. The name of the person who transmits the fax, if other than the medical practitioner.
  2. A medical practitioner or medical practitioner’s agent may fax a prescription order for a Schedule II controlled substance for information purposes only, unless the faxed prescription order meets the requirements of A.R.S. § 36-2525(F) and (G).

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3. A pharmacy may receive a faxed prescription order for a Schedule II controlled substance for information purposes only, except a faxed prescription order for a Schedule II controlled substance that meets the requirements of A.R.S. § 36-2525(F) and (G) may serve as the original written prescription order.
  4. To meet the seven-year record retention requirement of A.R.S. § 32-1964, a pharmacy shall receive a faxed prescription order on plain paper or may make a photocopy of the faxed prescription order.
  5. A medical practitioner or the medical practitioner's agent may fax refill authorizations to a pharmacy if the faxed authorization includes the medical practitioner's telephone and fax numbers, the medical practitioner's signature or medical practitioner's agent's name, and date of authorization.
- G. Electronic transmission of a prescription order from a medical practitioner to a pharmacy.**
1. Unless otherwise prohibited by law, a medical practitioner or medical practitioner's agent may transmit a prescription order by electronic means, directly or through an intermediary, including an E-prescribing network, to the dispensing pharmacy as specified in A.R.S. § 32-1968.
  2. For electronic transmission of a Schedule II, III, IV, or V controlled substance prescription order, the medical practitioner and pharmacy shall ensure the transmission complies with any security or other requirements of federal law.
  3. The medical practitioner and pharmacy shall ensure all electronic transmissions comply with all the security requirements of state or federal law related to the privacy of protected health information.
  4. In addition to the information required to be included on a prescription order as specified in A.R.S. § 32-1968, a medical practitioner shall ensure an electronically transmitted prescription order includes:
    - a. The date of transmission; and
    - b. If the individual transmitting the prescription is not the medical practitioner, the name of the medical practitioner's authorized agent who transmits the prescription order.
  5. A pharmacy receiving an electronically transmitted prescription order shall maintain the prescription order as specified in A.R.S. § 32-1964 or R4-23-408(H)(2).
  6. A medical practitioner or medical practitioner's agent shall transmit an electronic prescription order only to the pharmacy of the patient's choice.
- H. Exceptions under A.R.S. § 36-2525 regarding electronic prescribing requirements:**
1. Medical practitioner exceptions. A medical practitioner who is authorized to prescribe a controlled substance may furnish a written prescription order in accordance with R4-23-407 rather than an electronically transmitted prescription order if the prescription order is written:
    - a. In this state to be filled in a jurisdiction outside this state;
    - b. For a medication that requires compounding two or more ingredients;
    - c. For a medication that is not in the E-prescribing database;
    - d. For an individual who is detained by or in custody of an Arizona or federal law enforcement agency; or
    - e. Under A.R.S. § 36-2525(N) or (O); and
  2. Pharmacist exceptions. A pharmacist may dispense a controlled substance from a written rather than electronically transmitted prescription order if the prescription order:
    - a. Is written by a medical practitioner who is not licensed in this state but rather, is licensed in a jurisdiction outside this state. The pharmacist is not required to verify whether the medical practitioner is licensed;
    - b. Is written for a medication that requires compounding two or more ingredients;
    - c. Is written for a medication that is not in the E-prescribing database;
    - d. Is written for an individual who is detained by or in custody of an Arizona or federal law enforcement agency; or
    - e. Is received under A.R.S. § 36-2525(D).

**Historical Note**

Adopted effective November 18, 1983 (Supp. 83-6).  
 Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 3605, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).  
 Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020; and amended by final rulemaking at 26 A.A.R. 544, with an immediate effective date of March 3, 2020 (Supp. 20-1).

**R4-23-407.1. Dispensing an Opioid Antagonist****A. As used in this Section:**

1. "Community member" means any person in position to assist an individual at risk of experiencing an opioid-related overdose. This includes emergency first responders, peace officers or other law enforcement personnel, fire department personnel, school district employees, and personnel of a facility or center that provides services to individuals at risk of experiencing an opioid-related overdose.
2. "Opioid antagonist" means any drug approved by the U.S. Food and Drug Administration that binds to opioid receptors, effectively blocking or inhibiting the receptor and preventing the body from responding to the opioid. Naloxone hydrochloride is an opioid antagonist.
3. "Opioid-related overdose" means an acute condition caused by excessive opioids. An opioid-related overdose can be identified by a triad of symptoms: decreased level of consciousness, pinpoint pupils, and respiratory depression. Other symptoms may include seizures, muscle spasms, and coma or death. An opioid-related overdose requires medical assistance.

**B. When dispensing an opioid antagonist under A.R.S. § 32-1979, a pharmacist or pharmacy intern shall provide the following education to the individual to whom the opioid antagonist is dispensed:**

1. How to prevent an opioid-related overdose;
2. How to recognize an opioid-related overdose;
3. How to administer an opioid antagonist safely to an individual experiencing an opioid-related overdose;
4. Precautions regarding:
  - a. Potential side effects, and

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- b. Possible adverse events associated with administration of the opioid antagonist; and
- 5. Importance of seeking emergency medical assistance for the individual experiencing an opioid-related overdose before or after administering the opioid antagonist.
- C. Before dispensing an opioid antagonist under A.R.S. § 32-1979(A), a licensed pharmacist shall complete an opioid prevention and treatment training program that includes the following information:
  - 1. How to recognize the symptoms of an opioid-related overdose,
  - 2. How to respond to a suspected opioid-related overdose,
  - 3. How to administer all preparations of an opioid antagonist, and
  - 4. The information needed by an individual to whom an opioid antagonist is dispensed.
- D. A pharmacist who has completed an opioid prevention and treatment training program described in subsection (C):
  - 1. May administer an opioid antagonist to an individual the pharmacist believes is experiencing an opioid-related overdose, and
  - 2. Is exempt from civil liability under the terms of A.R.S. § 36-2267(B).
- E. Dispensing an opioid antagonist under A.R.S. § 32-1979 by invoice to a community member is not wholesale distribution as defined at A.R.S. § 32-1981.
- F. When dispensing an opioid antagonist on a standing order, as defined under A.R.S. § 32-1968, a pharmacist or pharmacy intern shall comply with R4-23-407 except subsection (A)(1)(b), R4-23-408, and R4-23-409.

**Historical Note**

New Section made by emergency rulemaking at 23 A.A.R. 31, effective December 15, 2016 for 180 days (Supp. 16-4). New Section made by final rulemaking before emergency expired at 23 A.A.R. 967, effective June 3, 2017 (Supp. 17-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-407.2. Dispensing a Self-administered Hormonal Contraceptive**

- A. Standard procedures. The first time a pharmacist dispenses a self-administered hormonal contraceptive under a standing prescription order, as authorized under A.R.S. § 32-1979.01, to a patient, the pharmacist shall:
  - 1. Determine the patient is at least 18 years old;
  - 2. Obtain from the patient a completed self-screening risk assessment based on nationally recognized guidelines;
  - 3. Provide the patient with written information prepared by the manufacturer of the hormonal contraceptive; and
  - 4. Provide the following information orally to the patient:
    - a. How hormonal contraception works;
    - b. When and how to take the self-administered hormonal contraceptive;
    - c. Risks associated with taking a self-administered hormonal contraceptive; and
    - d. When to seek medical assistance while taking a self-administered hormonal contraceptive.
- B. A pharmacist who dispenses a self-administered hormonal contraceptive under a standing prescription order shall have a patient complete the self-screening risk assessment based on nationally recognized guidelines, required under subsection (A)(2), annually.
- C. A pharmacist who dispenses a self-administered hormonal contraceptive under a standing prescription order shall main-

tain evidence of the patient's age at the time of initial dispensing and the completed nationally recognized self-screening risk assessment for at least seven years. The pharmacist shall ensure this information is readily retrievable and available to the Board on request.

- D. When dispensing a self-administered hormonal contraceptive under a standing prescription order, a pharmacist shall comply with R4-23-407 except subsection (A)(1)(b), R4-23-408, and R4-23-409.
- E. During each biennial renewal period, a pharmacist who dispenses self-administered hormonal contraceptives under a standing prescription order shall complete the three contact hours of continuing education specified under R4-23-204(A)(2)(c).

**Historical Note**

New Section made by final rulemaking 29 A.A.R. 1655 (July 28, 2023) with an immediate effective date of July 5, 2023 (Supp. 23-3).

**R4-23-408. Computer Records**

- A. Systems manual. A pharmacy permittee or pharmacist-in-charge shall:
  - 1. Develop, implement, and comply with policies and procedures for the following operational aspects of a computer system:
    - a. Examples of all output documentation provided by the computer system that contains original or refill prescription order or patient profile information;
    - b. Steps a pharmacy employee follows when the computer system is not operational due to scheduled or unscheduled system interruption;
    - c. Regular and routine backup file procedure and file maintenance, including secure storage of backup files;
    - d. Audit procedures, personnel code assignments, and personnel responsibilities; and
    - e. Quality assurance mechanism for data entry validation;
  - 2. Review biennially and, if necessary, revise the policies and procedures required under this Section;
  - 3. Document the review required under subsection (A)(2);
  - 4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee; and
  - 5. Make the policies and procedures available within the pharmacy for reference by pharmacy personnel and inspection by the Board or its designee.
- B. Computer system data storage and retrieval. A pharmacy permittee or pharmacist-in-charge shall ensure the computer system is capable of:
  - 1. Producing sight-readable information on all original and refill prescription orders and patient profiles;
  - 2. Providing online retrieval (via CRT display or hard-copy printout) of original prescription order information required in A.R.S. § 32-1968(C), R4-23-402(A), and R4-23-407(A);
  - 3. Providing online retrieval (via CRT display or hard-copy printout) of patient profile information required in R4-23-402(A);
  - 4. Providing documentation identifying the pharmacist responsible for dispensing each original or refill prescription order, except a pharmacy permittee with a computer system that is in use before the effective date of this Section that cannot provide documentation identifying the

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- dispensing pharmacist may continue to use the computer system by providing manual documentation identifying the dispensing pharmacist;
5. Producing a printout of all prescription order information, including a single-drug usage report that contains:
    - a. The name of the prescribing medical practitioner;
    - b. The name and address of the patient;
    - c. The quantity dispensed on each original or refill prescription order;
    - d. The date of dispensing for each original or refill prescription order;
    - e. The name or identification code of the dispensing pharmacist; and
    - f. The serial number of each prescription order; and
  6. Providing a printout of requested prescription order information to an individual pharmacy within 72 hours of the request if prescription order information is maintained in a centralized computer record system.
- C.** A pharmacy permittee or pharmacist-in-charge of a pharmacy that uses a pharmacy computer system:
1. Shall notify the D.E.A. and the Board in writing that original and refill prescription order information and patient profiles are stored in a pharmacy computer system;
  2. Shall comply with this Section if the pharmacy computer system's refill records are used as an alternative to the manual refill records required in R4-23-407(B);
  3. Is exempt from the manual refill recordkeeping requirements of R4-23-407(B), if the pharmacy computer system complies with the requirements of this Section; and
  4. Shall ensure that documentation of the accuracy of original and refill prescription order information entered into a computer system is provided by each pharmacist using the computer system and kept on file in the pharmacy for seven years from the date of the last refill. Documentation includes one of the following:
    - a. A hard-copy printout of each day's original and refill prescription order data that:
      - i. States original and refill data for prescriptions dispensed by each pharmacist is reviewed for accuracy;
      - ii. Includes the printed name of each dispensing pharmacist; and
      - iii. Is signed and initialed by each dispensing pharmacist; or
    - b. A log book or separate file of daily statements that:
      - i. States original and refill data for prescriptions dispensed by each pharmacist is reviewed for accuracy;
      - ii. Includes the printed name of each dispensing pharmacist; and
      - iii. Is signed and initialed by each dispensing pharmacist.
- D.** If a pharmacy computer system does not comply with the requirements of subsections (A), (B), and (F), the pharmacy permittee or pharmacist-in-charge shall bring the computer system into compliance within three months of a notice of noncompliance or violation letter. If the computer system is still noncompliant with subsection (A), (B), or (F) after three months, the pharmacy permittee or pharmacist-in-charge shall immediately comply with the manual recordkeeping requirements of R4-23-402 and R4-23-407.
- E.** If a pharmacy's personnel perform manual recordkeeping under subsection (D), the pharmacy's personnel shall continue manual recordkeeping until the pharmacist-in-charge sends proof, verified by a Board compliance officer, that the computer system complies with subsections (A), (B), and (F).
- F.** Security. To maintain the confidentiality of patient records, a pharmacy permittee or pharmacist-in-charge shall ensure:
1. The computer system has security and systems safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription order information and patient profiles; and
  2. After a prescription order is dispensed, any alteration of prescription order information is documented, including the identification of the pharmacist responsible for the alteration.
- G.** A computer system that does not comply with all the requirements of subsections (A), (B), and (F) may be used in a pharmacy if:
1. The computer system was in use in the pharmacy before July 11, 2001, and
  2. The pharmacy complies with the manual recordkeeping requirements of R4-23-402 and R4-23-407.
- H.** Prescription records and retention.
1. Instead of filing the original hard-copy prescription order as required in A.R.S. § 32-1964, a pharmacy permittee or pharmacist-in-charge may use an electronic imaging recordkeeping system, if:
    - a. The system is capable of capturing, storing, and reproducing the exact image of a prescription order, including the reverse side of the prescription order if necessary;
    - b. Any notes of clarification of or alterations to a prescription order are directly associated with the electronic image of the prescription order;
    - c. A prescription order image and any associated notes of clarification of or alterations to the prescription order are retained for no fewer than seven years from the date the prescription order is last dispensed;
    - d. Policies and procedures for the use of an electronic imaging recordkeeping system are developed, implemented, reviewed, and revised in the same manner described in subsection (A) and complied with; and
    - e. The prescription is not for a controlled substance.
  2. If a pharmacy's computer system fields are automatically populated by an electronically transmitted prescription order, the automated record constitutes the original prescription order and a hard-copy or electronic image is not required if the computer system is capable of maintaining, printing, and providing all the prescription order information required in A.R.S. §§ 32-1968 and 36-2525 and R4-23-407(A) within 72 hours of a request by the Board, the Board's compliance officers, other authorized regulatory board agents, or authorized officers of the law.
- I.** A pharmacy permittee or pharmacist-in-charge shall make all prescription records available within 72 hours after a Board request.

**Historical Note**

Adopted effective November 18, 1983 (Supp. 83-6).  
 Amended by final rulemaking at 7 A.A.R. 646, effective January 11, 2001 (Supp. 01-1). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 4270, effective December 6, 2005 (Supp. 05-4).  
 Amended by final rulemaking at 12 A.A.R. 274, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006



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(Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 440, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-409. Returning Drugs and Devices**

- A.** After a person for whom a drug is prescribed or the person's agent takes the drug from the premises where sold, distributed, or dispensed, a pharmacist or pharmacy permittee shall not accept the drug for return or exchange for the purpose of resale unless the pharmacist determines that:
1. The drug is in its original, manufacturer's, unopened container; and
  2. The drug or its container has not been subjected to contamination or deterioration.
- B.** The provisions of subsection (A) of this Section do not apply to a drug dispensed to:
1. A hospital inpatient as defined in R4-23-651; or
  2. A resident of a long-term care facility where a licensed health care professional administers the drug, and the pharmacist ensures and documents that the drug:
    - a. Has been stored in compliance with the requirements of the official compendium; and
    - b. Is not obviously contaminated or deteriorated.
- C.** After a person for whom a device is prescribed or the person's agent takes the device from the premises where sold, distributed, or dispensed, a pharmacist or pharmacy permittee shall not accept the device for return or exchange for the purpose of resale or reuse unless the pharmacist determines that:
1. The device is inspected and is free of defects;
  2. The device is rendered incapable of transferring disease; and
  3. The device, if resold or reused, is not claimed to be new or unused.

**Historical Note**

Adopted effective November 18, 1983 (Supp. 83-6).  
Amended by final rulemaking at 8 A.A.R. 1256, effective March 7, 2002 (Supp. 02-1).

**R4-23-410. Current Good Compounding Practices**

- A.** This Section establishes the current good compounding practices to be used by a pharmacist licensed by the Board, in a pharmacy permitted by the Board, and in compliance with applicable federal and state law governing the practice of pharmacy.
- B.** A pharmacy permittee shall ensure compliance with the provisions in this subsection.
1. All substances for compounding that are received, stored, or used by the pharmacy permittee:
    - a. Meet official compendium requirements;
    - b. Are of high quality, such as Chemically Pure (CP), Analytical Reagent (AR), certified American Chemical Society (ACS), or Food Chemical Codex (FCC) grade; or
    - c. Are obtained from a source that, in the professional judgment of the pharmacist, is acceptable and reliable.
  2. Before compounding a pharmaceutical product in excess of the quantity dispensed in anticipation of receiving valid prescriptions for the pharmaceutical product, a pharmacist, employed by the pharmacy permittee, shall establish a history of compounding valid prescriptions for the pharmaceutical product.
  3. Neither the pharmacy permittee nor a pharmacist employed by the pharmacy permittee provides a compounded pharmaceutical product to a pharmacy, medical practitioner, or other person for dispensing or distributing except that a compounded pharmaceutical product may be provided to a medical practitioner to administer to a patient of the medical practitioner if each container is accompanied by the written list required in subsection (I)(5) and has a label that includes the following:
    - a. The pharmacy's name, address, and telephone number;
    - b. The pharmaceutical product's name and the information required in subsection (I)(4);
    - c. A lot or control number;
    - d. A beyond-use-date based upon the pharmacist's professional judgment, but not more than the maximum guidelines recommended in the Pharmacy Compounding Practices chapter of the official compendium unless there is published or unpublished stability test data that shows a longer period is appropriate;
    - e. The statement "Not For Dispensing;" and
    - f. The statement "For Office or Hospital Administration Only."
- C.** A pharmacy permittee shall ensure compliance with the organization, training, and personnel issues in this subsection.
1. Before dispensing a compounded pharmaceutical product, a pharmacist:
    - a. Inspects and approves or rejects, or assumes responsibility for inspecting and approving or rejecting, components, pharmaceutical product containers and closures, in-process materials, and labeling;
    - b. Prepares or assumes responsibility for preparing all compounding records;
    - c. Reviews all compounding records to ensure that no errors occur in the compounding process;
    - d. Ensures the proper use, cleanliness, and maintenance of all compounding equipment; and
    - e. Documents by hand-written initials or signature in the compounding record the completion of the requirements of subsections (C)(1)(a), (b), (c), and (d).
  2. A pharmacist engaged in compounding:
    - a. Complies with the current good compounding practices and applicable state pharmacy laws;
    - b. Maintains compounding proficiency through current awareness, training, and continuing education; and
    - c. Ensures that personnel engaged in compounding wear:
      - i. Clean clothing appropriate to the work performed; and
      - ii. Protective apparel, such as coats, aprons, gowns, gloves or masks to protect the personnel from chemical exposure and prevent pharmaceutical product contamination.
- D.** A pharmacy permittee shall ensure the security, safety, and quality of a compounded pharmaceutical product by conforming with the following standards:
1. Implement procedures to exclude from direct contact with components, pharmaceutical product containers and closures, in-process materials, labeling, and pharmaceutical products, any person with an apparent illness or open lesion that may adversely affect the safety or quality of a

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compounded pharmaceutical product, until the illness or lesion, as determined by competent medical personnel, does not jeopardize the safety or quality of a compounded pharmaceutical product; and

2. Require all personnel to inform a pharmacist of any health condition that may adversely affect a compounded pharmaceutical product.
- E.** A pharmacy permittee shall provide compounding facilities that conform with the standards in this subsection.
1. In addition to the minimum area requirements of R4-23-609, R4-23-655, or R4-23-673, the compounding area:
    - a. Complies with the requirements in R4-23-611; and
    - b. Has sufficient space to permit efficient pharmacy practice, free movement of personnel, and visual surveillance by a pharmacist.
  2. If sterile pharmaceutical product or radiopharmaceutical product compounding is performed, the compounding area complies with the requirements of R4-23-670, R4-23-681, and R4-23-682.
  3. A clean, dry, and temperature-controlled area and, if required, a refrigerated area, in which to store properly labeled containers of bulk drugs, chemicals, and materials used in compounding, that complies with state statutes and rules.
- F.** To protect pharmaceutical product safety, identity, strength, quality, and purity, a pharmacy permittee shall ensure that equipment and utensils used in pharmaceutical product compounding are:
1. Of appropriate design, adequate size, and suitably located for proper operation, cleaning, and maintenance;
  2. Made of material that is not reactive, additive, or absorptive when exposed to components, in-process materials, or pharmaceutical products;
  3. Cleaned and protected from contamination before use;
  4. Inspected and determined suitable for use before initiation of compounding operations; and
  5. Routinely inspected, calibrated, or checked to make proper performance certain.
- G.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with procedures to prevent cross-contamination when pharmaceutical products that require special precautions to prevent cross-contamination, such as penicillin, are used in a compounding procedure. The procedures shall include either the dedication of equipment or the meticulous cleaning of contaminated equipment before its use in compounding other pharmaceutical products.
- H.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with control procedures for components and pharmaceutical product containers and closures, either written or electronically stored with printable documentation, that conform with the standards in this subsection.
1. Components and pharmaceutical product containers and closures are:
    - a. Stored off the floor,
    - b. Handled and stored to prevent contamination, and
    - c. Rotated so the oldest approved stock is used first.
  2. Container closure systems comply with official compendium standards.
  3. Pharmaceutical product containers and closures are clean and made of material that is not reactive, additive, or absorptive.
- I.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with pharma-

ceutical product compounding controls that conform with the standards in this subsection.

1. Pharmaceutical product compounding procedures are available in either written form or electronically stored with printable documentation:
  - a. To ensure that a finished pharmaceutical product has the identity, strength, quality, and purity it is purported or represented to possess, the procedures include, for each pharmaceutical product compounded, a description of:
    - i. The components, their manufacturer, lot number, expiration date, and amounts, the order of component addition, if applicable, and the compounding process;
    - ii. The equipment and utensils used; and
    - iii. The pharmaceutical product container and closure system proper for the sterility and stability of the pharmaceutical product as it is intended to be used.
  - b. To test the pharmaceutical product being compounded, the procedures monitor the output and validate the performance of compounding processes that may cause variability in the final pharmaceutical product, including assessing:
    - i. Dosage form weight variation;
    - ii. Adequacy of mixing to ensure uniformity and homogeneity; and
    - iii. Clarity, completeness, and pH of solutions, if applicable.
2. Components for pharmaceutical product compounding are accurately weighed, measured, or subdivided. To ensure that each weight, measure, or subdivision is correct as stated in the compounding procedures, a pharmacist:
  - a. Checks and rechecks, or assumes responsibility for checking and re-checking, the operations at each stage of the compounding process; and
  - b. Documents by hand-written initials or signature the completion and accuracy of the compounding process.
3. Compounding equipment and utensils are properly cleaned and maintained.
4. In addition to the labeling requirements of A.R.S. § 32-1968(D), the label contains:
  - a. A statement, symbol, designation, or abbreviation that the pharmaceutical product is a compounded pharmaceutical product, and
  - b. A beyond-use-date as specified in subsection (B)(3)(d).
5. A written list of the compounded pharmaceutical product's active ingredients is given to the patient at the time of dispensing.
6. When a component is removed from its original container and transferred to another container, the new container label contains, in full text or an abbreviated code system, the following:
  - a. The component name,
  - b. The manufacturer's or supplier's name,
  - c. The lot or control number,
  - d. The weight or measure,
  - e. The beyond-use-date as specified in subsection (B)(3)(d), and
  - f. The transfer date.

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**J.** A pharmacy permittee shall ensure that the pharmacist-in-charge stores any quantity of compounded pharmaceutical product produced in excess of the quantity dispensed in accordance with subsection (B):

1. In an appropriate container with a label that contains:
  - a. A complete list of components or the pharmaceutical product's name;
  - b. The preparation date;
  - c. The assigned lot or control number; and
  - d. A beyond-use-date as specified in subsection (B)(3)(d); and
2. Under conditions, dictated by the pharmaceutical product's composition and stability characteristics, that ensure its strength, quality, and purity.

**K.** A pharmacy permittee shall ensure that the pharmacist-in-charge establishes, implements, and complies with record-keeping procedures that comply with this subsection:

1. Pharmaceutical product compounding procedures and other records required by this Section are maintained by the pharmacy for not less than seven years, and
2. Pharmaceutical product compounding procedures and other records required by this Section are readily available for inspection by the Board or its designee.

**Historical Note**

Adopted effective August 5, 1997 (Supp. 97-3).  
Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4).

**R4-23-411. Pharmacist-administered or Intern-administered Immunizations**

**A.** Authorization to administer immunizations, vaccines, and emergency medications, as defined at A.R.S. § 32-1974(N), to an eligible adult patient or eligible minor patient. As used in this Section, "eligible adult patient" means an eligible patient 13 years of age or older and "eligible minor patient" means an eligible patient at least three years of age but less than 13 years of age. A pharmacist or an intern in the presence of and under the immediate personal supervision of a pharmacist may administer, without a prescription, immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient, if:

1. Both the pharmacist and intern meet the qualifications and standards specified by A.R.S. § 32-1974 and this Section;
2. The Board authorizes both the pharmacist and intern as specified in subsection (D);
3. For an eligible adult patient, the immunization or vaccine is:
  - a. Recommended for adults by the United States Centers for Disease Control and Prevention; or
  - b. Recommended by the United States Centers for Disease Control and Prevention's Health Information for International Travel;
4. For an eligible adult patient, the immunization or vaccine is not on the Arizona Department of Health Services list specified in A.A.C. R9-6-1301 as required under A.R.S. § 32-1974(I);
5. For an eligible minor patient, the immunization or vaccine is for influenza or a booster dose as described under A.R.S. § 32-1974(B)(2); and
6. For an eligible minor patient, any immunizations or vaccines other than influenza or a booster dose as described

under A.R.S. § 32-1974(B)(2) are administered in response to a public health emergency declared by the Governor under A.R.S. § 36-787.

**B.** A pharmacist or an intern in the presence of and under the immediate personal supervision of a pharmacist, may administer, with a prescription, any immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient, if:

1. Both the pharmacist and intern meet the qualifications and standards specified by A.R.S. § 32-1974 and this Section; and
2. The Board authorizes both the pharmacist and intern as specified in subsection (D).

**C.** A pharmacist or intern who is authorized to administer immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient shall:

1. Not delegate the authority to any other pharmacist, intern, or employee not specifically authorized by rule; and
2. Maintain their current certificate for inspection by the Board or its designee or review by the public.

**D.** Qualifications to administer immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient. After receipt of a completed application form, the Board shall authorize the administration of immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient by a pharmacist or intern who meets the following qualifications:

1. Has a current license to practice pharmacy in this state,
2. Successfully completes a training program specified in subsection (E), and
3. Has a current certificate in basic cardiopulmonary resuscitation.

**E.** Immunizations training program requirements. A training program for pharmacists or interns to administer immunizations, vaccines, and emergency medications to an eligible adult patient or eligible minor patient shall include the following courses of study:

1. Basic immunology and the human immune response;
2. Mechanics of immunity, adverse effects, dose, and administration schedule of available vaccines;
3. Response to an emergency situation as a result of the administration of an immunization, vaccine, or medication including administering an emergency medication to counteract the adverse effects of the immunization, vaccine, or medication given;
4. Administration of intramuscular injections;
5. Other immunization administration methods; and
6. Recordkeeping and reporting requirements specified in subsection (F).

**F.** Recordkeeping and reporting requirements.

1. A pharmacist or intern authorized under this Section to administer immunizations, vaccines, and emergency medications to an eligible patient shall provide to the pharmacy the following information and documentation regarding each immunization, vaccine, or emergency medication administered:
  - a. The name, address, and date of birth of the patient;
  - b. The date of administration and site of injection;
  - c. The name, dose, manufacturer's lot number, and expiration date of the vaccine, immunization, or emergency medication;
  - d. The name and address of the patient's identified primary-care provider or physician;

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- e. The name of the pharmacist or intern administering the immunization, vaccine, or emergency medication;
  - f. A record of the pharmacist's or intern's consultation with the patient determining that the patient is an eligible patient as defined in R4-23-110;
  - g. Consultation or other professional information provided to the patient by the pharmacist or intern;
  - h. The name and date of the immunization or vaccine information sheet provided to the patient; and
  - i. For an immunization or vaccine given to an eligible minor patient, a consent form signed by the minor's parent or guardian.
2. As required under A.R.S. § 32-1974(F)(1), the pharmacist or intern shall provide a written or electronic report to the patient's primary-care provider or physician containing the documentation required in subsection (F)(1)(a) through (d). The pharmacy shall document the time and date the report is sent and make the record of compliance with this subsection available in the pharmacy or on request, within 72 hours, for inspection by the Board or its designee.
3. A pharmacy's pharmacist-in-charge or permittee shall maintain the records required in subsection (F)(1) in the pharmacy or database for a minimum of seven years from the administration date.
- G.** Confidentiality of records. A pharmacist, intern, pharmacy permittee, or pharmacist-in-charge shall comply with applicable state and federal privacy statutes and rules when releasing patient health information.
- H.** Pharmacist-administered or intern-administered adult immunizations that require a prescription order. A pharmacist or intern authorized by the Board to administer adult immunizations or vaccines shall not administer any immunization or vaccine listed in A.A.C. R9-6-1301 without a prescription order. In addition to filing a prescription order as required in A.R.S. § 32-1964, a pharmacist or pharmacy intern who administers an immunization or vaccine listed in A.A.C. R9-6-1301 shall comply with the recordkeeping requirements of subsection (F)(1).

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3967, effective November 13, 2004 (Supp. 04-3).  
 Amended by final rulemaking at 12 A.A.R. 279, effective March 11, 2006 (Supp. 06-1). Amended by final rulemaking at 14 A.A.R. 3674, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 15 A.A.R. 1930, effective November 3, 2009 (Supp. 09-4).  
 Amended by final rulemaking at 17 A.A.R. 2596, effective February 4, 2012 (Supp. 11-4). Amended by final rulemaking at 23 A.A.R. 211, effective March 5, 2017 (Supp. 17-1). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 28 A.A.R. 994 (May 13, 2022), effective July 2, 2022 (Supp. 22-2).

**R4-23-412. Emergency Refill Prescription Dispensing**

- A.** When a state of emergency is declared under A.R.S. § 32-1910(A) or (B) and the state of emergency results in individuals being unable to refill existing prescriptions, a pharmacist may work in the affected county, city, or town and may dispense a one-time emergency refill prescription of up to a 30-

day supply of a prescribed medication to an affected individual if both of the following apply:

1. In the pharmacist's professional opinion the medication is essential to the maintenance of life or to the continuation of therapy, and
  2. The pharmacist makes a good faith effort to reduce the information to a written prescription marked "emergency prescription" and files and maintains the prescription as required by law.
- B.** If the state of emergency declared under A.R.S. § 32-1910(A) or (B) continues for at least 21-days after the pharmacist dispenses an emergency prescription under subsection (A), the pharmacist may dispense one additional emergency refill prescription of up to a 30-day supply of the prescribed medication if the pharmacist complies with subsection (A)(2).
- C.** A pharmacist's authority to dispense emergency prescriptions under this Section ends when the declared state of emergency is terminated.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

**R4-23-413. Temporary Recognition of Nonresident Licensure**

- A.** When a state of emergency is declared under A.R.S. § 32-1910(A) or (B):
1. A pharmacist who is not licensed in this state, but who is currently licensed in another state, may dispense prescription medications in those affected counties, cities, or towns in this state during the time that a declared state of emergency exists under A.R.S. § 32-1910(A) or (B) if both of the following apply:
    - a. The pharmacist provides proof of current licensure in another state, and
    - b. The pharmacist is engaged in a relief effort during a state of emergency.
  2. Acting under the direct supervision of a pharmacist, a pharmacy technician or pharmacy intern not licensed in this state, but currently licensed or registered in another state, may assist a pharmacist in dispensing prescription medications in affected counties, cities, or towns in this state during the time that a declared state of emergency exists under A.R.S. § 32-1910(A) or (B) if both of the following apply:
    - a. The pharmacy technician or pharmacy intern provides proof of current licensure or registration in another state, and
    - b. The pharmacy technician or pharmacy intern is engaged in a relief effort during a state of emergency.
- B.** The recognition of nonresident licensure or registration shall end with the termination of the declared state of emergency.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

**R4-23-414. Reserved****R4-23-415. Impaired Licensees – Treatment and Rehabilitation**

- A.** The Board may contract with qualified organizations to operate a program for the treatment and rehabilitation of licensees impaired as the result of alcohol or other drug abuse, pursuant to A.R.S. § 32-1932.01.

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- B.** Participants in the program are either “confidential” or “known.” Confidential participants are self-referred and may remain unidentified to the Board, subject to maintaining compliance with their program contract. Known participants are under Board order to complete a minimum tenure in the program. After a known participant completes the minimum tenure, the Board may terminate the Board order and reinstate the participant’s license to practice pharmacy.
- C.** The program contract with a qualified organization shall include as a minimum the following:
1. Duties and responsibilities of each party.
  2. Duration, not to exceed two years, of contract and terms of compensation.
  3. Quarterly reports from the program administrator to the Board indicating:
    - a. Identity of participants;
      - i. By name, if a known participant; or
      - ii. By case number, if a confidential participant;
    - b. Status of each participant, including;
      - i. Clinical findings;
      - ii. Diagnosis and treatment recommendations;
      - iii. Program activities; and
      - iv. General recovery and rehabilitation program information.
  4. The program administrator shall report immediately to the Board the name of any impaired licensee who poses a danger to self or others.
  5. The program administrator shall report to the Board, as soon as possible, the name of any impaired licensee:
    - a. Who refuses to submit to treatment,
    - b. Whose impairment is not substantially alleviated through treatment, or
    - c. Who violates the terms of their contract.
  6. The program administrator shall periodically provide informational programs to the profession, including approved continuing education programs on the topic of drug and chemical impairment, treatment, and rehabilitation.
- D.** Under A.R.S. § 32-1903(F), the Board may publish the names of participants under current Board orders.
- E.** The Board or its executive director may request the treatment records for any participant. The program administrator shall provide treatment records within 10 working days of receiving a written request from the Board or its executive director for such records. Upon request of the program administrator or the Board or its executive director, a program participant shall authorize a drug and alcohol treatment facility or program or a private practitioner or treatment program to release the participant’s records to the program administrator or the Board or its executive director.
- F.** On the recommendation of the program administrator or a Board member and by mutual consent, the program administrator, Board member, Board staff, and program participant may meet informally to discuss program compliance.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 467, effective January 4, 2000 (Supp. 00-1). Amended by final rulemaking at 14 A.A.R. 3611, effective November 8, 2008 (Supp. 08-3).

**R4-23-416. Reserved****R4-23-417. Reserved****R4-23-418. Reserved****R4-23-419. Reserved****R4-23-420. Reserved****R4-23-421. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-422. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-423. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-424. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-425. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-426. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-427. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-428. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

**R4-23-429. Repealed****Historical Note**

New Section made by final rulemaking at 8 A.A.R. 4052, effective November 9, 2002 (Supp. 02-3). Section

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repealed by final rulemaking at 17 A.A.R. 2600, effective February 4, 2012 (Supp. 11-4).

### ARTICLE 5. CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM

*New Article 5, consisting of Sections R4-23-501 through R4-23-505, made effective August 2, 2014 (Supp. 14-2).*

*Article 5, consisting of Sections R4-23-501 through R4-23-505, expired effective August 30, 2013 (Supp. 14-1).*

*Article 5, consisting of Sections R4-23-501 and R4-23-502, recodified to Article 8 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).*

*New Article 5, consisting of Sections R4-23-501 through R4-23-505, made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).*

#### R4-23-501. Controlled Substances Prescription Monitoring (CSPMP) Program Registration and Database Access

- A. Under A.R.S. § 36-2606, a medical practitioner who is issued a license under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 21, 25, or 29 and possesses a current DEA registration under the Federal Controlled Substances Act shall have a current CSPMP registration issued by the Board.
- B. Application.
  1. An applicant for CSPMP registration shall:
    - a. Submit a completed application for CSPMP registration electronically or manually on a form furnished by the Board, and
    - b. Submit with the application form the documents specified in the application form.
  2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.
- C. Registration. Within seven business days of receipt of a completed application specified in subsection (B), the Board office shall determine whether an application is complete. If the application is complete, the Board office shall issue a registration number and provide a current registration certificate to the applicant by mail or electronic transmission. If the application is incomplete, the Board office shall issue a written notice of incompleteness. An applicant with an incomplete application shall comply with the requirements of R4-23-202(F).
- D. Registration renewal. As specified in A.R.S. § 36-2606(C), the Board shall automatically suspend the registration of any registrant that fails to renew the registration on or before May 1 of the year in which the renewal is due. The Board shall vacate a suspension if the registrant submits a renewal application. A suspended registrant with CSPMP database access credentials is prohibited from accessing information in the prescription monitoring program database.
- E. CSPMP database access.
  1. A medical practitioner that chooses to use the CSPMP database shall request access from the CSPMP Director by completing an access user registration form electronically. Upon receipt of the access user registration form, the CSPMP Director or designee shall issue access credentials provided the medical practitioner is in compliance with the registration requirements of this Section.
  2. A pharmacist that chooses to use the CSPMP database shall request access from the CSPMP Director by completing an access user registration form electronically. Upon receipt of the access user registration form, the CSPMP Director or designee shall issue access creden-

tials provided the pharmacist has a current active pharmacist license.

3. A medical practitioner or pharmacist who is not licensed in Arizona may request access from the CSPMP Director by:
  - a. Completing an access user registration form electronically;
  - b. Printing the access user registration form;
  - c. Having the access user registration form signed and notarized; and
  - d. Mailing the notarized access user form along with a current copy of the applicant's nonresident state license and driver's license. Upon receipt of the notarized access user registration form and other required documents, the CSPMP Director or designee shall issue access credentials provided the nonresident licensed medical practitioner or pharmacist credentials show an current active license in another state.

#### Historical Note

Former Rule 5.2110; Amended effective August 9, 1983 (Supp. 83-4). Amended by final rulemaking at 8 A.A.R. 4898, effective January 5, 2003 (Supp. 02-4). Recodified to R4-23-801 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Amended by final rulemaking at 19 A.A.R. 94, effective March 10, 2013 (Supp. 13-1). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

#### R4-23-502. Requirements for Data Format and Transmission

- A. Each dispenser shall submit to the Board or its designee by electronic means information regarding each prescription dispensed for a controlled substance listed in Schedules II, III, and IV of A.R.S. Title 36, Chapter 27, the Arizona Uniform Controlled Substances Act. The information reported shall conform to the August 31, 2005 Version 003, Release 000 ASAP Rules-based Standard Implementation Guide for Prescription Monitoring Programs published by the American Society for Automation in Pharmacy as specified in A.R.S. § 36-2608(B). The information submitted for each prescription shall include:
  1. The name, address, telephone number, prescription number, and DEA registration number of the dispenser;
  2. The name, address, gender, date of birth, and telephone number of the person or, if for an animal, the owner of the animal for whom the prescription is written;
  3. The name, address, telephone number, and DEA registration number of the prescribing medical practitioner;
  4. The quantity and National Drug Code (NDC) number of the Schedule II, III, or IV controlled substance dispensed;
  5. The date the prescription was dispensed;
  6. The number of refills, if any, authorized by the medical practitioner;
  7. The date the prescription was issued;
  8. The method of payment identified as cash or third party; and
  9. Whether the prescription is new or a refill.
- B. A dispenser shall submit the required information electronically unless the Board or its designee approves a waiver as specified in subsection (D).

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- C. A dispenser's electronic data transfer equipment including hardware, software, and internet connections shall meet the privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and A.R.S. § 12-2292, in addition to common internet industry standards for privacy and security. A dispenser shall ensure that each electronic transmission meets the following data protection requirements:
  - 1. Data shall be at least 128-bit encryption in transmission and at rest; and
  - 2. Data shall be transmitted via secure e-mail, telephone modem, diskette, CD-ROM, tape, secure File Transfer Protocol (FTP), Virtual Private Network (VPN), or other Board-approved media.
- D. A dispenser who does not have an automated recordkeeping system capable of producing an electronic report in the Board established format may request a waiver from electronic reporting by submitting a written request to the Board or its designee. The Board or its designee shall grant the request if the dispenser agrees in writing to report the data by submitting a completed universal claim form supplied by the Board or its designee.
- E. Unless otherwise approved by the Board, a dispenser shall report by the close of business on each Friday the required information for the previous week, Sunday through Saturday. If a Friday falls on a state holiday, the dispenser shall report the information on the following business day. The Board or its designee may approve a less frequent reporting period if a dispenser makes a showing that a less frequent reporting period will not reduce the effectiveness of the system or jeopardize the public health.
- 3. A professional licensing board established under A.R.S. Title 32, Chapter 7, 11, 13, 14, 15, 16, 17, 18, 21, 25, or 29. Except as required under subsection (B), the Board or its designee shall provide this information only if the requesting board states in writing that the information is necessary for an open investigation or complaint;
- 4. A local, state, or federal law enforcement or criminal justice agency. Except as required under subsection (B), the Board or its designee shall provide this information only if the requesting agency states in writing that the information is necessary for an open investigation or complaint;
- 5. The Arizona Health Care Cost Containment System Administration regarding individuals who are receiving services under A.R.S. Title 36, Chapter 29. Except as required under subsection (B), the Board or its designee shall provide this information only if the Administration states in writing that the information is necessary for an open investigation or complaint;
- 6. A person serving a lawful order of a court of competent jurisdiction;
- 7. A person who is authorized to prescribe or dispense a controlled substance and who performs an evaluation on an individual under A.R.S. § 23-1026; and
- 8. The Board staff for purposes of administration and enforcement of A.R.S. Title 36, Chapter 28 and this Article.
- D. The Board or its designee may provide data to public or private entities for statistical, research, or educational purposes after removing information that could be used to identify individual patients or persons who received prescriptions from dispensers.

**Historical Note**

Former Rule 5.2510. Amended by final rulemaking at 8 A.A.R. 4898, effective January 5, 2003 (Supp. 02-4). Recodified to R4-23-802 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-503. Access to Controlled Substances Prescription Monitoring Program Data**

- A. Except as provided in A.R.S. § 36-2604(B) and (C) and this Section, prescription information submitted to the Board or its designee is confidential and is not subject to public inspection.
- B. The Board or its designee shall review the prescription information collected under A.R.S. Title 36, Chapter 28 and R4-23-502. If the Board or its designee has reason to believe an act of unprofessional or illegal conduct has occurred, the Board or its designee shall notify the appropriate professional licensing board or law enforcement or criminal justice agency and provide the prescription information required for an investigation.
- C. The Board or its designee is authorized to release data collected by the program to the following:
  - 1. A person who is authorized to prescribe or dispense a controlled substance to assist that person to provide medical or pharmaceutical care to a patient or to evaluate a patient;
  - 2. An individual who requests the individual's own controlled substance prescription information under A.R.S. § 12-2293;

**Historical Note**

Former Rules 5.3500, 5.3520, 5.3540, 5.3550, 5.3560, 5.3570, 5.3580, 5.3590, 5.4110, and 5.6110; Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-504. Computerized Central Database Tracking System Task Force**

- A. The Board shall appoint a task force to help it administer the computerized central database tracking system as specified in A.R.S. § 36-2603.
- B. The Task Force shall meet at least once each year and at the call of the chairperson to establish the procedures and conditions relating to the release of prescription information specified in A.R.S. § 36-2604 and R4-23-503.
- C. The Task Force shall determine:
  - 1. The information to be screened;
  - 2. The frequency and thresholds for screening; and
  - 3. The parameters for using the information to notify medical practitioners, patients, and pharmacies to educate and provide for patient management and treatment options.
- D. The Board shall review and approve the procedures and conditions established by the Task Force as needed but at least once every calendar year.

**Historical Note**

Former Rule 5.7010; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3).

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Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-505. Reports**

- A. Before releasing prescription monitoring program data, the Board or its designee shall receive a written or electronic request for controlled substance prescription information.
- B. A person authorized to access CSPMP data under R4-23-503(C)(1) through (7) shall submit a written or electronic request that:
  1. Specifies the information requested for the report;
  2. For a medical practitioner, provides a statement that the report's purpose is to provide medical or pharmaceutical care to a patient or to evaluate a patient;
  3. For an individual obtaining the individual's own controlled substance prescription information, provides a form of non-expired government-issued photo identification;
  4. For a professional licensing board, states that the information is necessary for an open investigation or complaint;
  5. For a local, state, or federal law enforcement or criminal justice agency, states that the information is necessary for an open investigation or complaint;
  6. For the AHCCCS Administration, states that the information is necessary for an open investigation or complaint; and
  7. For a person serving a lawful order of a court of competent jurisdiction, provides a copy of the court order.
- C. The Board or its designee may provide reports through U.S. mail, other common carrier, facsimile, or secured electronic media or may allow reports to be picked up in-person at the Board office.

**Historical Note**

Former Rules 5.7100, 5.8100, 5.8500, 5.9100, and 5.9500; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective August 2, 1982 (Supp. 82-4). New Section made by final rulemaking at 14 A.A.R. 3410, effective October 4, 2008 (Supp. 08-3). Section expired under A.R.S. § 41-1056(J) at 20 A.A.R. 133, effective August 30, 2013 (Supp. 14-1). New Section made by final rulemaking at 20 A.A.R. 1359, effective August 2, 2014 (Supp. 14-2).

**R4-23-506. Repealed****Historical Note**

Adopted effective December 3, 1974 (Supp. 75-1).  
Repealed effective August 24, 1992 (Supp. 92-3).

**ARTICLE 6. PERMITS AND DISTRIBUTION OF DRUGS****R4-23-601. General Provisions**

- A. Permit required to sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical. A person shall have a current Board permit to:
  1. Sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical in Arizona; or
  2. Sell a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical from outside Arizona and ship the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona.
- B. A medical practitioner is exempt from subsection (A) to administer a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical for the emergency needs of a patient.
- C. Permit fee. Permits are issued biennially on an odd- and even-year expiration based on the assigned permit number. The fee, specified in R4-23-205, is not refundable unless the Board fails to comply with the permit time frames established in R4-23-602.
- D. Record of receipt and disposal of narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.
  1. Every person manufacturing a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, including repackaging or relabeling, shall prepare and retain for no fewer than three years the manufacturing, repackaging, or relabeling date for each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical.
  2. Every person receiving, selling, delivering, or disposing of a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical shall record and retain for no fewer than three years the following information:
    - a. The name, strength, dosage form, and quantity of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical received, sold, delivered, or disposed;
    - b. The name, address, and license or permit number, if applicable, of the person from whom each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is received;
    - c. The name, address, and license or permit number, if applicable, of the person to whom each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is sold or delivered, or of the person who disposes of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
    - d. The receipt, sale, deliver, or disposal date of each narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical.
  3. The record required in this subsection shall be available for inspection by the Board or its compliance officer during regular business hours.
  4. If the record required in this subsection is stored in a centralized recordkeeping system and not immediately available for inspection, a permittee, manager, or pharmacist-in-charge shall provide the record within four working days of the Board's or its compliance officer's request.
- E. Narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals damaged by water, fire, or from human or animal consumption or use. A person shall not sell or offer



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to sell any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical damaged by water, fire, or from human or animal consumption or use.

- F. At least 14 days before there is a change in ownership, as defined at R4-23-110, of a license or permit issued under this Chapter, the new licensee or permittee shall apply to the Board for a new license or permit.

**Historical Note**

Former Rules 6.1100, 6.1200, 6.1300, 6.1400, and 6.1500. Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (C) effective August 9, 1983 (Supp. 83-4). Amended subsection (C) effective August 12, 1988 (Supp. 88-3). Amended by final rulemaking at 6 A.A.R. 4656, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-602. Permit Application Process and Time frames**

- A. A person applying for a permit shall:
1. Submit a completed application for the desired permit electronically or manually on a form furnished by the Board, and
  2. Submit with the application form:
    - a. The documents specified in the application form, and
    - b. The permit fee specified in R4-23-205.
- B. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.
- C. Time frames for permits.
1. The Board office shall finish an administrative completeness review within 60 days from the date the application form is received.
    - a. The Board office shall issue a written notice of administrative completeness to the applicant if no deficiencies are found in the application form.
    - b. If the application form is incomplete, the Board office shall provide the applicant with a written notice that includes a comprehensive list of the missing information. The 60-day time frame for the Board office to finish the administrative completeness review is suspended from the date the notice of incompleteness is served until the applicant provides the Board office with all missing information.
    - c. If the Board office does not provide the applicant with written notice regarding administrative completeness, the application form shall be deemed complete 60 days after receipt by the Board office.
  2. An applicant with an incomplete application form shall submit to the Board office all of the missing information within 90 days of service of the notice of incompleteness.
    - a. If an applicant cannot submit all missing information within 90 days of service of the notice of incompleteness, the applicant may send a written request for an extension to the Board office postmarked or delivered no later than 90 days from service of the notice of incompleteness;
    - b. The written request for an extension shall document the reasons the applicant is unable to meet the 90-day deadline; and
  3. If an applicant fails to submit a complete application form within the time allowed, the Board office shall close the applicant's file. An applicant whose file is closed and who later wishes to obtain a permit shall submit a new application and fee as specified in subsection (A).
  4. For a nonprescription drug permit applicant, a compressed medical gas distributor permit applicant, and a durable medical equipment and compressed medical gas supplier permit applicant, the Board office shall issue a permit on the day the Board office determines an administratively complete application form is received.
  5. Except as described in subsection (C)(4), from the date on which the administrative completeness review of an application form is finished, the Board office shall complete a substantive review of the applicant's qualifications in no more than 120 days.
    - a. If an applicant is found to be ineligible, the Board office shall issue a written notice of denial to the applicant.
    - b. If an applicant is found to be eligible, the Board office shall recommend to the Board that the applicant be issued a permit. Upon receipt of the Board office's recommendation, the Board shall either issue a permit to the applicant or if the Board determines the applicant does not meet eligibility requirements, return the matter to the Board office.
    - c. If the Board office finds deficiencies during the substantive review of the application form, the Board office shall issue a written request to the applicant for additional documentation.
    - d. The 120-day time frame for a substantive review for the issuance or denial of a permit is suspended from the date of the written request for additional documentation until the date all documentation is received. The applicant shall submit the additional documentation according to subsection (C)(2).
    - e. If the applicant and the Board office mutually agree in writing, the 120-day substantive review time frame may be extended once for no more than 45 days.
  6. For the purpose of A.R.S. § 41-1072 et seq., the Board establishes the following time frames for permits:
    - a. Administrative completeness review time frame: 60 days.
    - b. Substantive review time frame:
      - i. Nonprescription drug permit, compressed medical gas distributor permit, and durable medical equipment and compressed medical gas supplier permit: none.
      - ii. Except as described in subsection (C)(6)(b)(i): 120 days.
    - c. Overall time frame:
      - i. Nonprescription drug permit, compressed medical gas distributor permit, and durable medical

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- equipment and compressed medical gas supplier permit: 60 days.
- ii. Except as described in subsection (C)(6)(c)(i): 180 days.

**D. Permit renewal.**

1. To renew a permit, a permittee shall submit a completed application for permit renewal electronically or manually on a form furnished by the Board with the biennial renewal fee specified in R4-23-205.
2. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1931, the permit is suspended. The permittee shall pay a penalty as provided in A.R.S. § 32-1931 and R4-23-205 to vacate the suspension.
3. Time frames for permit renewals. The Board office shall follow the time frames established in subsection (C).

**E. Display of permit.** A permittee shall conspicuously display the permit in the location to which it applies.**Historical Note**

Former Rules 6.2100, 6.2200, 6.2300, 6.2400, 6.2500, 6.2600, 6.2610, 6.2620, 6.2630, 6.2640, and 6.2650.  
 Amended effective August 10, 1978 (Supp. 78-4).  
 Amended effective August 9, 1983 (Supp. 83-4).  
 Repealed effective August 12, 1988 (Supp. 88-3). New Section adopted effective August 5, 1997 (Supp. 97-3).  
 Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-603. Resident-Nonprescription Drugs, Retail**

- A. Permit.** A person, including the following, shall not sell or distribute a nonprescription drug without a current Board-issued permit:
1. A grocer;
  2. Other non-pharmacy retail outlet; or
  3. Mobile or non-fixed location retailer, such as a swap-meet vendor.
- B.** A medical practitioner licensed under A.R.S. Title 32 is exempt from the requirements of subsection (A).
- C. Application.** To obtain a permit to sell a nonprescription drug, a person shall submit:
1. A completed application form and fee as specified in R4-23-602; and
  2. Documentation of compliance with local zoning laws, if required by the Board.
- D. Drug sales.** A nonprescription drug permittee:
1. Shall sell a drug only in the original container packaged and labeled by the manufacturer; and
  2. Shall not package, repack, label, or relabel any drug.
- E. Inspection.** A nonprescription drug permittee shall consent to inspection during business hours by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
- F. Quality control.** A nonprescription drug permittee shall:
1. Ensure that all drugs stocked, sold, or offered for sale are:
    - a. Kept clean;
    - b. Protected from contamination, excessive heat, cold, sunlight, and other deteriorating factors;
    - c. In compliance with federal law; and
    - d. Received from a supplier with a current Board-issued permit as specified in R4-23-601(A).
  2. Develop and implement a program to ensure that:

- a. Any expiration-dated drug is reviewed regularly;
- b. Any drug, that exceeds its expiration date, is deteriorated or damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
- c. Any quarantined drug is destroyed or returned to its source of supply.

**G. Notification.** A nonprescription drug permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, e-mail or mailing address, or business name.**H. Change of ownership.** A nonprescription drug permittee shall comply with R4-23-601(F).**I. Relocation.** No less than 30 days before an existing nonprescription drug permittee relocates, the permittee shall submit a completed application for relocation electronically or manually on a form furnished by the Board, and the documentation required in subsection (C).**J. Records.** A nonprescription drug permittee shall:

1. Retain records of the receipt and disposal of nonprescription drugs as required in R4-23-601(D), and
2. Comply with the requirements of A.R.S. § 32-1977 and federal law for the retail sale of methamphetamine precursors.

**K. Permit renewal.** To renew a nonprescription drug permit, the permittee shall comply with R4-23-602(D).**L. Nonprescription drug vending machine outlet.** In addition to the requirements of R4-23-601, R4-23-602, and subsections (A) through (K), a person selling or distributing a nonprescription drug in a vending machine shall comply with the following requirements:

1. Each individual vending machine is considered an outlet and shall have a Board-issued nonprescription drug permit;
2. Each nonprescription-drug-permitted vending machine shall display in public view an identification seal, furnished by the Board, containing the permit number, vending machine's serial number, owner's name, and telephone contact number;
3. Each nonprescription-drug-permitted vending machine is assigned a specific location that is within a weather-tight structure, protected from direct sunlight, and maintained at a temperature not less than 59° F and not greater than 86° F;
4. Each nonprescription drug sold in a vending machine is packaged and labeled in the manufacturer's original FDA-approved container;
5. A nonprescription-drug-permitted vending machine is subject to inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901 as follows:
  - a. The owner, manager, or other staff of the nonprescription drug permittee shall provide access to the contents of the vending machine within 24 hours of a request from a Board compliance officer or other authorized officer of the law; or
  - b. The Board compliance staff shall have independent access to the vending machine;
6. Before relocating or retiring a nonprescription-drug-permitted vending machine, the owner or manager shall notify the Board in writing. The notice shall include:
  - a. Permit number;
  - b. Vending machine's serial number;

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- c. Action planned (relocate or retire); and
- d. If retiring a vending machine, the disposition of the nonprescription drug contents of the vending machine;
- 7. The sale or distribution of a precursor chemical or regulated chemical in a vending machine is prohibited; and
- 8. Under no circumstance may expired drugs be sold or distributed.

**Historical Note**

Adopted effective August 10, 1978 (Supp. 78-4).  
 Amended subsection (D) paragraph (1) and added subsection (G) effective April 20, 1982 (Supp. 82-2).  
 Amended effective August 12, 1988 (Supp. 88-3).  
 Amended effective February 8, 1991 (Supp. 91-1).  
 Amended effective August 5, 1997 (Supp. 97-3).  
 Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-604. Resident Drug Manufacturer**

- A.** Permit. A person shall not manufacture, package, repack, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical without a current Board-issued drug manufacturer permit.
- B.** Application. To obtain a permit to operate a drug manufacturing firm in Arizona, a person shall submit a completed application, on a form furnished by the Board, and the fee specified in R4-23-205.
- C.** Before issuing a drug manufacturer permit, the Board shall:
  - 1. Receive and approve a completed permit application;
  - 2. Interview the applicant and manager, if different from the applicant, at a Board meeting; and
  - 3. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer.
- D.** Notification. A resident drug manufacturer permittee shall notify the Board of changes involving the drug list, address, telephone number, business name, or manager, including manager's telephone number. The resident drug manufacturer permittee shall submit using the permittee's online profile or a written notice by mail, fax, or e-mail to the Board office within 24 hours of the change.
- E.** Change of ownership. A resident drug manufacturer permittee shall comply with R4-23-601(F).
- F.** Before an existing resident drug manufacturer permittee relocates, the drug manufacturer permittee shall submit the application packet described in subsection R4-23-604(B), excluding the fee. The facility at the new location shall pass a final inspection by a Board compliance officer before operations begin.
- G.** No later than 14 days after the change occurs, a resident drug manufacturer permittee shall submit the application described under subsection R4-23-604(B), excluding the fee, for any change of officers in a corporation.
- H.** Manufacturing and distribution.
  - 1. A drug manufacturer permittee shall manufacture and distribute a drug only:
    - a. To a pharmacy, drug manufacturer, or full-service or nonprescription drug wholesaler currently permitted by the Board;

- b. To a medical practitioner currently licensed as a medical practitioner as defined in A.R.S. § 32-1901; or
- c. To a properly permitted, registered, licensed, or certified person or firm of another jurisdiction.
- 2. Before manufacturing and distributing a drug that is not listed on a drug manufacturer's permit application, the drug manufacturer permittee shall send to the Board office a written request to amend the permit application, including documentation of FDA approval to manufacture the drug not listed on the original permit application. If a request to amend a permit application includes the documentation required in this subsection, the Board or its designee shall approve the request to amend within 30 days of receipt.
- I.** A drug manufacturer permit is subject to denial, suspension, probation, or revocation under A.R.S. § 32-1927.02.
- J.** Current Good Manufacturing Practice. A drug manufacturer permittee is required under federal law to follow the good manufacturing practice requirements of 21 CFR 210 through 211.
- K.** Records. A drug manufacturer permittee shall:
  - 1. Establish and implement written procedures for maintaining records pertaining to production, process control, labeling, packaging, quality control, distribution, complaints, and any information required by federal or state law;
  - 2. Retain the records required by this Article and 21 CFR 210 through 211 for at least two years after distribution of a drug or one year after the expiration date of a drug, whichever is longer; and
  - 3. Make the records required by this Article and 21 CFR 210 through 211 available within 48 hours for review by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
- L.** Inspections. A drug manufacturer permittee shall make the drug manufacturer's facility available for inspection by the Board or its compliance officer under A.R.S. § 32-1904.
- M.** Nonresident drug manufacturer. A nonresident drug manufacturer shall comply with the requirements of R4-23-607.
- N.** Manufacturing radiopharmaceuticals. Before manufacturing a radiopharmaceutical, a drug manufacturer permittee shall:
  - 1. Comply with the regulatory requirements of the Arizona Radiation Regulatory Agency, the U.S. Nuclear Regulatory Commission, the FDA, and this Section; and
  - 2. Hold a current Arizona Radiation Regulatory Agency Radioactive Materials License. If a drug manufacturer permittee who manufactures radiopharmaceuticals fails to maintain a current Arizona Radiation Regulatory Agency Radioactive Materials License, the permittee's drug manufacturer permit shall be immediately suspended pending a hearing by the Board.

**Historical Note**

Former Rules 6.4001, 6.4002, 6.4003, 6.4004, 6.4005, 6.4006, 6.4007, 6.4008, 6.4009, 6.4100, 6.4110, 6.4111, 6.4115, 6.4116, 6.4120, 6.4122, 6.4190, 6.4191, 6.4200, 6.4250, 6.4300, 6.4350, 6.4355, 6.4360, 6.4400, 6.4401, 6.4403, 6.4410, 6.4430, 6.4450, 6.4500, 6.4510, 6.4530, 6.4533, 6.4600, 6.4610, 6.4640, 6.4660, 6.4700, 6.4710, and 6.4750. Adopted effective December 3, 1974 (Supp. 75-1). Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (B) paragraph (2) effective April 20, 1982 (Supp. 82-2). Amended subsections (B), (G), (K) and (L) effective August 12, 1988 (Supp. 88-3).

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Amended effective August 24, 1992 (Supp. 92-3).

Amended effective November 1, 1993 (Supp. 93-4).

Amended by final rulemaking at 7 A.A.R. 3815, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 19 A.A.R. 702, effective June 1, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-605. Resident Drug Wholesaler Permit**

- A.** Permit. A person shall not operate a business or firm for the wholesale distribution of any drug, device, precursor chemical, or regulated chemical without a current Board-issued full-service or nonprescription drug wholesale permit.
- B.** Application.
  - 1. To obtain a permit to operate a full-service or nonprescription drug wholesale firm in Arizona, a person shall submit a completed application, on a form furnished by the Board, and the fee specified in R4-23-205.
  - 2. Before issuing a full-service or nonprescription drug wholesale permit, the Board shall:
    - a. Receive and approve a completed permit application;
    - b. Interview the applicant and the designated representative, if different from the applicant, at a Board meeting;
    - c. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer; and
    - d. For a full-service drug wholesale permit, issue a fingerprint clearance to a qualified designated representative, as specified in subsection (L). If the fingerprint clearance of a designated representative for a full-service drug wholesale permit applicant is denied, the full-service drug wholesale permit applicant shall appoint another designated representative and submit the documentation, fingerprints, and fee specified in the application required in subsection (B).
- C.** Notification. A resident full-service or nonprescription drug wholesale permittee shall notify the Board of changes involving the type of drugs sold or distributed, address, telephone number, business name, or manager or designated representative, including the manager's or designated representative's telephone number.
  - 1. The resident full-service or nonprescription drug wholesale permittee shall submit using the permittee's online profile or a written notice by mail, fax, or e-mail to the Board office within 10 days of the change.
  - 2. For a change of designated representative, a resident full-service drug wholesale permittee shall submit the documentation, fingerprints, and fee specified in the application required in subsection (B).
- D.** Change of ownership. A resident full-service or nonprescription drug wholesale permittee shall comply with R4-23-601(F).
- E.** Before an existing resident full-service or nonprescription drug wholesaler permittee relocates, the resident full-service or nonprescription drug wholesaler permittee shall submit the application required under subsection (B), excluding the fee. The facility at the new location shall pass a final inspection by a Board compliance officer before operations begin.
- F.** No later than 14 days after the change occurs, a resident full-service or nonprescription drug wholesale permittee shall sub-

mit the application described under subsection (B), excluding the fee, for any change of officers in a corporation.

- G.** Distribution restrictions. In addition to the requirements of this subsection, a resident full-service wholesale permittee shall comply with the distribution restrictions specified in A.R.S. § 32-1983.

- 1. Records.

- a. A full-service drug wholesale permittee shall:

- i. Maintain records to ensure full accountability of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical including dates of receipt and sales, names, addresses, and DEA registration numbers, if required, of suppliers or sources of merchandise, and customer names, addresses, and DEA registration numbers, if required;
    - ii. File the records required in subsection (G)(1)(a)(i) in a readily retrievable manner for a minimum of three years;
    - iii. Make the records required in subsection (G)(1)(a)(i) available upon request during regular business hours for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5). Records kept at a central location apart from the business location and not electronically retrievable shall be made available within two business days; and
    - iv. In addition to the records requirements of subsection (G)(1)(a)(i), comply with the retention of track and trace documents required under the Drug Supply Chain and Security Act for all prescription-only drugs that leave the normal distribution channel as defined in A.R.S. § 32-1981.

- b. A nonprescription drug wholesale permittee shall:

- i. Maintain records to ensure full accountability of any nonprescription drug, precursor chemical, or regulated chemical including dates of receipt and sales, names, addresses, and DEA registration numbers, if required, of suppliers or sources of merchandise, and customer names, addresses, and DEA registration numbers, if required;
    - ii. File the records required in subsection (G)(1)(b)(i) in a readily retrievable manner for a minimum of three years; and
    - iii. Make the records required in subsection (G)(1)(b)(i) available upon request during regular business hours for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5). Records kept at a central location apart from the business location and not electronically retrievable shall be made available within two business days.

- 2. Drug sales.

- a. A full-service drug wholesale permittee shall:

- i. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemi-

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- cal, except in the original container packaged and labeled by the manufacturer or repackager;
- ii. Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;
- iii. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, or prescription-only drug or device, to anyone except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- iv. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical, to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- v. Provide track and trace documents required under the Drug Supply Chain and Security Act upon request, if immediately available, or within two business days from the date of a request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901;
- vi. Maintain a copy of the current permit or license of each person that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
- vii. Provide permit and license records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
- b. A nonprescription drug wholesale permittee shall:
  - i. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical except in the original container packaged and labeled by the manufacturer or repackager;
  - ii. Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;
  - iii. Not sell or distribute any nonprescription drug, precursor chemical, or regulated chemical to anyone except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
  - iv. Maintain a record of the current permit or license of each person that buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and
  - v. Provide permit and license records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
- c. Nothing in this subsection shall be construed to prevent the return of a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to the original source of supply.
- 3. Out-of-state drug sales.
  - a. A full-service drug wholesale permittee shall:
    - i. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical except in the original container packaged and labeled by the manufacturer or repackager;
    - ii. Not package, repackage, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical;
    - iii. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone except a person that is properly permitted, registered, licensed, or certified in another jurisdiction;
    - iv. Provide track and trace documents required under the Drug Supply Chain and Security Act upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901;
    - v. Maintain a copy of the current permit, registration, license, or certificate of each person that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
    - vi. Provide permit, registration, license, and certificate records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5); and
  - b. A nonprescription drug wholesale permittee shall:
    - i. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical except in the original container packaged and labeled by the manufacturer or repackager;
    - ii. Not package, repackage, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical;
    - iii. Not sell or distribute any nonprescription drug, precursor chemical, or regulated chemical to anyone except a person that is properly permitted, registered, licensed, or certified in another jurisdiction;
    - iv. Maintain a record of the current permit, registration, license, or certificate of each person that buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and

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- v. Provide permit, registration, license, or certificate records upon request, if immediately available, or within two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5).
- 4. Cash-and-carry sales.
  - a. A full-service drug wholesale permittee shall complete a cash-and-carry sale or distribution of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical only after:
    - i. Verifying the validity of the order;
    - ii. Verifying the identity of the pick-up person for each transaction by confirming that the person represented placed the cash-and-carry order; and
    - iii. For a prescription-only drug order, verifying that the cash-and-carry sale or distribution is used only to meet the immediate needs of a particular patient of the person that placed the cash-and-carry order; and
  - b. A nonprescription drug wholesale permittee shall complete a cash-and-carry sale or distribution of any nonprescription drug, precursor chemical, or regulated chemical only after:
    - i. Verifying the validity of the order; and
    - ii. Verifying the identity of the pick-up person for each transaction by confirming that the person represented placed the cash-and-carry order.
- H. Prescription-only drug returns or exchanges. A full-service drug wholesale permittee shall ensure that any prescription-only drug returned or exchanged by a pharmacy or chain pharmacy warehouse under A.R.S. § 32-1983(A) meets the following criteria:
  - 1. The prescription-only drug is not adulterated or counterfeited, except an adulterated or counterfeited prescription-only drug that is the subject of an FDA or manufacturer recall may be returned for destruction or subsequent return to the manufacturer;
  - 2. The quantity of prescription-only drug returned or exchanged does not exceed the quantity of prescription-only drug that the full-service drug wholesale permittee or a full-service drug wholesale permittee under common ownership sold to the pharmacy or chain pharmacy warehouse; and
  - 3. The pharmacy or chain pharmacy warehouse provides documentation that:
    - a. Lists the name, strength, and manufacturer of the prescription-only drug being returned or exchanged; and
    - b. States that the prescription-only drug was maintained in compliance with storage conditions prescribed on the drug label or manufacturer's package insert.
- I. Returned, outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, and contraband drugs.
  - 1. Except as specified in subsection (H)(1) for a prescription-only drug, a full-service drug wholesale permittee shall ensure that the return of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical meets the following criteria.
    - a. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, or otherwise deemed unfit for human or animal consumption shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.
    - b. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical whose immediate or sealed outer or secondary containers or product labeling are misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA. When the immediate or sealed outer or secondary containers or product labeling are determined to be misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, the full-service drug wholesale permittee shall provide notice of the misbranding, counterfeiting, or contrabanding or suspected misbranding, counterfeiting, or contrabanding within three business days of the determination to the Board, FDA, and manufacturer or wholesale distributor from which the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical was acquired.
    - c. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that has been opened or used, but is not adulterated, misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be identified as opened or used, or both, and quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it

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was acquired as authorized by the Board and the FDA.

- d. If the conditions under which a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical shall be quarantined and physically separated from other narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals until the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA, except as provided in subsection (I)(1)(d)(i).
    - i. If examination, testing, or other investigation proves that the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical meets appropriate standards of safety, identity, strength, quality, and purity, it does not have to be destroyed or returned to the manufacturer or wholesale distributor.
    - ii. In determining whether the conditions under which a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical, the full-service drug wholesale permittee shall consider, among other things, the conditions under which the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical has been held, stored, or shipped before or during its return and the condition of the narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical and the condition of its container, carton, or product labeling as a result of storage or shipping.
  - e. For any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical identified under subsections (I)(1)(a) or (b), the full-service drug wholesale permittee shall ensure that the identified item or items and other evidence of criminal activity, and accompanying documentation is retained and not destroyed until its disposition is authorized by the Board and the FDA.
2. A nonprescription drug wholesale permittee shall ensure that the return of any nonprescription drug, precursor chemical, or regulated chemical meets the following criteria.
    - a. Any nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, or otherwise deemed unfit for human or animal consumption shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.
    - b. Any nonprescription drug, precursor chemical, or regulated chemical whose immediate or sealed outer or secondary containers or product labeling are misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA. When the immediate or sealed outer or secondary containers or product labeling are determined to be misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, the nonprescription drug wholesale permittee shall provide notice of the misbranding, counterfeiting, or contrabanding or suspected misbranding, counterfeiting, or contrabanding within three business days of the determination to the Board, FDA, and manufacturer or wholesale distributor from which the nonprescription drug, precursor chemical, or regulated chemical was acquired.
    - c. Any nonprescription drug, precursor chemical, or regulated chemical that has been opened or used, but is not adulterated, misbranded, counterfeited, or contraband or suspected of being misbranded, counterfeited, or contraband, shall be identified as opened or used, or both, and quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired as authorized by the Board and the FDA.
    - d. If the conditions under which a nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the nonprescription drug, precursor chemical, or regulated chemical, the nonprescription drug, precursor chemical, or regulated chemical shall be quarantined and physically separated from other nonprescription drugs, precursor chemicals, or regulated chemicals until the nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was

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acquired as authorized by the Board and the FDA, except as provided in subsection (I)(2)(d)(i).

- i. If examination, testing, or other investigation proves that the nonprescription drug, precursor chemical, or regulated chemical meets appropriate standards of safety, identity, strength, quality, and purity, the nonprescription drug, precursor chemical, or regulated chemical does not need to be destroyed or returned to the manufacturer or wholesale distributor.
- ii. In determining whether the conditions under which a nonprescription drug, precursor chemical, or regulated chemical has been returned cast doubt on the safety, identity, strength, quality, or purity of the nonprescription drug, precursor chemical, or regulated chemical, the nonprescription drug wholesale permittee shall consider, among other things, the conditions under which the nonprescription drug, precursor chemical, or regulated chemical has been held, stored, or shipped before or during its return and the condition of the nonprescription drug, precursor chemical, or regulated chemical and the condition of its container, carton, or product labeling as a result of storage or shipping.
- e. For any nonprescription drug, precursor chemical, or regulated chemical identified under subsections (I)(2)(a) or (b), the nonprescription drug wholesale permittee shall ensure that the identified item or items and other evidence of criminal activity, and accompanying documentation is retained and not destroyed until its disposition is authorized by the Board and the FDA.
3. A full-service drug wholesale permittee and nonprescription drug wholesale permittee shall comply with the recordkeeping requirements of subsection (G) for all outdated, damaged, deteriorated, adulterated, misbranded, counterfeited and contraband narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.

**J. Facility.** A full-service or nonprescription drug wholesale permittee shall:

1. Ensure that the facility occupied by the full-service or nonprescription drug wholesale permittee is of adequate size and construction, well-lighted inside and outside, adequately ventilated, and kept clean, uncluttered, and sanitary;
2. Ensure that the permittee's warehouse facility:
  - a. Is secure from unauthorized entry; and
  - b. Has an operational security system designed to provide protection against theft;
3. In a full-service drug wholesale facility, ensure that only authorized personnel may enter areas where any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is kept;
4. In a nonprescription drug wholesale facility, ensure that only authorized personnel may enter areas where any nonprescription drug, precursor chemical, or regulated chemical is kept;
5. In a full-service drug wholesale facility, ensure that any thermolabile narcotic or other controlled substance, pre-

scription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is stored in an area where room temperature is maintained in compliance with storage conditions prescribed on the product label;

6. In a nonprescription drug wholesale facility, ensure that any thermolabile nonprescription drug, precursor chemical, or regulated chemical is stored in an area where room temperature is maintained in compliance with storage conditions prescribed on the product label;
7. Make the facility available for inspection by a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901(5) during regular business hours;
8. In a full-service drug wholesale facility, provide a quarantine area for storage of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, otherwise deemed unfit for human or animal consumption, or that is in an open container; and
9. In a nonprescription drug wholesale facility, provide a quarantine area for storage of any nonprescription drug, precursor chemical, or regulated chemical that is outdated, damaged, deteriorated, adulterated, misbranded, counterfeited, or contraband or suspected of being adulterated, misbranded, counterfeited, or contraband, otherwise deemed unfit for human or animal consumption, or that is in an open container.

**K. Quality controls.**

1. A full-service drug wholesale permittee shall:
  - a. Ensure that any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that meets the criteria specified in subsection (I)(1) is not sold, distributed, or delivered to any person for human or animal consumption;
  - b. Ensure that a narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is not manufactured, packaged, repackaged, labeled, or relabeled by any of its employees;
  - c. Ensure that any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical stocked, sold, offered for sale, or delivered is:
    - i. Kept clean,
    - ii. Protected from contamination and other deteriorating environmental factors, and
    - iii. Stored in a manner that complies with applicable federal and state law and official compendium storage requirements;
  - d. Maintain manual or automatic temperature and humidity recording devices or logs to document conditions in areas where any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is stored; and
  - e. Develop and implement a program to ensure that:
    - i. Any expiration-dated narcotic or other controlled substance, prescription-only drug or



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- device, nonprescription drug, precursor chemical, or regulated chemical is reviewed regularly;
- ii. Any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical that has less than 120 days remaining on the expiration date, or is deteriorated, damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
  - iii. Any quarantined narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired.
2. A nonprescription drug wholesale permittee shall:
    - a. Ensure that any nonprescription drug, precursor chemical, or regulated chemical that meets the criteria specified in subsection (I)(2) is not sold, distributed, or delivered to any person for human or animal consumption;
    - b. Ensure that a nonprescription drug, precursor chemical, or regulated chemical is not manufactured, packaged, repackaged, labeled, or relabeled by any of its employees;
    - c. Ensure that any nonprescription drug, precursor chemical, or regulated chemical stocked, sold, offered for sale, or delivered is:
      - i. Kept clean,
      - ii. Protected from contamination and other deteriorating environmental factors, and
      - iii. Stored in a manner that complies with applicable federal and state law and official compendium storage requirements;
    - d. Maintain manual or automatic temperature and humidity recording devices or logs to document conditions in areas where any nonprescription drug, precursor chemical, or regulated chemical is stored; and
    - e. Develop and implement a program to ensure that:
      - i. Any expiration-dated nonprescription drug, precursor chemical, or regulated chemical is reviewed regularly;
      - ii. Any nonprescription drug, precursor chemical, or regulated chemical that has fewer than 120 days remaining on the expiration date, or is deteriorated, damaged, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
      - iii. Any quarantined nonprescription drug, precursor chemical, or regulated chemical is destroyed or returned to the manufacturer or wholesale distributor from which it was acquired.
- L. Fingerprint clearance.**
1. After receiving the state and federal criminal history record of a designated representative, the Board shall compare the record with the list of criminal offenses that preclude a designated representative from receiving a fingerprint clearance. If the designated representative's criminal history record does not contain any of the offenses listed in subsection (L)(2), the Board shall issue the designated representative a fingerprint clearance.
  2. The Board shall not issue a fingerprint clearance to a designated representative who is awaiting trial for or who has been convicted of committing or attempting or conspiring to commit one or more of the following offenses in this state or the same or similar offenses in another state or jurisdiction:
    - a. Unlawfully administering intoxicating liquors, controlled substances, dangerous drugs, or prescription-only drugs;
    - b. Sale of peyote;
    - c. Possession, use, or sale of marijuana, dangerous drugs, prescription-only drugs, or controlled substances;
    - d. Manufacture or distribution of an imitation controlled substance;
    - e. Manufacture or distribution of an imitation prescription-only drug;
    - f. Possession or possession with intent to use an imitation controlled substance;
    - g. Possession or possession with intent to use an imitation prescription-only drug; or
    - h. A felony offense involving sale, distribution, or transportation of, offer to sell, transport, or distribute, or conspiracy to sell, transport, or distribute marijuana, dangerous drugs, prescription-only drugs, or controlled substances.
  3. If the Board determines, after conducting a state and federal criminal history record check, that it is not authorized to issue a fingerprint clearance, the Board shall notify the full-service drug wholesale applicant or permittee that employs the designated representative that the Board is not authorized to issue a fingerprint clearance. This notice shall include the criminal history information on which the denial was based. This criminal history information is subject to dissemination restrictions under A.R.S. § 41-1750 and federal law.

**Historical Note**

Former Rules 6.5110, 6.5120, 6.5130, 6.5140, 6.5210, 6.5220, 6.5230, 6.5240, 6.5310, 6.5320, 6.5410, and 6.5420. Amended effective August 10, 1978 (Supp. 78-4). Amended effective April 20, 1982 (Supp. 82-2). Amended subsection (A) effective August 12, 1988 (Supp. 88-3). Amended effective February 8, 1991 (Supp. 91-1). Amended effective August 24, 1992 (Supp. 92-3). Amended by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 10 A.A.R. 232, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 11 A.A.R. 4270, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4). Amended by final rulemaking at 19 A.A.R. 702, effective June 1, 2013 (Supp. 13-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-606. Resident-Pharmacy Permit: Community, Hospital, and Limited Service**

- A. Permit.** A person shall not operate a pharmacy in Arizona without a current Board-issued pharmacy permit.
- B. Application.**
  1. To obtain a permit to operate a pharmacy in Arizona, a person shall submit a completed application, on a form

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available from the Board, and the fee specified in R4-23-205.

2. Before issuing a pharmacy permit, the Board shall:
  - a. Receive and approve a completed permit application; and
  - b. Receive a satisfactory compliance inspection report on the facility from a Board compliance officer.
3. Before issuing a pharmacy permit, the Board may interview the applicant and the pharmacist-in-charge, if different from the applicant, at a Board meeting based on the need for additional information.
- C. Notification. A pharmacy permittee shall notify the Board office within 10 days of changes involving the type of pharmacy operated, telephone or fax number, e-mail or mailing address, business name, or staff pharmacist. A pharmacy permittee shall provide the Board office immediate notice of a change of the pharmacist-in-charge.
- D. If any nonprescription drugs are sold outside the pharmacy area when the pharmacy area is closed, the pharmacy permittee shall ensure that the business has a current, Board-issued nonprescription drug permit as required in Section R4-23-603.
- E. Change of ownership. A pharmacy permittee shall comply with R4-23-601(F).
- F. Relocation or remodel.
  1. No fewer than 30 days before the relocation or remodel of an existing pharmacy, the pharmacy permittee shall submit, electronically or manually, a completed application for remodel or relocation using the form specified under subsection (B). A fee is not required with an application for remodel or relocation.
  2. The new or remodeled facility shall pass a final inspection by a Board compliance officer before operations begin.
- G. Permit renewal. To renew a pharmacy permit, the permittee shall comply with R4-23-602(D).

**Historical Note**

Former Rules 6.6010, 6.6020, 6.6030, 6.6040, 6.6050, 6.6060, 6.6071, 6.6072, 6.6073, 6.6074, 6.6075, and 6.6076. Amended effective August 10, 1978 (Supp. 78-4). Amended subsections (G) and (H) effective April 20, 1982 (Supp. 82-2). Amended subsection (L) effective July 2, 1982 (Supp. 82-4). Amended subsections (G) and (H) effective August 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Section heading amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-607. Nonresident Permits**

- A. Permit. A person that is not a resident of Arizona shall not sell or distribute any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona without possessing both:
  1. A current Board-issued nonresident pharmacy permit, nonresident manufacturer permit, nonresident full-service or nonprescription drug wholesaler permit, or nonresident nonprescription drug permit; and
  2. A current equivalent license or permit issued by the licensing authority in the jurisdiction where the person resides.

- B. Application. To obtain a nonresident pharmacy, nonresident manufacturer, nonresident full-service or nonprescription drug wholesaler, or nonprescription drug permit, a person shall submit a completed application, on a form furnished by the Board, and the fee specified in R4-23-205.
- C. Notification. A permittee shall submit notification of any change required in this subsection using the permittee's online profile or as a written notice by mail, fax, or e-mail to the Board office within 10 days of the change.
  1. Nonresident pharmacy. A nonresident pharmacy permittee shall notify the Board of changes involving the type of pharmacy operated, address, telephone number, business name, or pharmacist-in-charge.
  2. Nonresident manufacturer. A nonresident manufacturer permittee shall notify the Board of changes involving listed drugs, address, telephone number, business name, or manager, including manager's telephone number.
  3. Nonresident drug wholesaler. A nonresident full-service or nonprescription drug wholesaler permittee shall notify the Board of changes involving the types of drugs sold or distributed, address, telephone number, business name, or manager or designated representative, including the manager's or designated representative's telephone number. For a change of designated representative, a nonresident full-service drug wholesaler permittee shall submit the documentation, fingerprints, and fee required with the application under subsection (B).
  4. Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall notify the Board of changes involving permit category, address, telephone number, business name, or manager, including manager's telephone number.
- D. Change of ownership. A nonresident permittee shall comply with R4-23-601(F).
- E. Drug sales.
  1. Nonresident pharmacy. A nonresident pharmacy permittee shall:
    - a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device to anyone in Arizona except:
      - i. A pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board;
      - ii. A medical practitioner currently licensed under A.R.S. Title 32; or
      - iii. An Arizona resident upon receipt of a valid prescription order for the resident;
    - b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except:
      - i. A pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board;
      - ii. A medical practitioner currently licensed under A.R.S. Title 32; or
      - iii. An Arizona resident either upon receipt of a valid prescription order for the resident or in the original container packaged and labeled by the manufacturer;
    - c. Except for a drug sale that results from the receipt and dispensing of a valid prescription order for an Arizona resident, maintain a copy of the current permit or license of each person in Arizona that buys,

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- receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
- d. Provide permit and license records upon request, if immediately available, or in no fewer than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
2. Nonresident manufacturer. A nonresident manufacturer permittee shall:
- a. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance or prescription-only drug or device to anyone in Arizona except a pharmacy, drug manufacturer, or full-service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- b. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- c. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
- d. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
3. Nonresident full-service drug wholesaler. In addition to complying with the distributions restrictions specified in A.R.S. § 32-1983, a nonresident full-service drug wholesale permittee shall:
- a. Not sell, distribute, give away, or dispose of, any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
- b. Not package, repack, label, or relabel any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
- c. Provide track and trace documents required under the Drug Supply Chain and Security Act upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901;
- d. Not sell, distribute, give away, or dispose of any narcotic or other controlled substance, prescription only drug or device, nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, or full service drug wholesaler currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- e. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- f. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical; and
- g. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
4. Nonresident nonprescription drug wholesaler. A nonresident nonprescription drug wholesale permittee shall:
- a. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona, except in the original container, packaged and labeled by the manufacturer or repackager;
- b. Not package, repack, label, or relabel any nonprescription drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona;
- c. Not sell, distribute, give away, or dispose of any nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except a pharmacy, drug manufacturer, full-service or nonprescription drug wholesaler, or nonprescription drug retailer currently permitted by the Board or a medical practitioner currently licensed under A.R.S. Title 32;
- d. Maintain a copy of the current permit or license of each person in Arizona that buys, receives, or disposes of any nonprescription drug, precursor chemical, or regulated chemical; and
- e. Provide permit and license records upon request, if immediately available, or in no more than two business days from the date of the request of a Board compliance officer or other authorized officer of the law as defined in A.R.S. § 32-1901.
5. Nonresident nonprescription drug retailer. A nonresident nonprescription drug permittee shall not:
- a. Sell, distribute, give away, or dispose of a nonprescription drug, precursor chemical, or regulated chemical to anyone in Arizona except in the original container packaged and labeled by the manufacturer;
- b. Package, repack, label, or relabel any drug, precursor chemical, or regulated chemical for shipment or delivery to anyone in Arizona; or
- c. Sell, distribute, give away, or dispose of any drug, precursor chemical, or regulated chemical to anyone in Arizona that exceeds its expiration date, is contaminated or deteriorated from excessive heat, cold, sunlight, moisture, or other factors, or does not comply with federal law.

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- F. When selling or distributing any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical into Arizona, a nonresident pharmacy, nonresident manufacturer, nonresident full-service or nonprescription drug wholesale, or nonprescription drug permittee shall comply with federal law, the permittee's resident state drug law, and this Section.

**Historical Note**

Former Rules 6.6110, 6.6120, and 6.6130; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective July 24, 1985 (Supp. 85-4). New Section adopted by final rulemaking at 6 A.A.R. 4589, effective November 14, 2000 (Supp. 00-4). Amended by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 10 A.A.R. 232, effective March 6, 2004 (Supp. 04-1). Amended by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3477, effective December 1, 2007 (Supp. 07-4).

Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-608. Change of Personnel and Responsibility**

- A. A community, hospital, or limited-service pharmacy permittee shall give the Board:
1. Notice by mail, facsimile, or electronic mail within ten days of employing or terminating a pharmacist; and
  2. Immediate notice of designating or terminating a pharmacist-in-charge.
- B. Responsibility of ownership and management. The owner and management of a pharmacy shall:
1. Ensure that pharmacists, interns, and other pharmacy employees comply with state and federal laws and administrative rules; and
  2. Not overrule a pharmacist in matters of pharmacy ethics and interpreting laws pertaining to the practice of pharmacy or the distribution of drugs and devices.
- C. The Board may suspend or revoke a pharmacy permit if the owner or management of a pharmacy violates subsection (B).

**Historical Note**

Former Rules 6.6140 and 6.6150; Amended subsection (A) effective August 9, 1983 (Supp. 83-4). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3).

**R4-23-609. Pharmacy Area of Community Pharmacy**

- A. Minimum area of community pharmacy. The minimum area of a community pharmacy, the actual area primarily devoted to stocking drugs restricted to pharmacists, and to the compounding and dispensing of prescription medication, exclusive of office area or other support function area, shall not be less than 300 square feet. A maximum of three pharmacy personnel may practice or work simultaneously in the minimum area. The pharmacy permittee shall provide an additional 60 square feet of floor area for each additional pharmacist, graduate intern, pharmacy intern, pharmacy technician, pharmacy technician trainee, or support personnel who may practice or work simultaneously. All of the allotted square footage area, including adequate shelving, shall lend itself to efficient pharmaceutical practice and permit free movement and visual surveillance of personnel by the pharmacist.

- B. Compounding and dispensing counter. On or after January 6, 2004, a pharmacy permit applicant or remodel or relocation applicant shall provide a compounding and dispensing counter that provides a minimum of three square feet of pharmacy counter working area of not less than 16 inches in depth and 24 inches in length for the practice of one pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee. For each additional pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee practicing simultaneously, there shall be an additional three square feet of pharmacy counter working area of not less than 16 inches in depth and 24 inches in length. The Board shall determine a pharmacy's total required compounding and dispensing counter area by multiplying the maximum number of personnel allowed in the pharmacy area using the requirements specified in subsection (A) by three square feet per person. A pharmacy permittee or pharmacist-in-charge may operate the pharmacy with a total pharmacy counter working area specified in subsection (A) that is equal to the actual maximum number of pharmacists, graduate interns, pharmacy interns, pharmacy technicians, and pharmacy technician trainees, working simultaneously in the pharmacy area times three square feet per person.
- C. Working area for compounding and dispensing counter. The aisle floor area used by the pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee at the compounding and dispensing counter shall extend the full length of the counter and be clear and continuous for a minimum of 36 inches from any counter, fixture, or structure.
- D. Area for patient counseling. On or after April 1, 1995, a pharmacy permit applicant or remodel or relocation applicant shall provide a separate and distinct patient counseling area that provides patient privacy. This subsection does not apply to a pharmacy exempt from the requirements of R4-23-402(B).
- E. Narcotic cabinet or safe. To prevent diversion, narcotics and other controlled substances may be:
1. Kept in a separate locked cabinet or safe, or
  2. Dispersed throughout the pharmacy's prescription-only drug stock.
- F. Building security standard of community pharmacy area. The pharmacy area shall be enclosed by a permanent barrier or partition from floor or counter to structural ceiling or roof, with entry doors that can be securely locked. The barrier shall be designed so that only a pharmacist can access the area where prescription-only drugs, narcotics, and other controlled substances are stored, compounded and dispensed. The permanent barrier may be constructed of other than a solid material. If constructed of a material other than a solid, the openings or interstices of the material shall not be large enough to permit removal of items in the pharmacy area through the barrier. Any material used in the construction of the permanent barrier must be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated, or bent. The pharmacy permittee shall submit plans and specifications of the permanent barrier to the Board for approval.
- G. Drug storage and security.
1. The pharmacy permittee shall ensure that drugs and devices are stored in a dry, well-lit, ventilated, and clean and orderly area. The pharmacy permittee shall maintain the drug storage area at temperatures that ensure the integrity of the drugs before dispensing as stated in the official compendium defined in A.R.S. § 32-1901(55) or the manufacturer's or distributor's labeling.

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2. If the pharmacy permittee needs additional storage area for drugs that are restricted to sale by a pharmacist, the pharmacy permittee shall ensure that the area is contained by a permanent barrier from floor or counter to structural ceiling or roof. The pharmacy permittee shall lock all doors and gates to the drug storage area. Only a pharmacist with a key is permitted to enter the storage area, except in an extreme emergency.
- H. A pharmacy permittee or pharmacist-in-charge shall ensure that the pharmacy working counter area is protected from unauthorized access while the pharmacy is open for business by a barrier not less than 66 inches in height or another method approved by the Board or its designee.

**Historical Note**

Former Rules 6.6210, 6.6220, 6.6230, 6.6240, 6.6250, 6.6310, 6.6320, and 6.6330; Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 9 A.A.R. 5030, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 19 A.A.R. 97, effective March 10, 2013 (Supp. 13-1).

**R4-23-610. Community Pharmacy Personnel and Security Procedures**

- A. Every pharmacy shall have a pharmacist designated as the "pharmacist-in-charge."
  1. The pharmacist-in-charge shall ensure the communication and compliance of Board directives to the management, other pharmacists, interns, and technicians of the pharmacy.
  2. The pharmacist-in-charge shall:
    - a. Ensure that all pharmacy policies and procedures required under 4 A.A.C. 23 are prepared, implemented, and complied with;
    - b. Review biennially and, if necessary, revise all pharmacy policies and procedures required under 4 A.A.C. 23;
    - c. Document the review required under subsection (A)(2)(b);
    - d. Ensure that all pharmacy policies and procedures required under 4 A.A.C. 23 are assembled as a written or electronic manual; and
    - e. Make all pharmacy policies and procedures required under 4 A.A.C. 23 available in the pharmacy for employee reference and inspection by the Board or its staff.
- B. Personnel permitted in the pharmacy area of a community pharmacy include pharmacists, graduate interns, pharmacy interns, compliance officers, drug inspectors, peace officers acting in their official capacity, other persons authorized by law, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel. Pharmacy interns, graduate interns, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel shall be permitted in the pharmacy area only when a pharmacist is on duty, except in an extreme emergency as defined in R4-23-110.
  1. The pharmacist-in-charge shall comply with the minimum area requirements as described in R4-23-609 for a community pharmacy and for compounding and dispensing counter area.

2. A pharmacist employed by a pharmacy shall ensure that the pharmacy is physically secure while the pharmacist is on duty.
- C. In a community pharmacy, a pharmacist shall ensure that the pharmacy area, and any additional storage area for drugs that is restricted to access only by a pharmacist is locked when a pharmacist is not present, except in an extreme emergency.
- D. A pharmacist is the only person permitted by the Board to unlock the pharmacy area or any additional storage area for drugs restricted to access only by a pharmacist, except in an extreme emergency.
- E. A pharmacy permittee or pharmacist-in-charge shall ensure that any prescription-only drugs and controlled substances received in an area outside the pharmacy area are immediately transferred unopened to the pharmacy area. The pharmacist-in-charge shall ensure that any prescription-only drug and controlled substance shipments are opened and marked by pharmacy personnel in the pharmacy area under the supervision of a pharmacist, graduate intern, or pharmacy intern.
- F. A pharmacy permittee or pharmacist-in-charge may provide a small opening or slot through which a written prescription order or prescription medication container to be refilled may be left in the prescription area when the pharmacist is not present.
- G. A pharmacist shall ensure that prescription medication is not left outside the prescription area or picked up by the patient when the pharmacist is not present by either:
  1. Delivering the prescription medication to the patient, or
  2. Securing the prescription medication inside the locked pharmacy, except when using an automated storage and distribution system that complies with the requirements of R4-23-614.

**Historical Note**

Former Rules 6.6410, 6.6420, 6.6430, 6.6440, 6.6450, 6.6460, 6.6470, 6.6480, and 6.6490; Amended subsection (F), deleted subsection (I) effective August 9, 1983 (Supp. 83-4). Amended effective May 16, 1990 (Supp. 90-2). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 4441, effective November 2, 1999 (Supp. 99-4). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 2631, effective September 8, 2007 (Supp. 07-3).

**R4-23-611. Pharmacy Facilities**

- A. Facilities. A pharmacy permittee or pharmacist-in-charge shall ensure that:
  1. A pharmacy's facilities are constructed according to state and local laws and ordinances;
  2. A pharmacy facility's:
    - a. Walls, ceilings, windows, floors, shelves, and equipment are clean and in good repair and order; and
    - b. Counters, shelves, aisles, and open spaces are not cluttered;
  3. Adequate trash receptacles are provided and emptied periodically during the day;
  4. A pharmacy facility of any pharmacy permit issued or pharmacy remodeled after February 1, 2014 provides access to toilet facilities either:
    - a. Within the pharmacy area, or

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- b. No further than a walking distance of 100 feet from the pharmacy area or an alternative distance approved by the Board or its designee;
  5. The toilet facilities are maintained in a sanitary condition and in good repair;
  6. All professional personnel and staff of the pharmacy keep themselves and their apparel clean while in the pharmacy area;
  7. No animals, except licensed assistant animals and guard animals, are allowed in the pharmacy;
  8. The pharmacy facility is kept free of insects and rodents; and
  9. There is a sink with hot and cold running water, other than a sink in a toilet facility, within the pharmacy area for use in preparing drug products.
- B. Supply of drugs and chemicals.** A pharmacy permittee or pharmacist-in-charge shall ensure that:
1. A pharmacy maintains a stock of drugs and chemicals that:
    - a. Are sufficient to meet the normal demands of the trading area or patient base the pharmacy serves; and
    - b. Meet all standards of strength and purity as established by the official compendiums;
  2. All stock, materials, drugs, and chemicals held for ultimate sale or supply to the consumer are not contaminated;
  3. Policies and procedures are developed, implemented, and complied with to prevent the sale or use of a drug or chemical:
    - a. That exceeds its expiration date;
    - b. That is deteriorated or damaged by reason of age, heat, light, cold, moisture, crystallization, chemical reaction, rupture of coating, disintegration, solidification, separation, discoloration, change of odor, precipitation, or other change as determined by organoleptic examination or by other means;
    - c. That is improperly labeled;
    - d. Whose container is defective; or
    - e. That does not comply with federal law; and
  4. The policies and procedures described in subsection (B)(3):
    - a. Are made available in the pharmacy for employee reference and inspection by the Board or its designee; and
    - b. Provide the following:
      - i. Any expiration-dated drug or chemical is reviewed regularly;
      - ii. Any drug or chemical that exceeds its expiration date, is deteriorated or damaged, improperly labeled, has a defective container, or does not comply with federal law, is moved to a quarantine area and not sold or distributed; and
      - iii. Any quarantined drug or chemical is properly destroyed or returned to its source of supply.

**Historical Note**

Former Rules 6.6510, 6.6520, 6.6530, 6.6540, 6.6550, 6.6560, 6.6570, 6.6580, 6.6600, 6.6610, 6.6620, 6.6630, 6.6640, 6.6650, and 6.6660; Amended subsection (B) effective August 9, 1983 (Supp. 83-4). Amended effective April 1, 1995; filed with the Secretary of State January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

Amended by final rulemaking at 19 A.A.R. 4165, effective February 1, 2014 (Supp. 13-4).

**R4-23-612. Equipment**

A pharmacy permittee or pharmacist-in-charge shall ensure that a pharmacy has the necessary equipment to allow a pharmacist to practice the profession of pharmacy, including the following:

1. Adequate refrigeration equipment dedicated to the storage of drugs and biologicals;
2. A C-V controlled substance register, if C-V controlled substances are sold without an order of a medical practitioner;
3. Graduates in assorted sizes;
4. One mortar and pestle, not required if the pharmacy permittee states in the application that compounding will not be performed in the pharmacy;
5. Spatulas of assorted sizes including one nonmetallic;
6. Prescription balance, Class A with weights or an electronic balance of equal or greater accuracy, not required if the pharmacy permittee states in the application that compounding will not be performed in the pharmacy;
7. One ointment tile or equivalent, not required if the pharmacy permittee states in the application that compounding will not be performed in the pharmacy;
8. A current hard-copy or access to a current electronic copy of the Arizona Pharmacy Act and administrative rules and Arizona Controlled Substance Act;
9. A professional reference library consisting of a minimum of one current reference or text, in hard-copy or electronic media, addressing the following subject areas:
  - a. Pharmacology or toxicology,
  - b. Therapeutics,
  - c. Drug compatibility, and
  - d. Drug product equivalency;
10. An assortment of labels, including prescription labels, transfer labels for controlled substances, and cautionary and warning labels;
11. A red C stamp as defined in R4-23-110, if C-III, C-IV, and C-V controlled substance invoices are not filed separately from other invoices;
12. Current antidote and drug interaction information; and
13. Regional poison control phone number prominently displayed in the pharmacy area.

**Historical Note**

Former Rule 6.6670; Former Section R4-23-612 repealed, new Section R4-23-612 adopted effective August 10, 1978 (Supp. 78-4). Amended effective August 9, 1983 (Supp. 83-4). Amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 7 A.A.R. 4253, effective September 11, 2001 (Supp. 01-3). Amended by final rulemaking at 19 A.A.R. 4165, effective February 1, 2014 (Supp. 13-4).

**R4-23-613. Procedure for Discontinuing a Pharmacy**

**A.** A pharmacy permittee or pharmacist-in-charge shall provide written notice to the Board and the Drug Enforcement Administration (D.E.A.) at least 14 days before discontinuing operation of the pharmacy. The notice shall contain the following information:

1. Name, address, pharmacy permit number, and D.E.A. registration number of the pharmacy discontinuing business;
2. Name, address, pharmacy permit number (if applicable), and D.E.A. registration number (if applicable) of the licensee, permittee, or registrant to whom any narcotic or

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other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical will be sold or transferred;

3. Name and address of the location where the discontinuing pharmacy's records of purchase and disbursement of any narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical will be kept and the person responsible for the records. These records shall be kept for a minimum of three years from the date the pharmacy is discontinued;
  4. Name and address of the location where the discontinuing pharmacy's prescription files and patient profiles will be kept and the person responsible for the files and profiles. These records shall be kept for a minimum of seven years from the date the last original or refill prescription was dispensed; and
  5. The proposed date of discontinuing business operations.
- B.** The pharmacy permittee shall ensure that all pharmacy signs and symbols are removed from both the inside and outside of the premises.
- C.** The pharmacy permittee or pharmacist-in-charge shall ensure that all state permits and certificates of registration are returned to the Board office and that D.E.A. registration certificates and unused D.E.A. Schedule II order forms are returned to the D.E.A. Regional Office in Phoenix.
- D.** The pharmacist-in-charge of the pharmacy discontinuing business shall ensure that:
1. Only a pharmacist has access to the prescription-only drugs and controlled substances until they are transferred to the licensee, permittee, or registrant listed in subsection (A)(2);
  2. All narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals are removed from the premises on or before the date the pharmacy is discontinued; and
  3. All controlled substances are transferred as follows:
    - a. Take an inventory of all controlled substances that are transferred using the procedures in R4-23-1003;
    - b. Include a copy of the inventory with the controlled substances that are transferred;
    - c. Keep the original of the inventory with the discontinued pharmacy's records of narcotic or other controlled substance, prescription-only drug or device, nonprescription drug, precursor chemical, or regulated chemical purchase and disbursement for a minimum of three years from the date the pharmacy is discontinued;
    - d. Use a D.E.A. form 222 to transfer any Schedule II controlled substances; and
    - e. Transfer controlled substances that need destruction in the same manner as all other controlled substances.
- E.** Upon receipt of outdated or damaged controlled substances from a discontinued pharmacy, the licensee, permittee, or registrant described in subsection (A)(2) shall contact a D.E.A. registered reverse distributor for proper destruction of outdated or damaged controlled substances. If there are controlled substances a reverse distributor will not accept, the licensee, permittee, or registrant shall then contact the Board office and request an inspection for the purpose of drug destruction.
- F.** During the three-year record retention period specified in subsection (A)(3), the person described in subsection (A)(3) shall

provide to the Board upon its request a discontinued pharmacy's records of the purchase and disbursement of narcotics or other controlled substances, prescription-only drugs or devices, nonprescription drugs, precursor chemicals, or regulated chemicals.

- G.** During the seven-year record retention period specified in subsection (A)(4), the person described in subsection (A)(4) shall provide to the Board upon its request a discontinued pharmacy's records of prescription files and patient profiles.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 3825, effective August 9, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

**R4-23-614. Automated Storage and Distribution System**

- A.** Before using an automated storage and distribution system, a pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that the automated storage and distribution system and the policies and procedures comply with subsection (B); and
  2. Notify the Board in writing of the intent to use an automated storage and distribution system, including the type or name of the system.
- B.** A pharmacy permittee or pharmacist-in-charge shall establish policies and procedures for appropriate performance and use of the automated storage and distribution system that:
1. Ensure that the automated storage and distribution system is in good working order while maintaining appropriate recordkeeping and security safeguards;
  2. Ensure that an automated storage and distribution system used by the pharmacy that allows access to drugs or devices by a patient:
    - a. Only contains prescriptions that:
      - i. Do not require oral consultation as specified in R4-23-402(B); and
      - ii. Are properly labeled and verified by a pharmacist before placement into the automated storage and distribution system and subsequent release to patients;
    - b. Allows a patient to choose whether or not to use the system;
    - c. Is located either in a wall of a properly permitted pharmacy or within 20 feet of a properly permitted pharmacy if the automated storage and distribution system is secured against the wall or floor in such a manner that prevents the automated storage and distribution system's unauthorized removal;
    - d. Provides a method to identify the patient and only release that patient's prescriptions;
    - e. Is secure from access and removal of drugs or devices by unauthorized individuals;
    - f. Provides a method for a patient to obtain a consultation with a pharmacist if requested by the patient; and
    - g. Does not allow the system to dispense refilled prescriptions if a pharmacist determines that the patient requires oral counseling as specified in R4-23-402(B);
  3. Ensure that an automated storage and distribution system used by the pharmacy that allows access to drugs or

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devices only by authorized licensed personnel for the purposes of administration based on a valid prescription order or medication order:

- a. Provides for adequate security to prevent unauthorized individuals from accessing or obtaining drugs or devices; and
  - b. Provides for the filling, stocking, or restocking of all drugs or devices in the system only by a Board licensee or other authorized licensed personnel; and
4. Implement an ongoing quality assurance program that monitors compliance with the established policies and procedures of the automated storage and distribution system and federal and state law.
- C. A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that the policies and procedures required under subsection (B) are prepared, implemented, and complied with;
  2. Review biennially and, if necessary, revise the policies and procedures required under subsection (B);
  3. Document the review required under subsection (C)(2);
  4. Assemble the policies and procedures as a written or electronic manual; and
  5. Make the policies and procedures available for employee reference and inspection by the Board or its staff within the pharmacy and at any location outside the pharmacy where the automated storage and distribution system is used.
- D. The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using an automated storage and distribution system if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), or (C).

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1).

**R4-23-615. Mechanical Storage and Counting Device for a Drug in Solid, Oral Dosage Form**

- A. A pharmacy permittee or pharmacist-in-charge shall ensure that a mechanical storage and counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist complies with the following method to identify the contents of the device:
1. The drug name and strength are affixed to the front of each cell or cassette of the device;
  2. A paper or electronic log is kept for each cell or cassette that contains:
    - a. An identification of the cell or cassette by the drug name and strength or the number of the cell or cassette;
    - b. The drug's manufacturer or National Drug Code (NDC) number;
    - c. The expiration date and lot number from the manufacturer's stock bottle that is used to fill the cell or cassette. If multiple lot numbers of the same drug are added to a cell or cassette, each lot number and expiration date shall be documented, and the earliest expiration date shall become the expiration date of the mixed lot of drug in the cell or cassette;
    - d. The date the cell or cassette is filled;
    - e. Documentation of the identity of the licensee who placed the drug into the cell or cassette; and
- f. If the licensee who filled the cell or cassette is not a pharmacist, documentation of the identity of the pharmacist who supervised the non-pharmacist licensee who filled the cell or cassette; and
3. The paper or electronic log is available in the pharmacy for inspection by the Board or its designee for not less than two years.
- B. A pharmacy permittee or pharmacist-in-charge shall ensure that any drug previously counted by a mechanical storage and counting device for a drug in a solid, oral dosage form that has not left the pharmacy is not returned to the drug's cell, cassette, or stock bottle, unless the drug return method is approved by the Board or its designee as specified in subsection (G). This subsection does not prevent a pharmacy permittee or pharmacist-in-charge from using a manual or mechanical counting device to count and dispense a previously counted drug that has not left the pharmacy if the previously counted drug is dispensed before its beyond-use-date.
- C. A pharmacy permittee or pharmacist-in-charge shall ensure the accuracy of any mechanical storage and counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist by documenting completion of the following:
1. Training in the maintenance, calibration, and use of the mechanical storage and counting device for each employee who uses the mechanical storage and counting device;
  2. Maintenance and calibration of the mechanical storage and counting device as recommended by the device's manufacturer; and
  3. Routine quality assurance and accuracy validation testing for each mechanical storage and counting device.
- D. A pharmacy permittee or pharmacist-in-charge shall ensure that the documentation required in subsection (C) is available for inspection by the Board or its designee.
- E. A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that policies and procedures for the performance and use of a mechanical storage and counting device for a drug in a solid, oral dosage form are prepared, implemented, and complied with;
  2. Review biennially and, if necessary, revise the policies and procedures required under subsection (E)(1);
  3. Document the review required under subsection (E)(2);
  4. Assemble the policies and procedures as a written or electronic manual; and
  5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.
- F. The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using a mechanical storage and counting device for a drug in a solid, oral dosage form if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), (C), (D), or (E).
- G. Returning a drug previously counted by a mechanical storage and counting device for a drug in a solid, oral dosage form that has not left the pharmacy to the drug's cell or cassette.
1. Before returning a drug previously counted by a mechanical storage and counting device that has not left the pharmacy to the drug's cell or cassette, a pharmacy permittee or pharmacist-in-charge shall:



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- a. Apply for approval from the Board or its designee for the drug return method to be used in returning the drug;
  - b. Develop a drug return method that uses technology, such as bar coding, to prevent drug return errors;
  - c. Provide documentation depicting the drug return method;
  - d. Demonstrate the drug return method for a Board Compliance Officer; and
  - e. Receive approval from the Board or its designee for the drug return method to be used in returning the drug.
2. Before approving a request to waive the drug return prohibition in subsection (B), the Board or its designee shall:
    - a. Receive a request in writing from the pharmacy permittee or pharmacist-in-charge;
    - b. Review the documentation of the drug return method; and
    - c. Receive a satisfactory inspection report from a Board Compliance Officer that the drug return method uses technology to prevent drug return errors.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 3677, effective November 8, 2008 (Supp. 08-3).

**R4-23-616. Mechanical Counting Device for a Drug in Solid, Oral Dosage Form**

- A. A pharmacy permittee or pharmacist-in-charge shall ensure the accuracy of any mechanical counting device for a drug in a solid, oral dosage form that is used by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist by documenting completion of the following:
  1. Training in the maintenance, calibration, and use of the mechanical counting device for each employee who uses the mechanical counting device;
  2. Maintenance and calibration of the mechanical counting device as recommended by the device's manufacturer; and
  3. Routine quality assurance and accuracy validation testing for each mechanical counting device.
- B. A pharmacy permittee or pharmacist-in-charge shall ensure that the documentation required in subsection (A) is available for inspection by the Board or its designee.
- C. A pharmacy permittee or pharmacist-in-charge shall:
  1. Ensure that policies and procedures for the performance and use of a mechanical counting device for a drug in a solid, oral dosage form are prepared, implemented, and complied with;
  2. Review biennially and, if necessary, revise the policies and procedures required under subsection (C)(1);
  3. Document the review required under subsection (C)(2);
  4. Assemble the policies and procedures as a written or electronic manual; and
  5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.
- D. The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using a mechanical counting device for a drug in a solid, oral dosage form if the pharmacy permittee or the

pharmacy permittee's employees do not comply with the requirements of subsections (A), (B), or (C).

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 616, effective April 7, 2007 (Supp. 07-1).

**R4-23-617. Temporary Pharmacy Facilities or Mobile Pharmacies**

- A. Pharmacies located in declared disaster areas, nonresident pharmacies, and pharmacies licensed or permitted in another state but not licensed or permitted in this state, if necessary to provide pharmacy services during a declared state of emergency, may arrange to temporarily locate to a temporary pharmacy facility or mobile pharmacy or relocate to a temporary pharmacy facility or mobile pharmacy if the pharmacist-in-charge of the temporary pharmacy facility or mobile pharmacy ensures that:
  1. The pharmacy is under the control and management of the pharmacist-in-charge or a supervising pharmacist designated by the pharmacist-in-charge;
  2. The pharmacy is located within or adjacent to the declared disaster area;
  3. The Board is notified of the pharmacy's location;
  4. The pharmacy is properly secured to prevent theft and diversion of drugs;
  5. The pharmacy's records are maintained in accordance with Arizona statutes and rules; and
  6. The pharmacy stops providing pharmacy services when the declared state of emergency ends, unless it possesses a current resident pharmacy permit issued by the Board under A.R.S. §§ 32-1929, 32-1930, and 32-1931.
- B. The Board shall have the authority to approve or deny temporary pharmacy facilities, mobile pharmacies, and shall make arrangements for appropriate monitoring and inspection of the temporary pharmacy facilities and mobile pharmacies on a case-by-case basis.
- C. A temporary pharmacy facility wishing to permanently operate at its temporary site shall apply for and have received a permit issued under A.R.S. §§ 32-1929, 32-1930, and 32-1931 by following the application process under R4-23-606.
- D. A mobile pharmacy, placed in operation during a declared state of emergency, shall not operate permanently.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4400, effective January 3, 2009 (Supp. 08-4).

**R4-23-618. Reserved****R4-23-619. Reserved****R4-23-620. Continuous Quality Assurance Program**

- A. Each pharmacy permittee shall implement or participate in a continuous quality assurance (CQA) program. A pharmacy permittee meets the requirements of this Section if it holds a current general, special or rural general hospital license from the Arizona Department of Health Services and is any of the following:
  1. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare or Medicaid programs;
  2. Accredited by the Joint Commission on the Accreditation of Healthcare Organizations; or
  3. Accredited by the American Osteopathic Association.
- B. A pharmacy permittee or the pharmacist-in-charge shall ensure that:

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1. The pharmacy develops, implements, and utilizes a CQ program consistent with the requirements of this Section and A.R.S. § 32-1973;
  2. The medication error data generated by the CQA program is utilized and reviewed on a regular basis, as required by subsection (D); and
  3. Training records, policies and procedures, and other program records or documents, other than medication error data, are maintained for a minimum of two years in the pharmacy or in a readily retrievable manner.
- C.** A pharmacy permittee or pharmacist-in-charge shall:
1. Ensure that policies and procedures for the operation and management of the pharmacy's CQA program are prepared, implemented, and complied with;
  2. Review biennially and, if necessary, revise the policies and procedures required under subsection (C)(1);
  3. Document the review required under subsection (C)(2);
  4. Assemble the policies and procedures as a written or electronic manual; and
  5. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its staff.
- D.** The policies and procedures shall address a planned process to:
1. Train all pharmacy personnel in relevant phases of the CQA program;
  2. Identify and document medication errors;
  3. Record, measure, and analyze data collected to:
    - a. Assess the causes and any contributing factors relating to medication errors, and
    - b. Improve the quality of patient care;
  4. Utilize the findings from subsections (D)(2) and (3) to develop pharmacy systems and workflow processes designed to prevent or reduce medication errors; and
  5. Communicate periodically, and at least annually, with pharmacy personnel to review CQA program findings and inform pharmacy personnel of any changes made to pharmacy policies, procedures, systems, or processes as a result of CQA program findings.
- E.** The Board's regulatory oversight activities regarding a pharmacy's CQA program are limited to inspection of the pharmacy's CQA policies and procedures and enforcing the pharmacy's compliance with those policies and procedures.
- F.** A pharmacy's compliance with this Section shall be considered by the Board as a mitigating factor in the investigation and evaluation of a medication error.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 2603, effective December 2, 2012 (Supp. 12-4).

**R4-23-621. Shared Services**

- A.** Before participating in shared services, a pharmacy shall have either a current resident or non-resident pharmacy permit issued by the Board.
- B.** A pharmacy may provide or utilize shared services functions only if the pharmacies involved:
1. Have the same owner, or
  2. Have a written contract or agreement that outlines the services provided and the shared responsibilities of each party in complying with federal and state pharmacy statutes and rules, and
  3. Share a common electronic file or technology that allows access to information necessary or required to perform shared services in conformance with the pharmacy act and the Board's rules.
- C.** Notifications to patients.
1. Before using shared services provided by another pharmacy, a pharmacy permittee shall:
    - a. Notify patients that their orders may be processed or filled by another pharmacy; and
    - b. Provide the name of that pharmacy or, if the pharmacy is part of a network of pharmacies under common ownership and any of the network pharmacies may process or fill the order, notify the patient of this fact. The notification may be provided through a one-time written notice to the patient or through use of a sign in the pharmacy.
  2. If an order is delivered directly to the patient by a filling pharmacy and not returned to the requesting pharmacy, the filling pharmacy permittee shall ensure that the following is placed on the prescription container or on a separate sheet delivered with the prescription container:
    - a. The local, and if applicable, the toll-free telephone number of the pharmacy utilizing shared services that has access to the patient's records; and
    - b. A statement that conveys to the patient or patient's care-giver the following information: "Written information about this prescription has been provided for you. Please read this information before you take the medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer these questions at (insert the local and toll-free telephone numbers of the pharmacy utilizing shared services that has access to the patient's records)."
  3. The provisions of subsection (C) do not apply to orders delivered to patients in facilities where a licensed health care professional is responsible for administering the prescription medication to the patient.
- D.** A pharmacy permittee engaged in shared services shall:
1. Maintain manual or electronic records that identify, individually for each order processed, the name, initials, or identification code of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, and pharmacy technician trainee who took part in the order interpretation, order entry verification, drug utilization review, drug compatibility and drug allergy review, final order verification, therapeutic intervention, or refill authorization functions performed at that pharmacy;
  2. Maintain manual or electronic records that identify, individually for each order filled or dispensed, the name, initials, or identification code of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, and pharmacy technician trainee who took part in the filling, dispensing, and counseling functions performed at that pharmacy;
  3. Report to the Board as soon as practical the results of any disciplinary action taken by another state's pharmacy regulatory agency involving shared services;
  4. Maintain a mechanism for tracking the order during each step of the processing and filling procedures performed at the pharmacy;
  5. Provide for adequate security to protect the confidentiality and integrity of patient information; and
  6. Provide for inspection of any required record or information within 72 hours of any request by the Board or its designee.

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- E. Each pharmacy permittee that provides or utilizes shared services shall develop, implement, review, revise, and comply with joint policies and procedures for shared services in the manner described in R4-23-610(A)(2). Each pharmacy permittee is required to maintain only those portions of the joint policies and procedures that relate to that pharmacy's operations. The policies and procedures shall:
1. Outline the responsibilities of each of the pharmacies;
  2. Include a list of the name, address, telephone numbers, and all license and permit numbers of the pharmacies involved in shared services; and
  3. Include policies and procedures for:
    - a. Notifying patients that their orders may be processed or filled by another pharmacy and providing the name of that pharmacy;
    - b. Protecting the confidentiality and integrity of patient information;
    - c. Dispensing orders when the filled order is not received or the patient comes in before the order is received;
    - d. Maintaining required manual or electronic records to identify the name, initials, or identification code and specific activity or activities of each pharmacist, graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee who performed any shared services;
    - e. Complying with federal and state laws; and
    - f. Operating a continuous quality improvement program for shared services, designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.
- F. Nothing in this Section shall prohibit an individual pharmacist licensed in Arizona, who is an employee of or under contract with a pharmacy, or an Arizona-licensed graduate intern, pharmacy intern, pharmacy technician, or pharmacy technician trainee, working under the supervision of the pharmacist, from accessing that pharmacy's electronic database from inside or outside the pharmacy and performing the order processing functions permitted by the pharmacy act, if both of the following conditions are met:
1. The pharmacy establishes controls to protect the confidentiality and integrity of patient information; and
  2. None of the database is duplicated, downloaded, or removed from the pharmacy's electronic database.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 520, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 19 A.A.R. 97, effective March 10, 2013 (Supp. 13-1).

**R4-23-622. Reserved**  
**R4-23-623. Reserved**  
**R4-23-624. Reserved**  
**R4-23-625. Reserved**  
**R4-23-626. Reserved**  
**R4-23-627. Reserved**  
**R4-23-628. Reserved**  
**R4-23-629. Reserved**

**R4-23-630. Reserved**  
**R4-23-631. Reserved**  
**R4-23-632. Reserved**  
**R4-23-633. Reserved**  
**R4-23-634. Reserved**  
**R4-23-635. Reserved**  
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**R4-23-650. Reserved**

**R4-23-651. Definitions**

The following definitions apply to R4-23-651 through R4-23-659:

"Administration" means the giving of a dose of medication to a patient as a result of an order of a medical practitioner.

"Direct copy" means an electronic, facsimile or carbonized copy.

"Dispensing for hospital inpatients" means the interpreting, evaluating, and implementing a medication order including preparing for delivery a drug or device to an inpatient or inpatient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, an inpatient (hereafter referred to as "dispensing").

"Drug distribution" means the delivery of drugs other than "administering" or "dispensing."

"Emergency medical situation" means a condition of emergency in which immediate drug therapy is required for the preservation of health, life, or limb of a person or persons.

"Floor stock" means a supply of essential drugs not labeled for a specific patient and maintained and controlled by the pharmacy at a patient care area for the purpose of timely administration to a patient of the hospital.

"Formulary" means a continually revised compilation of pharmaceuticals (including ancillary information) that reflects the current clinical judgment of the medical staff.

"Hospital pharmacy" means a pharmacy, as defined in A.R.S. § 32-1901, that holds a current permit issued by the Board pursuant to A.R.S. § 32-1931, and is located in a hospital as defined in A.R.S. § 32-1901.

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“Inpatient” means any patient who receives non-self-administered drugs from a hospital pharmacy for use while within a facility owned by the hospital.

“Intravenous admixture” means a sterile parenteral solution to which one or more additional drug products have been added.

“Medication order” means a written, electronic, or verbal order from a medical practitioner or a medical practitioner’s authorized agent for administration of a drug or device.

“On-call” means a pharmacist is available to:

Consult or provide drug information regarding drug therapy or related issues; or

Dispense a medication order and review a patient’s medication order for pharmaceutical and therapeutic feasibility under R4-23-653(E)(2) before any drug is administered to a patient, except as specified in R4-23-653(E)(1).

“Patient care area” means any area for the primary purpose of providing a physical environment that is owned by or operated in conjunction with a hospital, for a patient to obtain health care services, except those areas where a physician, dentist, veterinarian, osteopath, or other medical practitioner engages primarily in private practice.

“Repackaged drug” means a drug product that is transferred by pharmacy personnel from an original manufacturer’s container to another container properly labeled for subsequent dispensing.

“Satellite pharmacy” means a work area in a hospital setting under the direction of a pharmacist that is a remote extension of a centrally licensed hospital pharmacy and owned by and dependent upon the centrally licensed hospital pharmacy for administrative control, staffing, and drug procurement.

“Single unit” means a package of medication that contains one discrete pharmaceutical dosage form.

“Supervision” means the process by which a pharmacist directs the activities of hospital pharmacy personnel to a sufficient degree to ensure that all activities are performed accurately, safely, and without risk of harm to patients.

**Historical Note**

Former Rules 6.7110, 6.7120, and 6.7130; Amended effective August 10, 1978 (Supp. 78-4). Amended subsection (B) effective April 20, 1982 (Supp. 82-2). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Amended effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-652. Hospital Pharmacy Permit**

- A. The following rules are applicable to all hospitals as defined by A.R.S. § 32-1901 and hospital pharmacies as defined by R4-23-651.
- B. Before opening a hospital pharmacy, a person shall obtain a pharmacy permit as specified in R4-23-602 and R4-23-606.
- C. Discontinued hospitals. If a hospital license is discontinued by the state Department of Health Services, the pharmacy permittee or pharmacist-in-charge shall follow the procedures described in R4-23-613 for discontinuing a pharmacy.

**Historical Note**

Former Rules 6.7210, 6.7220, 6.7230, 6.7231, 6.7232,

and 6.7233. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-653. Personnel: Professional or Technician**

- A. Each hospital pharmacy shall be directed by a pharmacist who is licensed to engage in the practice of pharmacy in Arizona and is referred to as the Director of Pharmacy. The Director of Pharmacy shall be the pharmacist-in-charge, as defined in A.R.S. § 32-1901 or shall appoint a pharmacist-in-charge. The Director of Pharmacy and the pharmacist-in-charge, if a different individual, shall:
  1. Be responsible for all the activities of the hospital pharmacy and for meeting the requirements of the Arizona Pharmacy Act and these rules;
  2. Ensure that the policies and procedures required by these rules are prepared, implemented, and complied with;
  3. Review biennially and, if necessary, revise the policies and procedures required under these rules;
  4. Document the review required under subsection (A)(3);
  5. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee; and
  6. Make the policies and procedures available within the pharmacy for employee reference and inspection by the Board or its designee.
- B. In all hospitals, a pharmacist shall be in the hospital during the time the pharmacy is open for pharmacy services, except for an extreme emergency as defined in R4-23-110. Pharmacy services shall be provided for a minimum of 40 hours per week, unless an exception for less than the minimum hours is made upon written request by the hospital and with express permission of the Board or its designee.
- C. In a hospital where the pharmacy is not open 24 hours per day for pharmacy services, a pharmacist shall be “on-call” as defined in R4-23-651 when the pharmacy is closed.
- D. The Director of Pharmacy may be assisted by other personnel approved by the Director of Pharmacy in order to operate the pharmacy competently, safely, and adequately to meet the needs of the hospital’s patients.
- E. Pharmacists. A pharmacist or a pharmacy intern or graduate intern under the supervision of a pharmacist shall perform the following professional practices:
  1. Verify a patient’s medication order before administration of a drug to the patient, except:
    - a. In an emergency medical situation; or
    - b. In a hospital where the pharmacy is open less than 24 hours a day for pharmacy services, a pharmacist shall verify a patient’s medication order within four hours of the time the pharmacy opens for pharmacy services;
  2. Verify a medication order’s pharmaceutical and therapeutic feasibility based upon:
    - a. The patient’s medical condition,
    - b. The patient’s allergies,
    - c. The pharmaceutical and therapeutic incompatibilities, and
    - d. The recommended dosage limits;
  3. Measure, count, pour, or otherwise prepare and package a drug needed for dispensing, except a pharmacy technician or pharmacy technician trainee may measure, count, pour, or otherwise prepare and package a drug needed for dispensing under the supervision of a pharmacist accord-

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ing to written policies and procedures approved by the Board or its designee;

4. Compound, admix, combine, or otherwise prepare and package a drug needed for dispensing, except a pharmacy technician may compound, admix, combine, or otherwise prepare and package a drug needed for dispensing under the supervision of a pharmacist according to written policies and procedures approved by the Board or its designee;
  5. Verify the accuracy, correct procedure, compounding, admixing, combining, measuring, counting, pouring, preparing, packaging, and safety of a drug prepared and packaged by a pharmacy technician or pharmacy technician trainee according to subsections (E)(3) and (4) and according to the policies and procedures in subsection (G);
  6. Supervise drug repackaging and check the completed repackaged product as specified in R4-23-402(A);
  7. Supervise training and education in aseptic technique and drug incompatibilities for all personnel involved in the admixture of parenteral products within the hospital pharmacy;
  8. Consult with the medical practitioner regarding the patient's drug therapy or medical condition;
  9. When requested by a medical practitioner, patient, patient's agent, or when the pharmacist deems it necessary, provide consultation with a patient regarding the medication order, patient's profile, or overall drug therapy;
  10. Monitor a patient's drug therapy for safety and effectiveness;
  11. Provide drug information to patients and health care professionals;
  12. Manage the activities of pharmacy technicians, pharmacy technician trainees, other personnel, and systems to ensure that all activities are performed accurately, safely, and without risk of harm to patients;
  13. Verify the accuracy of all aspects of the original, completed medication order; and
  14. Ensure compliance by pharmacy personnel with a quality assurance program developed by the hospital.
- F.** Pharmacy technicians and pharmacy technician trainees. Before working as a pharmacy technician or pharmacy technician trainee, an individual shall meet the eligibility and licensure requirements prescribed in 4 A.A.C. 23, Article 11
- G.** Pharmacy technician policies and procedures. Before employing a pharmacy technician or pharmacy technician trainee, a Director of Pharmacy or pharmacist-in-charge shall develop the policies and procedures required under R4-23-1104.
- H.** Pharmacy technician training program.
1. A Director of Pharmacy or pharmacist-in-charge shall comply with the training program requirements of R4-23-1105 based on the needs of the hospital pharmacy;
  2. A pharmacy technician or pharmacy technician trainee shall:
    - a. Perform only those tasks for which training and competency have been demonstrated; and
    - b. Not perform professional practices reserved for a pharmacist, graduate intern, or pharmacy intern in subsection (E), except as specified in subsections (E)(3) and (4).
- I.** Supervision. A hospital pharmacy's Director of Pharmacy and the pharmacist-in-charge, if a different individual, shall supervise all of the activities and operations of a hospital pharmacy.

A pharmacist shall supervise all functions and activities of pharmacy technicians, pharmacy technician trainees, and other hospital pharmacy personnel to ensure that all functions and activities are performed competently, safely, and without risk of harm to patients.

**Historical Note**

Former Rules 6.7310 and 6.7320; Amended effective August 10, 1978 (Supp. 78-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-654. Absence of Pharmacist**

- A.** If a pharmacist will not be on duty in the hospital, the Director of Pharmacy or pharmacist-in-charge shall arrange, before the pharmacist's absence, for the medical staff and other authorized personnel of the hospital to have access to drugs in the remote drug storage area defined in R4-23-110 or in the hospital pharmacy if a drug is not available in a remote drug storage area and is required to treat the immediate needs of a patient. A pharmacist shall be on-call during all absences.
- B.** If a pharmacist will not be on duty in the hospital pharmacy, the Director of Pharmacy or pharmacist-in-charge shall arrange, before the pharmacist's absence, for the medical staff and other authorized personnel of the hospital to have telephone access to an on-call pharmacist.
- C.** The hospital pharmacy permittee shall ensure that the hospital pharmacy is not without a pharmacist on duty in the hospital for more than 72 consecutive hours.
- D.** Remote drug storage area. The Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate committee of the hospital:
  1. Develop and maintain an inventory listing of the drugs to be included in a remote drug storage area; and
  2. Develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures that ensure proper storage, access, and accountability for drugs in a remote drug storage area.
- E.** Access to hospital pharmacy. If a drug is not available from a remote drug storage area and the drug is required to treat the immediate needs of a patient whose health may be compromised, the drug may be obtained from the hospital pharmacy according to the requirements of this subsection.
  1. The Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate committee of the hospital, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures to ensure that access to the hospital pharmacy during the pharmacist's absence conforms to the following requirements:
    - a. Access is delegated to only one supervisory nurse in each shift;
    - b. The policy and name of supervisory nurse is communicated in writing to the medical staff of the hospital;
    - c. Access is delegated only to a nurse who has received training from the Director of Pharmacy, pharmacist-in-charge, or Director's designee in the procedures required for proper access, drug removal, and recordkeeping; and

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- d. Access is delegated by the supervisory nurse to another nurse only in an emergency.
2. If a nurse to whom authority is delegated to access the hospital pharmacy removes a drug from the hospital pharmacy, the nurse shall:
  - a. Record the following information on a form or by another method approved by the Board or its designee:
    - i. Patient's name;
    - ii. Drug name, strength, and dosage form;
    - iii. Quantity of drug removed; and
    - iv. Date and time of removal;
  - b. Sign or initial, if a corresponding signature is on file in the hospital pharmacy, the form recording the drug removal;
  - c. Attach the original or a direct copy of the medication order for the drug to the form recording the drug removal; and
  - d. Place the form recording the drug removal conspicuously in the hospital pharmacy.
3. Within four hours after a pharmacist returns from an absence, the pharmacist shall verify all records of drug removal that occurred during the pharmacist's absence according to R4-23-653(E).

**Historical Note**

Former Rules 6.7410, 6.7420, 6.7430, 6.7440, 6.7450, and 6.7460; Amended subsection (A) effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-655. Physical Facility**

- A. General. A hospital pharmacy permittee shall ensure that the hospital pharmacy has sufficient equipment and physical facilities for proper compounding, dispensing, and storage of drugs, including parenteral preparations.
- B. Minimum area of hospital pharmacy. The minimum area of a hospital pharmacy depends on the type of hospital, the number of beds, and the pharmaceutical services provided. Any hospital pharmacy permit issued or hospital pharmacy remodeled after January 31, 2003 shall provide a minimum hospital pharmacy area, the actual area primarily devoted to drug dispensing and preparation functions, exclusive of bulk drug storage, satellite pharmacy, and office areas that is not less than 500 square feet. The minimum area requirement, not including unusable area, may be varied upon approval by the Board for out-of-the-ordinary conditions or for systems that require less space.
- C. The Board may also require that a hospital pharmacy permittee or applicant provide:
  1. More than the minimum area if equipment, inventory, personnel, or other factors cause crowding to a degree that interferes with safe pharmacy practice;
  2. Additional dispensing, preparation, or storage areas because of the increased number of specific drugs prescribed per day, the increased use of intravenous and irrigating solutions, and the increased use of disposable and prepackaged products;
  3. Additional dispensing, preparation, or storage areas to handle investigational drugs, emergency drug kits, che-

- motherapeutics, alcohol and other flammables, poisons, external preparations, and radioisotopes, and to accommodate quality control procedures; and
  4. Additional office space to provide for an increased number of personnel, a drug information library, a poison information library, research support, teaching and conferences, and a waiting area.
- D. Hospital pharmacy area. A hospital pharmacy permittee shall ensure that the hospital pharmacy area is enclosed by a permanent barrier or partition from floor to ceiling with entry doors that can be securely locked, constructed according to R4-23-609(F).
  - E. Hospital pharmacy storage areas. The hospital pharmacy permittee, Director of Pharmacy, or pharmacist-in-charge shall ensure that all undispensed or undistributed drugs are stored in designated areas within the hospital pharmacy or other locked areas under the control of a pharmacist that ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

**Historical Note**

Former Rules 6.7471, 6.7472, 6.7473, 6.7474, and 6.7490; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to Table 1 ("spare feet" changed to "square feet") (Supp. 91-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 11 A.A.R. 462, effective March 5, 2005 (Supp. 05-1).

**R4-23-656. Sanitation and Equipment**

A hospital pharmacy permittee or Director of Pharmacy shall ensure that a hospital pharmacy:

1. Has a professional reference library consisting of hard-copy or electronic media appropriate for the scope of pharmacy services provided by the hospital;
2. Has a sink, other than a sink in a toilet facility, that:
  - a. Has hot and cold running water;
  - b. Is within the hospital pharmacy area for use in preparing drug products; and
  - c. Is maintained in a sanitary condition and in good repair;
3. Maintains a room temperature within a range compatible with the proper storage of drugs;
4. Has a refrigerator and freezer with a temperature maintained within a range compatible with the proper storage of drugs requiring refrigeration or freezing; and
5. Has a designated area for a laminar air flow hood and other supplies required for the preparation of sterile products as specified in R4-23-670.

**Historical Note**

Former Rule 6.7480. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-657. Security**

- A. Personnel security standards. A Director of Pharmacy shall ensure that:
  1. No one is permitted in the pharmacy unless a pharmacist is present except as provided in this Section and R4-23-654. If only one pharmacist is on duty in the pharmacy and that pharmacist must leave the pharmacy for an emergency or patient care duties, nonpharmacist personnel may remain in the pharmacy to perform duties as outlined

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- in R4-23-653, provided that all C-II controlled substances are secured to prohibit access by other than a pharmacist, and that the pharmacist remains available in the hospital;
2. All hospital pharmacy areas are kept locked by key or programmable lock to prevent access by unauthorized personnel; and
  3. Pharmacists, pharmacy or graduate interns, pharmacy technicians, pharmacy technician trainees, and other personnel working in the pharmacy wear identification badges, including name and position, whenever on duty.

**B. Prescription blank security.** The Director of Pharmacy shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures for the safe distribution and control of prescription blanks bearing identification of the hospital.

**Historical Note**

Former Rule 6.7500; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-658. Drug Distribution and Control**

- A. General.** The Director of Pharmacy or pharmacist-in-charge shall in consultation with the medical staff, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with written policies and procedures for the effective operation of a drug distribution system that optimizes patient safety.
- B. Responsibility.** The Director of Pharmacy is responsible for the safe and efficient procurement, dispensing, distribution, administration, and control of drugs, including the following:
1. In consultation with the appropriate department personnel and medical staff committee, develop a medication formulary for the hospital;
  2. Proper handling, distribution, and recordkeeping of investigational drugs; and
  3. Regular inspections of drug storage and preparation areas within the hospital.
- C. Physician orders.** A Director of Pharmacy or pharmacist-in-charge shall ensure that:
1. Drugs are dispensed from the hospital pharmacy only upon a written order, direct copy or facsimile of a written order, or verbal order of an authorized medical practitioner; and
  2. A pharmacist reviews the original, direct or facsimile copy, or verbal order before an initial dose of medication is administered, except as specified in R4-23-653(E)(1).
- D. Labeling.** A Director of Pharmacy or pharmacist-in-charge shall ensure that all drugs distributed or dispensed by a hospital pharmacy are packaged in appropriate containers and labeled as follows:
1. For use inside the hospital.
    - a. Labels for all single unit packages contain at a minimum, the following information:
      - i. Drug name, strength, and dosage form;
      - ii. Lot number and beyond-use-date; and
      - iii. Appropriate auxiliary labels;
    - b. Labels for repackaged preparations contain at a minimum the following information:
      - i. Drug name, strength, and dosage form;

- ii. Lot number and beyond-use-date;
  - iii. Appropriate auxiliary labels; and
  - iv. Mechanism to identify pharmacist accountable for repackaging;
- c. Labels for all intravenous admixture preparations contain at a minimum the following information:
- i. Patient's name and location;
  - ii. Name and quantity of the basic parenteral solution;
  - iii. Name and amount of drug added;
  - iv. Date of preparation;
  - v. Beyond-use-date and time;
  - vi. Guidelines for administration;
  - vii. Appropriate auxiliary label or precautionary statement; and
  - viii. Initials of pharmacist responsible for admixture preparation; and

2. For use outside the hospital. Any drug dispensed to a patient by a hospital pharmacy that is intended for self-administration outside of the hospital is labeled as specified in A.R.S. §§ 32-1963.01(C) and 32-1968(D) and A.A.C. R4-23-402.

- E. Controlled substance accountability.** A Director of Pharmacy or pharmacist-in-charge shall ensure that effective policies and procedures are developed, implemented, reviewed, and revised in the same manner described in R4-23-653(A) and complied with regarding the use, accountability, and record-keeping of controlled substances in the hospital, including the use of locked storage areas when controlled substances are stored in patient care areas.
- F. Emergency services dispensing.** If a hospital permits dispensing of drugs from the emergency services department when the pharmacy is unable to provide this service, the Director of Pharmacy, in consultation with the appropriate department personnel and medical staff committee shall develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with written policies and procedures for dispensing drugs for outpatient use from the hospital's emergency services department. The policies and procedures shall include the following requirements:
1. Drugs are dispensed only to patients who have been admitted to the emergency services department;
  2. Drugs are dispensed only by an authorized medical practitioner, not a designee or agent;
  3. The nature and type of drugs available for dispensing are designed to meet the immediate needs of the patients treated within the hospital;
  4. Drugs are dispensed only in quantities sufficient to meet patient needs until outpatient pharmacy services are available;
  5. Drugs are prepackaged by a pharmacist or a pharmacy intern, graduate intern, pharmacy technician, or pharmacy technician trainee under the supervision of a pharmacist in suitable containers and appropriately prelabeled with the drug name, strength, dosage form, quantity, manufacturer, lot number, beyond-use-date, and any appropriate auxiliary labels;
  6. Upon dispensing, the authorized medical practitioner completes the label on the prescription container that complies with the requirements of R4-23-658(D); and
  7. The hospital pharmacy maintains a dispensing log, hard-copy prescription, or electronic record, approved by the Board or its designee and includes the patient name and address, drug name, strength, dosage form, quantity,

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directions for use, medical practitioner's signature or identification code, and DEA registration number, if applicable.

**Historical Note**

Former Rules 6.7610, 6.7620, and 6.7710; Amended effective Aug. 9, 1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Correction to subsection (I)(5) ("unnecessary" changed to "necessary") (Supp. 91-1). Amended effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-659. Administration of Drugs**

- A. Self-administration. A hospital shall not allow self-administration of medications by a patient unless the Director of Pharmacy or pharmacist-in-charge, in consultation with the appropriate department personnel and medical staff committee, develops, implements, reviews, and revises in the same manner described in R4-23-653(A) and complies with policies and procedures for self-administration of medications by a patient. The policies and procedures shall specify that self-administration of medications, if allowed, occurs only when:
  1. Specifically ordered by a medical practitioner, and
  2. The patient is educated and trained in the proper manner of self-administration.
- B. Drugs brought in by a patient. If a hospital allows a patient to bring a drug into the hospital and before a patient brings a drug into the hospital, the Director of Pharmacy or pharmacist-in-charge shall, in consultation with the appropriate department personnel and medical staff committee, develop, implement, review, and revise in the same manner described in R4-23-653(A) and comply with policies and procedures for a patient-owned drug brought into the hospital. The policies and procedures shall specify the following criteria for a patient-owned drug brought into the hospital:
  1. When policy allows the administration of a patient-owned drug, the drug is not administered to the patient unless:
    - a. A pharmacist or medical practitioner identifies the drug, and
    - b. A medical practitioner writes a medication order specifying administration of the identified patient-owned drug; and
  2. If a patient-owned drug will not be used during the patient's hospitalization, the hospital pharmacy's personnel shall:
    - a. Package, seal, and give the drug to the patient's agent for removal from the hospital; or
    - b. Package, seal, and store the drug for return to the patient at the time of discharge from the hospital.
- C. Drug samples. The Director of Pharmacy or pharmacist-in-charge is responsible for the receipt, storage, distribution, and accountability of drug samples within the hospital, including developing, implementing, reviewing, and revising in the same manner described in R4-23-653(A) and complying with specific policies and procedures regarding drug samples.

**Historical Note**

Former Rules 6.7720, 6.7730, 6.7740, 6.7760, 6.7770, 6.7780, 6.7800, 6.7810, 6.7820, 6.7830, 6.7840, 6.7850, 6.7871, 6.7872, and 6.7873; Amended effective Aug. 9,

1983 (Supp. 83-4). Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1).

Correction to Section heading ("rules" changed to "roles") (Supp. 91-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-660. Investigational Drugs**

The Director of Pharmacy or pharmacist-in-charge shall ensure that:

1. The following information concerning an investigational drug is available for use by hospital personnel:
  - a. Composition,
  - b. Pharmacology,
  - c. Adverse reactions,
  - d. Administration guidelines, and
  - e. All other available information concerning the drug, and
2. An investigational drug is:
  - a. Properly stored in, labeled, and dispensed from the pharmacy, and
  - b. Not dispensed before the drug is approved by the appropriate medical staff committee of the hospital.

**Historical Note**

Former Rules 6.7881, 6.7882, and 6.7883; Amended subsection (A) effective Aug. 9, 1983 (Supp. 83-4). Repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-661. Repealed****Historical Note**

Former Rules 6.7910, 6.7920, 6.7930, 6.7940, and 6.7950. Section repealed, new Section adopted effective February 7, 1990 (Supp. 90-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-662. Repealed****Historical Note**

Adopted effective February 7, 1990 (Supp. 90-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-663. Repealed****Historical Note**

Adopted effective February 7, 1990 (Supp. 90-1). Amended effective November 1, 1993 (Supp. 93-4). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-664. Repealed****Historical Note**

Adopted effective February 7, 1990 (Supp. 90-1). Subsection label removed (Supp. 91-1). Section repealed by final rulemaking at 8 A.A.R. 4902, effective January 5, 2003 (Supp. 02-4).

**R4-23-665. Reserved****R4-23-666. Reserved**



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**R4-23-667. Reserved****R4-23-668. Reserved****R4-23-669. Reserved****R4-23-670. Sterile Pharmaceutical Products**

**A.** In addition to the minimum area requirement of R4-23-609(A) and R4-23-655(B) and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall provide a minimum sterile pharmaceutical product compounding area that is not less than 100 square feet of contiguous floor area, except any pharmacy permit issued or pharmacy remodeled before November 1, 2006 may continue to use a sterile pharmaceutical product compounding area that is not less than 60 square feet of contiguous floor area, until a pharmacy ownership change occurs that requires issuance of a new permit or the pharmacy is remodeled. The pharmacy permittee or the pharmacist-in-charge shall ensure that the sterile pharmaceutical product compounding area:

1. Is dedicated to the purpose of preparing and compounding sterile pharmaceutical products;
2. Is isolated from other pharmacy functions;
3. Restricts entry or access;
4. Is free from unnecessary disturbances in air flow;
5. Is made of non-porous and cleanable floor, wall, and ceiling material; and
6. Meets the minimum air cleanliness standards of an ISO Class 7 environment as defined in R4-23-110, except an ISO class 7 environment is not required if all sterile pharmaceutical product compounding occurs within an ISO class 5 environment isolator, such as a glove box, pharmaceutical isolator, barrier isolator, pharmacy isolator, or hospital pharmacy isolator.

**B.** In addition to the equipment requirements in R4-23-611 and R4-23-612 or R4-23-656 and before compounding a sterile pharmaceutical product, a pharmacy permittee, limited-service pharmacy permittee, or applicant shall ensure that a pharmacist who compounds a sterile pharmaceutical product has the following equipment:

1. Environmental control devices capable of maintaining a compounding area environment equivalent to an "ISO class 5 environment" as defined in R4-23-110. Devices capable of meeting these standards include: laminar air-flow hoods, hepa filtered zonal airflow devices, glove boxes, pharmaceutical isolators, barrier isolators, pharmacy isolators, hospital pharmacy isolators, and biological safety cabinets;
2. Disposal containers designed for needles, syringes, and other material used in compounding sterile pharmaceutical products and if applicable, separate containers to dispose of cytotoxic, chemotherapeutic, and infectious waste products;
3. Freezer storage units with thermostatic control and thermometer, if applicable;
4. Packaging or delivery containers capable of maintaining official compendial drug storage conditions;
5. Infusion devices and accessories, if applicable; and
6. In addition to the reference library requirements of R4-23-612, a current reference pertinent to the preparation of sterile pharmaceutical products.

**C.** Before compounding a sterile pharmaceutical product, the pharmacy permittee, limited-service pharmacy permittee, or pharmacist-in-charge shall:

1. Prepare, implement, and comply with policies and procedures for compounding and dispensing sterile pharmaceutical products,
2. Review biennially and if necessary revise the policies and procedures required under subsection (C)(1),
3. Document the review required under subsection (C)(2),
4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee, and
5. Make the policies and procedures available in the pharmacy for employee reference and inspection by the Board or its designee.

**D.** The assembled policies and procedures shall include, where applicable, the following subjects:

1. Supervisory controls and verification procedures to ensure the quality and safety of sterile pharmaceutical products;
2. Clinical services and drug monitoring procedures for:
  - a. Patient drug utilization reviews;
  - b. Inventory audits;
  - c. Patient outcome monitoring;
  - d. Drug information; and
  - e. Education of pharmacy and other health professionals;
3. Controlled substances;
4. Supervisory controls and verification procedures for:
  - a. Cytotoxics handling, storage, and disposal;
  - b. Disposal of unused supplies and pharmaceutical products; and
  - c. Handling and disposal of infectious wastes;
5. Pharmaceutical product administration, including guidelines for the first dosing of a pharmaceutical product;
6. Drug and component procurement;
7. Pharmaceutical product compounding, dispensing, and storage;
8. Duties and qualifications of professional and support staff;
9. Equipment maintenance;
10. Infusion devices and pharmaceutical product delivery systems;
11. Investigational drugs and their protocols;
12. Patient profiles;
13. Patient education and safety;
14. Quality management procedures for:
  - a. Adverse drug reactions;
  - b. Drug recalls;
  - c. Expired pharmaceutical products;
  - d. Beyond-use-dating for both standard-risk and substantial-risk sterile pharmaceutical products consistent with the requirements of R4-23-410(B)(3)(d);
  - e. Temperature and other environmental controls;
  - f. Documented process and product validation testing; and
  - g. Semi-annual certification of the laminar air flow hood or other ISO class 5 environment, other equipment, and the ISO class 7 environment, including documentation of routine cleaning and maintenance for each laminar air flow hood or other ISO class 5 environment, other equipment, and the ISO class 7 environment; and
15. Sterile pharmaceutical product delivery requirements for:
  - a. Shipment to the patient;
  - b. Security; and
  - c. Maintaining official compendial storage conditions.

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- E.** Standard-risk sterile pharmaceutical product compounding. Before compounding a standard-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:
1. Compounding occurs only in an ISO class 5 environment within an ISO class 7 environment, and the ISO class 7 environment may have a specified prep area inside the environment;
  2. Compounding sterile pharmaceutical products from sterile commercial drugs or sterile pharmaceutical otic or ophthalmic products from non-sterile ingredients occurs using procedures that involve only a few closed-system, basic, simple aseptic transfers and manipulations;
  3. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and
  4. Each person who compounds completes an annual media-fill test to validate proper aseptic technique.
- F.** Substantial-risk sterile pharmaceutical product compounding. Before compounding a substantial-risk sterile pharmaceutical product, a pharmacy permittee or pharmacist-in-charge shall ensure compliance with the following minimum standards:
1. Compounding parenteral or injectable sterile pharmaceutical products from non-sterile ingredients occurs only in an ISO class 5 environment within an ISO class 7 environment and the ISO class 7 environment shall not have a prep area inside the environment;
  2. Each person who compounds wears adequate personnel protective clothing for sterile preparation that includes gown, gloves, head cover, and booties. Each person who compounds is not required to wear personnel protective clothing when all sterile pharmaceutical compounding occurs within an ISO class 5 environment isolator, and the ISO Class 5 environment isolator is not inside an ISO Class 7 environment; and
  3. Each person who compounds completes a semi-annual media-fill test that simulates the most challenging or stressful conditions for compounding using dry non-sterile media to validate proper aseptic technique.
- have access to particular areas of the limited-service pharmacy;
3. Implement procedures to guard against theft or diversion of drugs, including controlled substances; and
  4. Require all persons working in the limited-service pharmacy to wear badges, with their names and titles, while on duty.
- C.** To obtain permission to deviate from the minimum area requirement set forth in R4-23-609, R4-23-673, or R4-23-682, a limited-service pharmacy permittee shall submit a written request to the Board and include documentation that the deviation will facilitate experimentation or technological advances in the practice of pharmacy as defined in A.R.S. § 32-1901. If the Board determines the requested deviation from the minimum area requirement will enhance the practice of pharmacy and benefit the public, the Board shall grant the requested deviation.
- D.** The Board shall require more than the minimum area in a limited-service pharmacy when the Board determines that equipment, personnel, or other factors in the limited-service pharmacy cause crowding that interferes with safe pharmacy practice.
- E.** Before dispensing from a limited-service pharmacy, the limited-service pharmacy permittee or pharmacist-in-charge shall:
1. Prepare, implement, and comply with written policies and procedures for pharmacy operations and drug dispensing and distribution,
  2. Review biennially and if necessary revise the policies and procedures required under subsection (E)(1),
  3. Document the review required under subsection (E)(2),
  4. Assemble the policies and procedures as a written manual or by another method approved by the Board or its designee, and
  5. Make the policies and procedures available in the pharmacy for employee reference and inspection by the Board or its designee.

**Historical Note**

Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**Historical Note**

Adopted effective November 1, 1993 (Supp. 93-4). Amended by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3981, effective December 4, 2006 (Supp. 06-4).

**R4-23-671. General Requirements for Limited-service Pharmacy**

- A.** Before opening a limited-service pharmacy, a person shall obtain a permit in compliance with A.R.S. §§ 32-1929, 32-1930, 32-1931, and R4-23-606.
- B.** The limited-service pharmacy permittee shall secure the limited-service pharmacy by conforming with the following standards:
1. Permit no one to be in the limited-service pharmacy unless the pharmacist-in-charge or a pharmacist authorized by the pharmacist-in-charge is present;
  2. Require the pharmacist-in-charge to designate in writing, by name, title, and specific area, those persons who will

**R4-23-672. Limited-service Correctional Pharmacy**

- A.** The limited-service pharmacy permittee shall ensure that the limited-service correctional pharmacy complies with the standards for area, personnel, security, sanitation, equipment, drug distribution and control, administration of drugs, drug source, quality assurance, investigational drugs, and inspections as set forth in R4-23-608, R4-23-609(A) through (D) and (F) through (H), R4-23-610(A), R4-23-611, R4-23-612, R4-23-653(E), R4-23-658(B) through (E), R4-23-659, and R4-23-660.
- B.** The pharmacist-in-charge of a limited-service correctional pharmacy shall authorize only pharmacists, interns, pharmacy technicians, pharmacy technician trainees, compliance officers, drug inspectors, peace officers, and correctional officers acting in their official capacities, other persons authorized by law, support personnel, and other designated personnel to be in the limited-service correctional pharmacy.
- C.** When no pharmacist will be on duty in the correctional facility, the pharmacist-in-charge shall arrange, before there is no pharmacist on duty, for the medical staff and other authorized

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personnel of the correctional facility to have access to drugs in remote drug storage areas or, if a drug is not available in a remote drug storage area and is required to treat the immediate needs of a patient, in the limited-service correctional pharmacy.

1. The pharmacist-in-charge shall, in consultation with the appropriate committee of the correctional facility, develop and implement procedures to ensure that remote drug storage areas:
    - a. Contain only properly labeled drugs that might reasonably be needed and can be administered safely during the pharmacist's absence,
    - b. Contain drugs packaged only in amounts sufficient for immediate therapeutic requirements,
    - c. Are accessible only with a physician's written order,
    - d. Provide a written record of each drug withdrawn,
    - e. Are inventoried at least once each week, and
    - f. Are audited for compliance with the requirements of this rule at least once each month.
  2. The pharmacist-in-charge shall, in consultation with the appropriate committee of the correctional facility, develop and implement procedures to ensure that access to the limited-service correctional pharmacy when no pharmacist is on duty conforms to the following requirements:
    - a. Is delegated to only one nurse, who is in a supervisory position;
    - b. Is communicated in writing to medical staff of the correctional facility;
    - c. Is delegated only to a nurse who has received training from the pharmacist-in-charge in proper methods of access, removal of drugs, and recordkeeping procedures; and
    - d. Is delegated by the supervisory nurse to another nurse only in an emergency.
  3. When a nurse to whom authority to access the limited-service correctional pharmacy is delegated removes a drug from the limited-service correctional pharmacy, the nurse shall:
    - a. Record the following information on a form:
      - i. Patient's name,
      - ii. Name of the drug and its strength and dosage form,
      - iii. Dose prescribed,
      - iv. Amount of drug removed, and
      - v. Date and time of removal;
    - b. Sign the form recording the drug removal;
    - c. Attach the original or a direct copy of a physician's written order for the drug to the form recording the drug removal; and
    - d. Place the form recording the drug removal conspicuously in the limited-service correctional pharmacy.
  4. Within four hours after a pharmacist in the limited-service correctional pharmacy returns to duty following an absence in which the limited-service correctional pharmacy was accessed by a nurse to whom authority had been delegated, the pharmacist shall verify all records of drug removal according to R4-23-402.
- D.** When no pharmacist will be on duty in the correctional facility, the pharmacist-in-charge shall arrange, before there is no pharmacist on duty, for the medical staff and other authorized personnel of the correctional facility to have telephone access to a pharmacist.
- E.** The limited-service pharmacy permittee shall ensure that the limited-service correctional pharmacy is not without a pharmacist on duty for more than 96 consecutive hours.
- F.** In addition to the requirements of R4-23-671, the limited-service pharmacy permittee shall secure the limited-service correctional pharmacy as follows:
1. Permit no one to be in the limited-service correctional pharmacy unless a pharmacist is on duty except:
    - a. As provided in subsection (C)(3) when a pharmacist is not on duty; or
    - b. A pharmacy technician or pharmacy technician trainee may remain to perform duties in R4-23-1104(A), when a pharmacist is on duty and available in the correctional facility but temporarily absent from the pharmacy, provided:
      - i. All controlled substances are secured in a manner that prohibits access by persons other than a pharmacist;
      - ii. Activities performed by a pharmacy technician or pharmacy technician trainee while the pharmacist is temporarily absent are verified by the pharmacist immediately upon returning to the pharmacy;
      - iii. Any drug measured, counted, poured, or otherwise prepared and packaged by a pharmacy technician or pharmacy technician trainee while the pharmacist is temporarily absent is verified by the pharmacist immediately upon returning to the pharmacy; and
      - iv. Any drug that has not been verified by a pharmacist for accuracy is not dispensed, supplied, or distributed while the pharmacist is temporarily absent from the pharmacy; and
  2. Provide keyed or programmable locks to all areas of the limited-service correctional pharmacy.
- G.** The pharmacist-in-charge of a limited-service correctional pharmacy shall ensure that the written policies and procedures for pharmacy operations and drug distribution within the correctional facility include the following:
1. Physicians' orders, prescription orders, or both;
  2. Authorized abbreviations;
  3. Formulary system;
  4. Clinical services and drug utilization management including:
    - a. Participation in drug selection,
    - b. Drug utilization reviews,
    - c. Inventory audits,
    - d. Patient outcome monitoring,
    - e. Committee participation,
    - f. Drug information, and
    - g. Education of pharmacy and other health professionals;
  5. Duties and qualifications of professional and support staff;
  6. Products of abuse and contraband medications;
  7. Controlled substances;
  8. Drug administration;
  9. Drug product procurement;
  10. Drug compounding, dispensing, and storage;
  11. Stop orders;
  12. Pass or discharge medications;
  13. Investigational drugs and their protocols;
  14. Patient profiles;
  15. Quality management procedures for:

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- a. Adverse drug reactions;
  - b. Drug recalls;
  - c. Expired and beyond-use-date drugs;
  - d. Medication or dispensing errors;
  - e. Drug storage; and
  - f. Education of professional staff, support staff, and patients;
- 16. Recordkeeping;
  - 17. Sanitation;
  - 18. Security;
  - 19. Access to remote drug storage areas by non-pharmacists; and
  - 20. Access to limited-service correctional pharmacy by non-pharmacists.

**Historical Note**

Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4).

**R4-23-673. Limited-service Mail-order Pharmacy**

- A. The limited-service pharmacy permittee shall design and construct the limited-service mail-order pharmacy to conform with the following requirements:
  - 1. A dispensing area devoted to stocking, compounding, and dispensing prescription medications, which is physically separate from a non-dispensing area devoted to non-dispensing pharmacy services;
  - 2. A dispensing area of at least 300 square feet if three or fewer persons work in the dispensing area simultaneously;
  - 3. A dispensing area that provides 300 square feet plus 60 square feet for each person in excess of three persons if more than three persons work in the dispensing area simultaneously;
  - 4. Space in the dispensing area permits efficient pharmaceutical practice, free movement of personnel, and visual surveillance by the pharmacist;
  - 5. A non-dispensing area of at least 30 square feet for each person working simultaneously in the non-dispensing area; and
  - 6. Space in the non-dispensing area permits free movement of personnel and visual surveillance by the pharmacist; or
- B. The limited-service pharmacy permittee shall design and construct the limited-service mail-order pharmacy to conform with the following requirements:
  - 1. A contiguous area in which both dispensing and non-dispensing pharmacy services are provided;
  - 2. A contiguous area of at least 300 square feet if three or fewer persons work in the area simultaneously;
  - 3. A contiguous area that provides 300 square feet plus 60 square feet for each person in excess of three persons if more than three persons work in the area simultaneously; and
  - 4. Space in the contiguous area permits efficient pharmaceutical practice, free movement of personnel, and visual surveillance by the pharmacist.
- C. The limited-service pharmacy permittee shall ensure that the limited-service mail-order pharmacy complies with the standards for area, personnel, security, sanitation, and equipment set forth in R4-23-608, R4-23-609(B) through (H), R4-23-610 (A) and (C) through (F), R4-23-611, and R4-23-612.
- D. The pharmacist-in-charge of a limited-service mail-order pharmacy shall authorize only pharmacists, interns, pharmacy technicians, pharmacy technician trainees, compliance offi-

cers, drug inspectors, peace officers acting in their official capacities, support personnel, other persons authorized by law, and other designated personnel to be in the limited-service mail-order pharmacy.

- E. The pharmacist-in-charge of a limited-service mail-order pharmacy shall ensure that prescription medication is delivered to the patient or locked in the dispensing area when a pharmacist is not present in the pharmacy.
- F. In addition to the delivery requirements of R4-23-402, the limited-service pharmacy permittee shall, during regular hours of operation but not less than five days and a minimum 40 hours per week, provide toll-free telephone service to facilitate communication between patients and a pharmacist who has access to patient records at the limited-service mail-order pharmacy. The limited-service pharmacy permittee shall disclose this toll-free number on a label affixed to each container of drugs dispensed from the limited-service mail-order pharmacy.
- G. The pharmacist-in-charge of a limited-service mail-order pharmacy shall ensure that the written policies and procedures for pharmacy operations and drug distribution include the following:
  - 1. Prescription orders;
  - 2. Clinical services and drug utilization management for:
    - a. Drug utilization reviews,
    - b. Inventory audits,
    - c. Patient outcome monitoring,
    - d. Drug information, and
    - e. Education of pharmacy and other health professionals;
  - 3. Duties and qualifications of professional and support staff;
  - 4. Controlled substances;
  - 5. Drug product procurement;
  - 6. Drug compounding, dispensing, and storage;
  - 7. Patient profiles;
  - 8. Quality management procedures for:
    - a. Adverse drug reactions,
    - b. Drug recalls,
    - c. Expired and beyond-use-date drugs,
    - d. Medication or dispensing errors, and
    - e. Education of professional and support staff;
  - 9. Recordkeeping;
  - 10. Sanitation;
  - 11. Security;
  - 12. Drug delivery requirements for:
    - a. Transportation,
    - b. Security,
    - c. Temperature and other environmental controls,
    - d. Emergency provisions, and
  - 13. Patient education.

**Historical Note**

Adopted effective April 5, 1996 (Supp. 96-2). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 4453, effective December 4, 2004 (Supp. 04-4).

**R4-23-674. Limited-service Long-term Care Pharmacy**

- A. A limited-service pharmacy permittee shall ensure that the limited-service long-term care pharmacy complies with:
  - 1. The general requirements of R4-23-671;
  - 2. The professional practice standards of Article 4 and Article 11; and
  - 3. The permits and drug distribution standards of R4-23-606 through R4-23-612, R4-23-670, and this Section.

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- B. If a limited-service long-term care pharmacy permittee contracts with a long-term care facility as a Provider Pharmacy, as defined in R4-23-110, the limited-service long-term care pharmacy permittee shall ensure that the long-term care consultant pharmacist and the pharmacist-in-charge of the limited-service long-term care pharmacy comply with R4-23-701, R4-23-701.01, R4-23-701.02, R4-23-701.03, R4-23-701.04, and this Section.
- C. The limited-service long-term care pharmacy permittee or pharmacist-in-charge shall ensure that prescription medication is delivered to the patient's long-term care facility or locked in the dispensing area of the pharmacy when a pharmacist is not present in the pharmacy.
- D. The pharmacist-in-charge of a limited-service long-term care pharmacy shall authorize only those individuals listed in R4-23-610(B) to be in the limited-service long-term care pharmacy.
- E. In consultation with the long-term care facility's medical director and director of nursing, the long-term care consultant pharmacist and pharmacist-in-charge of the long-term care facility's provider pharmacy may develop, if necessary, a medication formulary for the long-term care facility that ensures the safe and efficient procurement, dispensing, distribution, administration, and control of drugs in the long-term care facility.
- F. The limited-service long-term care pharmacy permittee or pharmacist-in-charge shall ensure that the written policies and procedures required in R4-23-671(E) include the following:
  - 1. Clinical services and drug utilization management for:
    - a. Drug utilization reviews,
    - b. Inventory audits,
    - c. Patient outcome monitoring,
    - d. Drug information, and
    - e. Education of pharmacy and other health professionals;
  - 2. Controlled substances;
  - 3. Drug compounding, dispensing, and storage;
  - 4. Drug delivery requirements for:
    - a. Transportation,
    - b. Security,
    - c. Temperature and other environmental controls, and
    - d. Emergency provisions;
  - 5. Drug product procurement;
  - 6. Duties and qualifications of professional and support staff;
  - 7. Emergency drug supply unit procedures;
  - 8. Formulary, including development, review, modification, use, and documentation, if applicable;
  - 9. Patient profiles;
  - 10. Patient education;
  - 11. Prescription orders, including:
    - a. Approved abbreviations,
    - b. Stop-order procedures, and
    - c. Leave-of-absence and discharge prescription order procedures;
  - 12. Quality management procedures for:
    - a. Adverse drug reactions,
    - b. Drug recalls,
    - c. Expired and beyond-use-date drugs,
    - d. Medication or dispensing errors, and
    - e. Education of professional and support staff;
  - 13. Recordkeeping;
  - 14. Sanitation; and
  - 15. Security.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-675. Limited-service Sterile Pharmaceutical Products Pharmacy**

- A. The limited-service pharmacy permittee or the pharmacist-in-charge shall ensure that the limited-service sterile pharmaceutical products pharmacy complies with the standards for area, personnel, security, sanitation, equipment, sterile pharmaceutical products, and limited-service pharmacies established in R4-23-608, R4-23-609, R4-23-610, R4-23-611, R4-23-612, R4-23-670, and R4-23-671.
- B. The pharmacist-in-charge of a limited-service sterile pharmaceutical products pharmacy shall authorize only pharmacists, interns, compliance officers, peace officers acting in their official capacities, pharmacy technicians, pharmacy technician trainees, support personnel, and other designated personnel to be in the limited-service sterile pharmaceutical products pharmacy.
- C. The pharmacist-in-charge of a limited-service sterile pharmaceutical products pharmacy shall ensure that prescription medication is delivered to the patient or locked in the dispensing area when a pharmacist is not present in the pharmacy.
- D. In addition to the delivery requirements of R4-23-402, the limited-service pharmacy permittee shall, during regular hours of operation, but not less than a minimum 40 hours per week, provide toll-free telephone service to facilitate communication between patients and a pharmacist who has access to patient records at the limited-service sterile pharmaceutical products pharmacy. The limited-service pharmacy permittee shall disclose this toll-free number on a label affixed to each container dispensed from the limited-service sterile pharmaceutical products pharmacy.
- E. The limited-service pharmacy permittee or the pharmacist-in-charge shall ensure development, implementation, review and revision in the same manner described in R4-23-671(E) and compliance with policies and procedures for pharmacy operations, including pharmaceutical product compounding, dispensing, and distribution, that comply with the requirements of R4-23-402, R4-23-410, R4-23-670, and R4-23-671.
- F. The non-dispensing roles of the pharmacist may include chart reviews, audits, drug therapy monitoring, committee participation, drug information, and in-service training of pharmacy and other health professionals.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3391, effective October 2, 2004 (Supp. 04-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). This Section was not amended as originally stated in the historical note published in Supp. 13-3; therefore the reference to the amendment has been removed (Supp. 18-2).

**R4-23-676. Third-party Logistics Provider Permit**

- A. A person shall not provide logistics services, as described under A.R.S. § 32-1941(A), until the Board issues a third-party logistics provider permit for the facility.
- B. A person that wants to provide logistics services shall obtain a Board-issued third-party logistics provider permit for each facility.

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- C. Application. To obtain a third-party logistics provider permit for a facility, a person shall submit a completed application, using a form available on the Board's website, and the fee specified in R4-23-205.
- D. Change of ownership. A third-party logistics provider permittee shall comply with R4-23-601(F).
- E. A third-party logistics provider permittee shall renew the permit as specified under R4-23-602(D).
- F. The Board shall adhere to the time frames specified under R4-23-602(C) when processing an initial or renewal application for a third-party logistics provider permit.

**Historical Note**

New Section made by final rulemaking at 25 A.A.R.  
1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-677. Automated Prescription-dispensing Kiosk Permit****A. General provisions.**

- 1. Only a person issued a Board permit under A.R.S. § 32-1929 to operate a pharmacy in Arizona may apply to the Board under A.R.S. § 32-1930 for a permit to operate an automated prescription-dispensing kiosk.
- 2. A pharmacy permittee described under subsection (A)(1) shall apply for a separate permit for each automated prescription-dispensing kiosk to be operated.
- 3. To obtain an automated prescription-dispensing kiosk permit, a pharmacy permittee shall submit a completed application, using a form available on the Board's website, and the fee specified in R4-23-205.
- 4. A pharmacy permittee to which the Board issues an automated prescription-dispensing kiosk permit shall designate a pharmacist in charge of the automated prescription-dispensing kiosk.
- 5. A pharmacy permittee to which the Board issues an automated prescription-dispensing kiosk permit shall not place the automated prescription-dispensing kiosk in a gas station or convenience store.

**B. Policies and procedures.** A pharmacy permittee to which the Board issues an automated prescription-dispensing kiosk permit shall:

- 1. Ensure policies and procedures are established for the appropriate performance and use of the automated prescription-dispensing kiosk. The policies and procedures shall address:
  - a. Maintaining a record of each transaction in a manner that attaches the record to the permit number of the automated prescription-dispensing kiosk;
  - b. Controlling access to the automated prescription-dispensing kiosk;
  - c. Operating the automated prescription-dispensing kiosk;
  - d. Training personnel who use the automated prescription-dispensing kiosk;
  - e. Maintaining patient services when the automated prescription-dispensing kiosk is not operating or the prescribed drug or device is not available;
  - f. Securing the automated prescription-dispensing kiosk against unauthorized removal of the kiosk or access to or removal of drugs or devices from the kiosk;
  - g. Assuring a patient receives the pharmacy services necessary for appropriate pharmaceutical care including consultation with a pharmacist;
  - h. Maintaining integrity of information in the system and patient confidentiality;

- i. Stocking and restocking the automated prescription-dispensing kiosk;
- j. Ensuring compliance with packaging and labeling requirements; and
- k. Removing drugs and devices from the automated prescription-dispensing kiosk without dispensing them and handling wasted or discarded drugs and devices;
- 2. Ensure the policies and procedures are implemented and complied with by all personnel using the automated prescription-dispensing kiosk;
- 3. Maintain the policies and procedures by:
  - a. Reviewing the policies and procedures biennially and making needed revisions, if any;
  - b. Documenting the review required under subsection (B)(3)(a);
  - c. Assembling the policies and procedures as a written or electronic manual; and
  - d. Making the policies and procedures available within the pharmacy permittee to which the Board issued an automated prescription-dispensing kiosk permit for reference by pharmacy personnel and inspection by the Board; and
- 4. Implement a quality assurance program to monitor compliance with the policies and procedures and all state and federal law.

**C. Change of ownership.** An automated prescription-dispensing kiosk permittee shall comply with R4-23-601(F).**D. An automated prescription-dispensing kiosk permittee shall renew the permit as specified under R4-23-602(D).****E. The Board shall adhere to the time frames specified under R4-23-602(C) when processing an initial or renewal application for an automated prescription-dispensing kiosk permit.****Historical Note**

New Section made by final rulemaking at 25 A.A.R.  
1012, effective June 1, 2019 (Supp. 19-2).

**R4-23-678. Reserved****R4-23-679. Reserved****R4-23-680. Reserved****R4-23-681. General Requirements for Limited-service Nuclear Pharmacy****A. To be an authorized nuclear pharmacist, a pharmacist shall:**

- 1. Hold a current pharmacist license issued by the Board; and
- 2. Be certified as a nuclear pharmacist by:
  - a. The Board of Pharmaceutical Specialties, or
  - b. A similar group recognized by the Arizona State Board of Pharmacy; or
- 3. Satisfy each of the following requirements:
  - a. Meet minimal standards of training for status as an authorized user of radioactive material, as specified by the Arizona Radiation Regulatory Agency and the United States Nuclear Regulatory Commission;
  - b. Submit certification of completion of a Board-approved nuclear pharmacy training program or other training program recognized by the Arizona Radiation Regulatory Agency, with 200 hours of didactic training in the following areas:
    - i. Radiation physics and instrumentation,
    - ii. Radiation protection,
    - iii. Mathematics pertaining to the use and measurement of radioactivity,

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- iv. Radiation biology, and
  - v. Radiopharmaceutical chemistry;
  - c. Submit evidence of a minimum of 500 hours of clinical/practical nuclear pharmacy training under the supervision of an authorized nuclear pharmacist in the following areas:
    - i. Procuring radioactive materials;
    - ii. Compounding radiopharmaceuticals;
    - iii. Performing routine quality control procedures;
    - iv. Dispensing radiopharmaceuticals;
    - v. Distributing radiopharmaceuticals;
    - vi. Implementing basic radiation protection procedures; and
    - vii. Consulting and educating the nuclear medicine community, patients, pharmacists, other health professionals, and the general public; and
  - d. Submit written certification, signed by a preceptor who is an authorized nuclear pharmacist, that the above training was satisfactorily completed.
- B.** Radiopharmaceuticals are prescription-only drugs that require specialized techniques in their handling and testing, to obtain optimum results and minimize hazards.
1. A person shall not sell, barter, or otherwise dispose of, or be in possession of any radiopharmaceutical except under the conditions detailed in A.R.S. § 32-1929.
  2. A person shall not manufacture, compound, sell, or dispense any radiopharmaceutical unless the person is a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist in accordance with A.R.S. § 32-1961 and these rules, with the exception of the following, if the following are licensed by the Arizona Radiation Regulatory Agency to use radiopharmaceuticals in compliance with A.R.S. § 30-673;
    - a. A medical practitioner who administers a radiopharmaceutical to the medical practitioner's patient as provided in A.R.S. § 32-1921(A),
    - b. A hospital nuclear medicine department, and
    - c. A medical practitioner's office.
  3. The Board shall cooperate with the Arizona Radiation Regulatory Agency and other interested state and federal agencies, in the enforcement of these rules for the protection of the public. This cooperation may include exchange of licensing and other information, joint inspections, and other activities where indicated.
- C.** In addition to compliance with all the applicable federal and state laws and rules governing drugs, whether radioactive or not, a limited-service nuclear pharmacy permittee shall comply with all laws and rules of the Arizona Radiation Regulatory Agency and the U.S. Nuclear Regulatory Commission, including emergency and safety provisions.
- D.** A limited-service nuclear pharmacy permittee shall comply with the education, experience, and licensing requirements of the Arizona Radiation Regulatory Agency.
- E.** A limited-service nuclear pharmacy permittee shall ensure that radiopharmaceuticals are transferred only to a person or firm that holds a current Radioactive Materials License issued by the Arizona Radiation Regulatory Agency.
- A.** Before operating a limited-service nuclear pharmacy, a person shall obtain a permit in compliance with A.R.S. §§ 32-1929, 32-1930, and 32-1931, and R4-23-606.
  - B.** A permit to operate a limited-service nuclear pharmacy shall be issued only to a person who is or employs an authorized nuclear pharmacist and holds a current Arizona Radiation Regulatory Agency Radioactive Materials License. A limited-service nuclear pharmacy permittee that fails to maintain a current Arizona Radiation Regulatory Agency Radioactive Materials License shall be immediately suspended pending revocation by the Board. A limited-service nuclear pharmacy permittee shall have copies of Arizona Radiation Regulatory Agency inspection reports available upon request for Board inspection.
    1. A limited-service nuclear pharmacy permittee shall designate an authorized nuclear pharmacist as the pharmacist-in-charge. The pharmacist-in-charge shall be responsible to the Board:
      - a. For the operations of the pharmacy related to the practice of pharmacy and distribution of drugs and devices;
      - b. For communicating Board directives to the management, pharmacists, interns, and other personnel of the pharmacy; and
      - c. For the pharmacy's compliance with all federal and state pharmacy laws and rules.
    2. An authorized nuclear pharmacist shall directly supervise all personnel performing tasks in the preparation and distribution of radiopharmaceuticals and ancillary drugs.
    3. An authorized nuclear pharmacist shall be present whenever the limited-service nuclear pharmacy is open for business.
  - C.** A limited-service nuclear pharmacy permittee shall ensure that the limited-service nuclear pharmacy complies with the standards for personnel, area, security, sanitation, and general requirements in R4-23-608, R4-23-609, R4-23-610, R4-23-611, and R4-23-671.
    1. A limited-service nuclear pharmacy shall contain separate areas for:
      - a. Preparing and dispensing radiopharmaceuticals,
      - b. Receiving and shipping radiopharmaceuticals,
      - c. Storing radiopharmaceuticals, and
      - d. Decaying radioactive waste.
    2. The Board may require more than the minimum area in instances where equipment, inventory, personnel, or other factors cause crowding to a degree that interferes with safe pharmacy practice.
  - D.** The pharmacist-in-charge shall designate in writing, by title and specific area, the persons who may have access to particular pharmacy areas.
  - E.** A limited-service nuclear pharmacy permittee shall maintain records of acquisition, inventory, and disposition of radiopharmaceuticals, other radioactive substances, and other drugs in accordance with federal and state statutes and rules.
    1. A prescription order, in addition to the requirements in A.R.S. § 32-1968(C) and R4-23-407(A), shall contain:
      - a. The date and time of calibration of the radiopharmaceutical,
      - b. The name of the procedure for which the radiopharmaceutical is prescribed, and
      - c. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product.

**Historical Note**

Adopted effective December 3, 1974 (Supp. 75-1).  
 Amended subsections (A), (C) and (D) effective Aug. 12, 1988 (Supp. 88-3). Amended effective July 8, 1997 (Supp. 97-3).

**R4-23-682. Limited-service Nuclear Pharmacy**

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2. The lead container used to store and transport a radiopharmaceutical shall have a label that, in addition to the requirements in A.R.S. § 32-1968(D), includes:
    - a. The date and time of calibration of the radiopharmaceutical,
    - b. The name of the radiopharmaceutical,
    - c. The molybdenum 99 content to USP limits,
    - d. The name of the procedure for which the radiopharmaceutical is prescribed,
    - e. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product,
    - f. The words "Caution: Radioactive Material," and
    - g. The standard radiation symbol.
  3. The radiopharmaceutical container shall have a label that includes:
    - a. The date and time of calibration of the radiopharmaceutical;
    - b. The name of the patient, recorded before dispensing, if the radiopharmaceutical is therapeutic or for a blood product;
    - c. The words "Physician's Use Only" instead of the name of the patient if the radiopharmaceutical is nontherapeutic or for a nonblood product;
    - d. The name of the radiopharmaceutical;
    - e. The dose of radiopharmaceutical;
    - f. The serial number;
    - g. The words "Caution: Radioactive Material"; and
    - h. The standard radiation symbol.
- F.** The following minimum requirements are in addition to the requirements of the Arizona Radiation Regulatory Agency, the applicable U.S. Nuclear Regulatory Commission regulations, and the applicable regulations of the federal Food and Drug Administration. A limited-service nuclear pharmacy permittee shall provide:
1. In addition to the minimum pharmacy area requirements in R4-23-609:
    - a. An area for the storing, compounding, and dispensing of radiopharmaceuticals completely separate from pharmacy areas for nonradioactive drugs;
    - b. A minimum of 80 sq. ft. for a hot lab and storage area; and
    - c. A minimum of 300 sq. ft. of compounding and dispensing area;
  2. The following equipment:
    - a. Fume hood, approved by the Arizona Radiation Regulatory Agency;
    - b. Laminar flow hood;
    - c. Dose calibrator;
    - d. Refrigerator;
    - e. Prescription balance, Class A, and weights or an electronic balance of equal or greater accuracy;
    - f. Well scintillation counter;
    - g. Incubator oven;
    - h. Microscope;
    - i. An assortment of labels, including prescription labels and cautionary and warning labels;
    - j. Glassware necessary for compounding and dispensing radiopharmaceuticals as required by the Arizona Radiation Regulatory Agency;
    - k. Other equipment necessary for radiopharmaceutical quality control for products compounded or dispensed as required by the Arizona Radiation Regulatory Agency;
- l. Current antidote and drug interaction information; and
  - m. Regional poison control phone number prominently displayed in the pharmacy area;
3. Supplies necessary for compounding and dispensing radiopharmaceuticals as required by the Arizona Radiation Regulatory Agency;
  4. A professional reference library consisting of a minimum of one current reference or text addressing each of the following subject areas:
    - a. Therapeutics,
    - b. Nuclear pharmacy practice, and
    - c. Imaging;
  5. Current editions and supplements of:
    - a. A.R.S. §§ 30-651 through 30-696 pertaining to the Arizona Radiation Regulatory Agency,
    - b. Rules of the Arizona Radiation Regulatory Agency,
    - c. Regulations of the federal Food and Drug Administration pertaining to radioactive drugs,
    - d. Arizona Pharmacy Act and rules,
    - e. Arizona Uniform Controlled Substances Act, and
    - f. Radiological Health Handbook.
- G.** The pharmacist-in-charge of a limited-service nuclear pharmacy shall prepare, implement, review, and revise in the same manner described in R4-23-671(E) and comply with written policies and procedures for pharmacy operations and drug distribution.
- H.** The written policies and procedures of a limited-service nuclear pharmacy shall include the following:
1. Prescription orders;
  2. Clinical services and drug utilization management including:
    - a. Drug utilization reviews,
    - b. Inventory audits,
    - c. Patient outcome monitoring,
    - d. Drug information, and
    - e. Education of pharmacy and other health professionals;
  3. Duties and qualifications of professional and support staff;
  4. Radioactive material handling, storage, and disposal;
  5. Drug product procurement;
  6. Drug compounding, dispensing, and storage;
  7. Investigational drugs and their protocols;
  8. Patient profiles;
  9. Quality management procedures for:
    - a. Adverse drug reaction reports;
    - b. Drug recall;
    - c. Expired and beyond-use-date drugs;
    - d. Medication or dispensing errors;
    - e. Radiopharmaceutical quality assurance;
    - f. Radiological health and safety;
    - g. Drug storage and disposition; and
    - h. Education of professional staff, support staff, and patients;
  10. Recordkeeping;
  11. Sanitation;
  12. Security;
  13. Drug delivery requirements for:
    - a. Transportation,
    - b. Security,
    - c. Radiological health and safety procedures,
    - d. Temperature and other environmental controls, and
    - e. Emergency provisions; and



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## 14. Patient education.

**Historical note**

Adopted effective July 8, 1997 (Supp. 97-3). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3).

**R4-23-683. Reserved****R4-23-684. Reserved****R4-23-685. Reserved****R4-23-686. Reserved****R4-23-687. Reserved****R4-23-688. Reserved****R4-23-689. Reserved****R4-23-690. Reserved****R4-23-691. Repealed****Historical Note**

Adopted effective Dec. 3, 1974 (Supp. 75-1). Amended effective Aug. 12, 1988 (Supp. 88-3). Amended effective November 1, 1993 (Supp. 93-4). Repealed effective July 8, 1997 (Supp. 97-3).

**R4-23-692. Compressed Medical Gas (CMG) Distributor-Resident or Nonresident****A. Permit.**

1. A person shall not manufacture, process, transfill, package, or label a compressed medical gas in Arizona, or manufacture, process, transfill, package, or label a compressed medical gas outside Arizona and ship into Arizona without a current Board-issued resident or nonresident compressed medical gas distributor permit.
2. Before operating as a compressed medical gas distributor, a person shall register with the FDA as a medical gas manufacturer and comply with the drug listing requirements of the federal act.

**B. Application.** To obtain a resident or nonresident CMG distributor permit, a person shall submit to the Board a completed application form and the fee specified in R4-23-205.

1. A resident CMG distributor permit applicant shall include documentation of compliance with local zoning laws, if required by the Board.
2. A nonresident CMG distributor permit applicant that resides in a jurisdiction that issues an equivalent license or permit shall include a copy of the equivalent license or permit.

**C. Notification.** A resident or nonresident CMG distributor permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, e-mail or mailing address, or business name.**D. Change of ownership.** A resident or nonresident CMG distributor permittee shall comply with R4-23-601(F).**E. Relocation.**

1. No fewer than 30 days before a resident CMG distributor permittee relocates, the permittee shall electronically or manually submit a completed application for relocation using a form furnished by the Board, and the documentation required in subsection (B). A fee is not required with an application for relocation.

2. A nonresident CMG distributor permittee shall provide written notice by mail, fax, or e-mail to the Board office no fewer than 10 days before relocating.

**F.** A resident or nonresident CMG distributor permittee is authorized to sell or distribute a compressed medical gas under a compressed medical gas order only to durable medical equipment and compressed medical gas suppliers and other entities that are registered, licensed, or permitted to use, administer, or distribute compressed medical gases.**G.** Facility. A resident or nonresident CMG distributor permittee shall ensure the facility is clean, uncluttered, sanitary, temperature controlled, and secure from unauthorized access.**H.** Current Good Manufacturing Practice: A resident or nonresident CMG distributor permittee is required under federal law to follow the good manufacturing practice requirements of 21 CFR parts 210 and 211.**I.** Records: A resident or nonresident CMG distributor permittee shall:

1. Establish and implement written procedures for maintaining records pertaining to production, transfilling, process control, labeling, packaging, quality control, distribution, returns, recalls, training of personnel, complaints, and any information required by federal or state law.
2. Retain the records required by Section R4-23-601, this Section, and 21 CFR parts 210 and 211 for not fewer than three years or one year after the expiration date of the compressed medical gas, whichever is longer.
3. Make the records required by Section R4-23-601, this Section, and 21 CFR parts 210 and 211 available for inspection by the Board or its compliance officer, or if stored in a centralized recordkeeping system apart from the inspection location and not electronically retrievable, provide the records within four working days of a request by the Board or its compliance officer.

**J. Inspection.**

1. A resident CMG distributor permittee shall make the CMG distributor's facility available for inspection by the Board or its compliance officers under A.R.S. § 32-1904.
2. Within 10 days from the date of a request by the Board or its staff, a nonresident CMG distributor permittee shall provide a copy of the most recent inspection report completed by the permittee's resident licensing authority or the FDA or a copy of the most recent inspection report completed by a third-party auditor approved by the permittee's resident licensing authority or the Board or its designee. The Board may inspect, or may employ a third-party auditor to inspect, a nonresident permittee as specified in A.R.S. § 32-1904.

**K.** Permit renewal. To renew a CMG distributor permit, the permittee shall comply with R4-23-602(D).**L.** Nothing in this Section shall be construed to prohibit the emergency administration of oxygen by licensed health-care personnel, emergency medical technicians, first responders, fire fighters, law enforcement officers, and other emergency personnel trained in the proper use of emergency oxygen.**Historical Note**

Adopted effective January 12, 1998 (Supp. 98-1). Amended by final rulemaking at 19 A.A.R. 97, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 20 A.A.R. 1364, effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

**R4-23-693. Durable Medical Equipment (DME) and Com-**

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**pressed Medical Gas (CMG) Supplier-Resident or Nonresident**

**A.** Permit. A person shall not sell, lease, or supply durable medical equipment or a compressed medical gas to a patient or consumer in Arizona for use in a home or residence without a current Board-issued resident or nonresident durable medical equipment and compressed medical gas supplier permit.

1. The permit requirements of this Section do not apply to the following unless there is a separate business entity engaged in the business of providing durable medical equipment or a compressed medical gas to a patient or consumer for use in a home or residence:
  - a. A medical practitioner licensed under A.R.S. Title 32;
  - b. A hospital, long-term care facility, hospice, or other health-care facility using durable medical equipment or a compressed medical gas in the normal course of treating a patient; and
  - c. A pharmacy.

2. Nothing in this Section shall be construed to prohibit a person with a current Board-issued nonprescription drug permit from the retail sale of nonprescription drugs or devices.

**B.** Application. To obtain a resident or nonresident DME and CMG supplier permit, a person shall submit a completed application form and fee specified in R4-23-205.

1. A resident DME and CMG supplier permit applicant shall include documentation of compliance with local zoning laws, if required by the Board.
2. A nonresident DME and CMG supplier permit applicant that resides in a jurisdiction that issues an equivalent license or permit shall include a copy of the equivalent license or permit.

**C.** Notification. A resident or nonresident DME and CMG supplier permittee shall submit using the permittee's online profile or provide written notice by mail, fax, or e-mail to the Board office within 10 days of changes involving the telephone or fax number, email or mailing address, or business name.

**D.** Change of ownership. A resident or nonresident DME and CMG supplier permittee shall comply with R4-23-601(F).

**E.** Relocation.

1. No fewer than 30 days before a resident DME and CMG supplier permittee relocates, the permittee shall submit a completed application for relocation electronically or manually on a form furnished by the Board, and the documentation required in subsection (B). A fee is not required with an application for relocation.
2. A nonresident DME and CMG supplier permittee shall provide written notice by mail, fax, or e-mail to the Board office no fewer than 10 days before relocating.

**F.** Orders. A resident or nonresident DME and CMG supplier shall sell, lease, or provide:

1. Durable medical equipment that is a prescription-only device, as defined in A.R.S. § 32-1901, only under a prescription or medication order from a medical practitioner; and
2. A compressed medical gas only under a compressed medical gas order from a medical practitioner.

**G.** Restriction. A DME and CMG supplier permit authorizes the permittee to procure, possess, and provide a prescription-only device or compressed medical gas to a patient or consumer as specified in subsection (F). A DME and CMG supplier permit does not authorize the permittee to procure, possess, or provide narcotics or other controlled substances, prescription-

only drugs other than compressed medical gases, precursor chemicals, or regulated chemicals.

**H.** Facility. A resident or nonresident DME and CMG supplier permittee shall ensure the facility is clean, uncluttered, sanitary, temperature controlled, and secure from unauthorized access. A permittee shall maintain separate and identified storage areas in the facility and in delivery vehicles for clean, dirty, contaminated, or damaged durable medical equipment or compressed medical gases.

**I.** A resident or nonresident DME and CMG supplier permittee shall not manufacture, process, transfill, package, or label a compressed medical gas, except as stated in subsection (K).

**J.** Records. A resident or nonresident DME and CMG supplier permittee shall establish and implement written procedures for maintaining records about acquisition, distribution, returns, recalls, training of personnel, maintenance, cleaning, and complaints.

**K.** A permittee shall:

1. Ensure a prescription order, medication order, or compressed medical gas order is obtained as specified in subsection (F);
2. Ensure each compressed medical gas container supplied by the permittee contains a label bearing the name and address of the permittee;
3. Ensure all appropriate warning labels are present on the durable medical equipment or compressed medical gas;
4. Retain the records required by Section R4-23-601 and this Section for not fewer than three years, or if supplying a compressed medical gas, one year after the expiration date of the compressed medical gas, whichever is longer; and
5. Make the records required by Section R4-23-601 and this Section available for inspection by the Board or its compliance officer, or if stored in a centralized recordkeeping system apart from the inspection location and not electronically retrievable for inspection, provide the records within four working days of a request by the Board or its staff.

**L.** Inspection.

1. A resident DME and CMG supplier permittee shall make the DME and CMG supplier's facility available for inspection by the Board or its compliance officers under A.R.S. § 32-1904.
2. Within 10 days from the date of a request by the Board or its staff, a nonresident DME and CMG supplier permittee shall provide a copy of the most recent inspection report completed by the permittee's resident licensing authority, or a copy of the most recent inspection report completed by a third-party auditor approved by the permittee's resident licensing authority or the Board or its designee. The Board may inspect, or may employ a third-party auditor to inspect, a nonresident permittee as specified in A.R.S. § 32-1904.

**M.** Permit renewal. To renew a resident or nonresident DME and CMG supplier permit, the permittee shall comply with in R4-23-602(D).

**N.** Nothing in this Section shall be construed to prohibit the emergency administration of oxygen by licensed health-care personnel, emergency medical technicians, first responders, fire fighters, law enforcement officers, and other emergency personnel trained in the proper use of emergency oxygen.

**Historical Note**

Adopted effective January 12, 1998 (Supp. 98-1).

Amended by final rulemaking at 20 A.A.R. 1364,

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effective August 2, 2014 (Supp. 14-2). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2).

### ARTICLE 7. NON-PHARMACY LICENSED OUTLETS – GENERAL PROVISIONS

#### R4-23-701. Long-term Care Facilities Pharmacy Services: Consultant Pharmacist

A. The long-term care consultant pharmacist as defined in R4-23-110 shall:

1. Possess a valid Arizona pharmacist license issued by the Board;
2. Ensure the provision of pharmaceutical patient care services as defined in R4-23-110;
3. Review the distribution and storage of drugs and devices and assist the facility in establishing policies and procedures for the distribution and storage of drugs and devices;
4. Provide resident evaluation programs that relate to monitoring the therapeutic response and utilization of all drugs and devices prescribed or administered to residents, using as guidelines the most current indicators established by the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services as required in 42 CFR 483.60 (revised October 1, 2010, incorporated by reference and on file with the Board. This incorporated material contains no future editions or amendments.);
5. Serve as a resource for pharmacy-related education services within the facility;
6. Participate in quality management of resident care in the facility; and
7. Communicate with the provider pharmacy regarding areas of mutual concern and resolution.

B. A long-term care consultant pharmacist shall ensure that:

1. When a provider pharmacy is not open for business, arrangements are made in advance by the long-term care consultant pharmacist, in cooperation with the pharmacist-in-charge of the provider pharmacy and the director of nursing and medical staff of the long-term care facility, for providing emergency drugs for the licensed nursing staff to administer to the residents of the facility using an emergency drug supply unit located at the facility;
2. The label and packaging of prescription-only and nonprescription drugs intended for use within a long-term care facility complies with state and federal law; and
3. The long-term care facility:
  - a. Stores controlled substances listed in A.R.S. § 36-2513 in a separately locked and permanently affixed compartment, unless the facility uses a single-unit package medication distribution system; and
  - b. Maintains accurate records of controlled substance administration or ultimate disposition.

C. The long-term care consultant pharmacist shall:

1. Ensure availability of records and reports designed to provide the data necessary to evaluate the drug use of each long-term care facility resident that include the following:
  - a. Provider pharmacy patient profiles and long-term care facility medication administration records;
  - b. Reports of suspected adverse drug reactions;
  - c. Inspection reports of drug storage areas with emphasis on detecting outdated drugs; and
  - d. Accountability reports, that include:
    - i. Date and time of administration,
    - ii. Name of the person who administered the drug,
    - iii. Documentation and verification of any wasted or partial doses,
    - iv. Exception reports for refused doses, and
    - v. All drug destruction forms; and
2. Identify and report drug irregularities and dispensing errors to the prescriber, the director of nursing of the facility, and the provider pharmacy.

D. A long-term care consultant pharmacist or pharmacist-in-charge of a provider pharmacy shall ensure that:

1. Discontinued or outdated drugs, including controlled substances, are destroyed or disposed of in a timely manner using methods consistent with federal, state, and local requirements and subject to review by the Board or its staff; and
2. Drug containers with illegible or missing labels are:
  - a. Identified; and
  - b. Replaced or relabeled by a pharmacist employed by the pharmacy that dispensed the prescription medication.

#### Historical Note

Former Rules 6.8110, 6.8120, 6.8130, 6.8140, 6.8150, 6.8160, and 6.8170; Amended effective Aug. 10, 1978 (Supp. 78-4). Section repealed, new Section adopted effective December 18, 1992 (Supp. 92-4). Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

#### R4-23-701.01. Long-term Care Facilities Pharmacy Services: Provider Pharmacy

The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that:

1. A prescription medication is provided only by a valid prescription order for an individual long-term care facility resident, properly labeled for that resident, as specified in this subsection. Nothing in this Section shall prevent a provider pharmacy from supplying nonprescription drugs in a manufacturer's unopened container or emergency drugs using an emergency drug supply unit as specified in R4-23-701.02;
2. A prescription medication label for a long-term care facility resident complies with A.R.S. §§ 32-1968 and 36-2525 and contains:
  - a. The drug name, strength, dosage form, and quantity; and
  - b. The beyond-use-date;
3. Only a pharmacist employed by the pharmacy that dispensed the prescription medication may, through the exercise of professional judgment, relabel or alter a prescription medication label that is illegible or missing;
4. The provider pharmacy develops and implements drug recall policies and procedures that protect the health and safety of facility residents. The drug recall procedures shall include immediate discontinuation of any patient level recalled drug and notification of the prescriber and director of nursing of the facility; and
5. Drugs previously dispensed to a resident of the long-term care facility by another pharmacy, and drugs previously dispensed by the provider pharmacy, are not repackaged.

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**Historical Note**

Adopted effective December 18, 1992 (Supp. 92-4).  
Amended by final rulemaking at 9 A.A.R. 1064, effective  
May 4, 2003 (Supp. 03-1). Amended by final rulemaking  
at 19 A.A.R. 2894, effective November 10, 2013 (Supp.  
13-3).

**R4-23-701.02. Long-term Care Facilities Pharmacy Services: Emergency Drugs**

- A.** The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that:
1. An emergency drug supply unit is available within the long-term care facility,
  2. Drugs contained in an emergency drug supply unit remain the property of the provider pharmacy, and
  3. Controlled substance drugs contained in an emergency drug supply unit are included in all inventories required under A.R.S. § 36-2523(B) and R4-23-1003(A).
- B.** An emergency drug supply unit shall meet the following criteria:
1. The drugs are necessary to meet the immediate and emergency therapeutic needs of long-term care facility residents as determined by the provider pharmacy's pharmacist-in-charge in consultation with the long-term care facility's medical director and nursing director;
  2. The purpose of the emergency drug supply unit in a long-term care facility is not to relieve a provider pharmacy of the responsibility for timely provision of the resident's routine drug needs, but to ensure that an emergency drug supply unit is available for facility residents in need of immediate and emergency therapeutic drugs; and
  3. The drugs are provided in a manufacturer's unit of use package or are prepackaged and labeled to include the drug name, strength, dosage form, manufacturer, lot number, and expiration date and provider pharmacy's name, address, telephone number, and pharmacist's initials.
- C.** The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that an emergency drug supply unit:
1. Is stored in an area that:
    - a. Is temperature controlled; and
    - b. Prevents unauthorized access;
  2. Contains on the exterior of the emergency drug supply unit a label to indicate that the contents are for emergency use only;
  3. Contains on the exterior of the emergency drug supply unit a complete list of the contents of the unit by drug name, strength, dosage form, and quantity and the provider pharmacy's name, address, and telephone number;
  4. Contains on the exterior of the emergency drug supply unit a label that indicates the date of the earliest drug expiration date;
  5. Contains on the exterior of the emergency drug supply unit a label that indicates the date of and pharmacist responsible for the last inspection of the emergency drug supply unit; and
  6. Is secured with a tamper-evident seal, or is locked and sealed in a manner that obviously reveals when the unit has been opened or tampered with.
- D.** The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Prepare, implement, review, and revise in the same manner described in R4-23-671(E) and comply with written policies and procedures for the storage and use of an emergency drug supply unit in a long-term care facility;

2. Make the policies and procedures available in the provider pharmacy and long-term care facility for employee reference and inspection by the Board or its staff;
  3. Ensure that the written policies and procedures include the following:
    - a. Drug removal procedures that require:
      - i. The long-term care facility's personnel receive a valid prescription order for each drug removed from the emergency drug supply unit,
      - ii. The long-term care facility's personnel notify the provider pharmacy when a drug is removed from the emergency drug supply unit,
    - b. Outdated drug replacement procedures, and
    - c. Security and inspection procedures;
  4. Exchange or restock the emergency drug supply unit weekly, or more often as necessary, to ensure the availability of an adequate supply of emergency drugs within the long-term care facility. Restocking of the emergency drug supply unit at the facility shall be completed by an Arizona licensed pharmacist employed by the provider pharmacy, or by an Arizona licensed intern, graduate intern, technician or technician trainee under the direct onsite supervision of an Arizona licensed pharmacist; and
  5. Educate pharmacy and long-term care facility personnel in the storage and use of an emergency drug supply unit.
- E.** In addition to the requirements of subsections (A) through (D), an automated emergency drug supply unit may be used provided:
1. The pharmacy permittee or pharmacist-in-charge of the provider pharmacy notifies the Board or its staff in writing of the intent to use an automated emergency drug supply unit, including the name and type of unit;
  2. The provider pharmacy is notified electronically when the automated emergency drug supply unit has been accessed;
  3. All events involving the access of the automated emergency drug supply unit are recorded electronically and maintained for not less than two years;
  4. The provider pharmacy is capable of producing a report of all transactions of the automated emergency drug supply unit including a single drug usage report as required in R4-23-408(B)(5) on inspection by the Board or its staff;
  5. The provider pharmacy develops written policies and procedures for:
    - a. Accessing the automated emergency drug supply unit in the event of a system malfunction or downtime,
    - b. Authorizing and modifying user access,
    - c. An ongoing quality assurance program that includes:
      - i. Training in the use of the automated emergency drug supply unit for all authorized users,
      - ii. Maintenance and calibration of the automated emergency drug supply unit as recommended by the device manufacturer; and
  6. Documentation of the requirements of subsection (E)(5)(c)(ii) is maintained for inspection by the Board or its staff for not less than two years.
- F.** The Board may prohibit a pharmacy permittee or pharmacist-in-charge of a provider pharmacy from using an automated emergency drug supply unit if the pharmacy permittee or pharmacy permittee's employees do not comply with the requirements of subsections (A) through (E).

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**Historical Note**

Adopted effective December 18, 1992 (Supp. 92-4).  
Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-701.03. Long-term Care Facilities Pharmacy Services: Emergency Drug Prescription Order**

The limited-service pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure that every emergency drug prescription order is evaluated according to the requirements of R4-23-402(A) by a pharmacist within 72 hours of the first dose of drug administered by long-term care facility personnel under the emergency drug prescription order.

**Historical Note**

Adopted effective December 18, 1992 (Supp. 92-4).  
Amended by final rulemaking at 9 A.A.R. 1064, effective May 4, 2003 (Supp. 03-1).

**R4-23-701.04. Long-term Care Facilities Pharmacy Services: Automated Dispensing Systems**

- A.** Before using an automated dispensing system as defined in R4-23-110, a pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Notify the Board or its staff in writing of the intent to use an automated dispensing system, including the name and type of system;
  2. Obtain a separate controlled substances registration at the location of each long-term care facility at which an automated dispensing system containing controlled substances will be located as required by federal law; and
  3. Maintain copies of the registrations required under subsection (A)(2) at the provider pharmacy for inspection by the Board or its staff.
- B.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure:
1. Drugs contained in an automated dispensing system remain the property of the provider pharmacy;
  2. Controlled substance drugs contained in an automated dispensing system are included in all inventories required under A.R.S. § 36-2523(B) and R4-23-1003(A);
  3. Schedule II drugs are not stocked in an automated dispensing system; and
  4. A separate emergency drug supply unit is available in the long-term care facility to meet the requirements of R4-23-701.02.
- C.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
1. Ensure that policies and procedures as required in subsection (D) for the use of an automated dispensing system in a long-term care facility are prepared, implemented, and complied with;
  2. Review biennially and, if necessary, revise the policies and procedures required under subsection (D);
  3. Document the review required under subsection (C)(2);
  4. Assemble the policies and procedures as a written or electronic manual; and
  5. Make the policies and procedures available for employee reference and inspection by the Board or its staff within the pharmacy and at any location outside of the pharmacy where the automated dispensing system is used.

- D.** A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall ensure the written policies and procedures include:

1. Drug removal procedures that include the following:
  - a. A drug is provided only by a valid prescription order for an individual long-term care facility resident;
  - b. A drug is dispensed from an automated dispensing system only after a pharmacist has:
    - i. Reviewed and verified the resident's prescription order as required by R4-23-402(A), and
    - ii. Electronically authorized the access for that drug for that particular resident; and
  - c. The automated dispensing system labels each individual drug packet with a resident specific label that complies with R4-23-701.01(2) and contains the resident's room number or facility identification number; and
2. Security procedures that include the following:
  - a. The pharmacy permittee or pharmacist-in-charge of the provider pharmacy is responsible for authorizing user access, including adding and removing users and modifying user access;
  - b. Each authorized user is a licensee of the Board or authorized licensed personnel of the long-term care facility; and
  - c. The automated dispensing system is secured at the long-term care facility by electronic or mechanical means or a combination thereof designed to prevent unauthorized access;
3. Drug stocking procedures that include the following:
  - a. Automated dispensing systems that use non-removable containers that do not allow prepackaging of the container as set out in subsection (D)(3)(b):
    - i. Are stocked at the long-term care facility by an Arizona licensed pharmacist employed by the provider pharmacy, or by an Arizona licensed intern, graduate intern, technician or technician trainee under the direct onsite supervision of an Arizona licensed pharmacist; and
    - ii. Utilize bar code or other technologies to ensure the correct drug is placed in the correct canister or container; and
  - b. Automated dispensing systems that use removable containers may be stocked at the long-term care facility by an authorized user provided:
    - i. The prepackaging of the container occurs at the provider pharmacy;
    - ii. A pharmacist verifies the container has been properly filled and labeled, and the container is secured with a tamper-evident seal;
    - iii. The individual containers are transported to the long-term care facility in a secure, tamper-evident shipping container; and
    - iv. The automated dispensing system uses microchip, bar-coding, or other technologies to ensure the containers are accurately loaded in the automated dispensing system; and
4. Recordkeeping and report procedures that include the following:
  - a. All events involving the access of the automated dispensing system are recorded electronically and maintained for not less than two years;

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- b. The provider pharmacy is capable of producing a report of all transactions of the automated dispensing system including:
      - i. A single drug usage report that complies with R4-23-408(B)(5); and
      - ii. An authorized user history including date and time of access and type of transaction; and
    - c. The provider pharmacy has procedures to safeguard the storage, packaging, and distribution of drugs by monitoring:
      - i. Current inventory;
      - ii. Expiration dates;
      - iii. Controlled substance dispensing;
      - iv. Re-dispense requests; and
      - v. Wastage.
  - E. A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
    - 1. Ensure that an electronic log is kept for each container fill that includes:
      - a. An identification of the container by drug name and strength, and container number;
      - b. The drug's manufacturer or National Drug Code (NDC) number;
      - c. The expiration date and lot number from the manufacturer's stock bottle that is used to fill the container. If multiple lot numbers of the same drug are added to a container, each lot number and expiration date shall be documented;
      - d. The date the container is filled;
      - e. Documentation of the identity of the licensee who placed the drug into the container; and
      - f. If the licensee who filled the container is not a pharmacist, documentation of the identity of the pharmacist who supervised the non-pharmacist licensee; and
    - 2. Maintain the electronic log for inspection by the Board or its staff for not less than two years.
  - F. A pharmacy permittee or pharmacist-in-charge of a provider pharmacy shall:
    - 1. Implement an ongoing quality assurance program that monitors performance of the automated dispensing system and compliance with the established policies and procedures that includes:
      - a. Training in the use of the automated dispensing system for all authorized users,
      - b. Maintenance and calibration of the automated dispensing system as recommended by the device manufacturer,
      - c. Routine accuracy validation testing no less than every three months, and
      - d. Downtime and malfunction procedures to ensure the timely provision of medication to the long-term care facility resident, and
    - 2. Maintain documentation of the requirements of subsections (F)(1)(b) and (F)(1)(c) for inspection by the Board or its staff for not less than two years.
  - G. The Board may prohibit a pharmacy permittee or pharmacist-in-charge from using an automated dispensing system in a long-term care facility if the pharmacy permittee or the pharmacy permittee's employees do not comply with the requirements of subsections (A) through (F).

**Historical Note**

New Section made by final rulemaking at 19 A.A.R.

2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-702. Hospice Inpatient Facilities**

- A. If a pharmacy permittee contracts to provide pharmacy services to the patients of a hospice inpatient facility as defined in R4-23-110, the pharmacy permittee shall ensure that:
  - 1. A prescription medication is provided only by a valid prescription order for an individual hospice inpatient facility patient, properly labeled for that patient, as specified in this subsection. Nothing in this section shall prevent a provider pharmacy from supplying non-prescription drugs in a manufacturer's unopened container;
  - 2. A prescription medication label for a hospice inpatient facility patient complies with A.R.S. §§ 32-1968 and 36-2525 and contains:
    - a. The drug name, strength, dosage form, and quantity; and
    - b. The beyond-use date; and
  - 3. If the label on the hospice inpatient facility patient's drug container becomes damaged or soiled, a pharmacist employed by the pharmacy that dispensed the drug container, through the exercise of professional judgment, may relabel the drug container. Only a pharmacist is permitted to label a drug container or alter the label of a drug container.
- B. A pharmacist may help hospice inpatient facility personnel develop written policies and procedures for the procurement, administration, storage, control, recordkeeping, and disposal of drugs in the facility.
- C. The provider pharmacy may contract with the hospice inpatient facility to provide pharmacist services at the facility that include evaluation of the patient's response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action.
- D. A provider pharmacy that places an emergency drug supply unit at a hospice inpatient facility shall comply with the requirements of R4-23-701.02.
- E. A pharmacy shall not place an automated dispensing system as defined in R4-23-701.04 in a hospice inpatient facility.
- F. Drugs previously dispensed to a patient of the hospice inpatient facility by another pharmacy, and drugs previously dispensed by the provider pharmacy, shall not be repackaged.

**Historical Note**

Former Rules 6.8210, 6.8211, 6.8212, 6.8213, 6.8214, 6.8221, 6.8222, 6.8223, 6.8824, 6.8231, 6.8232, 6.8233, 6.8241, 6.8242, and 6.8243; Amended effective August 10, 1978 (Supp. 78-4). Repealed effective December 18, 1992 (Supp. 92-4). New Section made by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-703. Assisted Living Facilities**

- A. Before dispensing, selling, or delivering a prescription or non-prescription drug to an assisted living facility resident, a pharmacy permittee shall verify the assisted living facility has a current and active license issued by the Arizona Department of Health Services.
- B. A pharmacy permittee shall ensure that, except as provided under subsection (C):
  - 1. A controlled substance prescription drug is dispensed, sold, or delivered to an assisted living facility resident only after receiving a valid prescription order for the controlled substance prescription drug from the resident's medical practitioner; and

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2. The controlled substance prescription drug is labeled in accordance with A.R.S. §§ 32-1963.01, 32-1968, and 36-2525 and includes the beyond-use date on the label.
- C. A pharmacy permittee may dispense, sell, or deliver to an assisted living facility resident a Schedule III, IV, or V controlled substance prescription if the pharmacy permittee:
  1. Receives a written or oral prescription order for the Schedule III, IV, or V controlled substance from:
    - a. The resident's medical practitioner,
    - b. An individual licensed by the Arizona Board of Nursing who is acting within the scope of practice of the individual's license, or
    - c. The manager or a caregiver of the assisted living facility if the resident's medical practitioner has a written agreement with the assisted living facility designating a representative of the assisted living facility as an agent of the medical practitioner and a licensed medical practitioner provided the prescription order;
  2. Complies with subsection (D)(2); and
  3. Labels the Schedule III, IV, or V controlled substance as specified under subsection (B)(2).
- D. A pharmacy permittee may dispense, sell, or deliver to an assisted living facility resident a non-controlled substance prescription or non-prescription drug if the pharmacy permittee:
  1. Receives a written or oral prescription order for the non-controlled substance prescription or non-prescription drug from:
    - a. The resident's medical practitioner,
    - b. An individual licensed by the Arizona Board of Nursing who is acting within the scope of practice of the individual's license, or
    - c. An assisted living facility manager or caregiver acting under the authority of a licensed medical practitioner;
  2. Determines the written or oral prescription order:
    - a. Meets the requirements of R4-23-407, and
    - b. Includes the name and title of the individual transmitting the prescription order; and
  3. Labels the non-narcotic prescription or non-prescription drug in accordance with A.R.S. §§ 32-1963.01 and 32-1968 and includes the beyond-use date on the label.
- E. If the label on an assisted living facility resident's drug container becomes damaged or soiled, a pharmacist employed by the pharmacy permittee that dispensed the drug container, through the exercise of professional judgment, may relabel the drug container. Only a pharmacist is permitted to label a drug container or alter the label of a drug container.
- F. A pharmacist may help assisted living facility personnel develop written policies and procedures regarding procuring, administering, storing, controlling, keeping records, and disposing of drugs in the facility and provide information concerning safe and effective supervision of drug self-administration.
- G. A pharmacy permittee shall not place an emergency drug supply unit as described in R4-23-701.02 or an automated dispensing system as described in R4-23-701.04 in an assisted living facility.
- H. A pharmacist shall not repackage a drug previously dispensed to an assisted living facility resident.

**Historical Note**

Former Rules 6.8310, 6.8320, 6.8330, 6.8340, 6.8350, 6.8360, and 6.8370; Amended effective August 10, 1978 (Supp. 78-4). Amended by final rulemaking at 5 A.A.R.

2561, effective July 16, 1999 (Supp. 99-3). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 23 A.A.R. 2424, effective October 14, 2017 (Supp. 17-3).

**R4-23-704. Customized Patient Medication Packages**

In lieu of dispensing two or more prescribed drugs in separate containers, a pharmacist may, with the consent of the patient, the patient's caregiver, the prescriber, or the facility caring for the patient, provide a customized patient medication package. The pharmacist preparing a customized patient medication package shall abide by the guidelines set forth in the current edition of the official compendium for labeling, packaging, and recordkeeping, and state and federal law.

**Historical Note**

Former Rules 6.8410, 6.8411, 6.8412, 6.8413, 6.8414, 6.8415, 6.8416, and 6.8417. Section R4-23-704 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 19 A.A.R. 2894, effective November 10, 2013 (Supp. 13-3).

**R4-23-705. Repealed****Historical Note**

Former Rules 6.8420, 6.8421, 6.8422, 6.8423, 6.8424, 6.8425, 6.8426, 6.8427, 6.8428, and 6.8429. Amended effective August 10, 1978 (Supp. 78-4). Amended effective August 24, 1992 (Supp. 92-3). Repealed effective December 18, 1992 (Supp. 92-4).

**R4-23-706. Repealed****Historical Note**

Former Rules 6.8431, 6.8432, 6.8433, 6.8434, 6.8435, 6.8436, and 6.8437; Amended effective August 10, 1978 (Supp. 78-4). Amended subsections (C), (E), (F), and (G) effective April 20, 1982 (Supp. 82-2). Section R4-23-706 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

**R4-23-707. Repealed****Historical Note**

Former Rules 6.8441, 6.8442, 6.8450, 6.8451, 6.8452, 6.8453, 6.8454, 6.8455, 6.8456, and 6.8457. Section R4-23-707 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

**R4-23-708. Repealed****Historical Note**

Former Rules 6.8461, 6.8462, 6.8463, and 6.8464. Section R4-23-708 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

**R4-23-709. Repealed****Historical Note**

Former Rules 6.8471, 6.8472, and 6.8473. Section R4-23-709 repealed by final rulemaking at 5 A.A.R. 862, effective March 3, 1999 (Supp. 99-1).

**ARTICLE 8. DRUG CLASSIFICATION**

*Article 8, consisting of Sections R4-23-801 and R4-23-802, recodified from Article 5 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).*

**R4-23-801. Repealed****Historical Note**

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Former Rules 7.1110, 7.1120, and 7.1130. Repealed effective November 4, 1998 (Supp. 98-4). Recodified from R4-23-501 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3). Repealed by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1).

**R4-23-802. Veterinary**

Veterinary preparation: A veterinary drug manufacturer or supplier may distribute:

1. A prescription-only veterinary drug to:
  - a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
  - b. A full-service drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or
  - c. A pharmacy permitted under A.R.S. Title 32, Chapter 18, and
2. A nonprescription veterinary drug to:
  - a. A veterinary medical practitioner licensed under A.R.S. Title 32, Chapter 21,
  - b. A nonprescription drug retailer permitted under A.R.S. Title 32, Chapter 18,
  - c. A full-service or nonprescription drug wholesaler permitted under A.R.S. Title 32, Chapter 18, or
  - d. A pharmacy permitted under A.R.S. Title 32, Chapter 18.

**Historical Note**

Former Rules 7.1210, 7.1220, and 7.1230. Repealed effective November 4, 1998 (Supp. 98-4). Recodified from R4-23-502 at 9 A.A.R. 4011, effective August 18, 2003 (Supp. 03-3).

**R4-23-803. Repealed****Historical Note**

Former Rules 7.1300, 7.1400, 7.1500, and 7.1000. Repealed effective November 4, 1998 (Supp. 98-4).

**R4-23-804. Repealed****Historical Note**

Former Rules 7.2100, 7.2200, 7.2300, 7.2410, 7.2420, and 7.2430. Repealed effective November 4, 1998 (Supp. 98-4).

**ARTICLE 9. PENALTIES AND MISCELLANEOUS****R4-23-901. Penalty for Violations**

Any person, firm, or corporation violating any provision of 4 A.A.C. 23 is subject to the penalties in A.R.S. § 32-1996. In addition, a license or permit issued under the provisions of A.R.S. Title 32, Chapter 18 is subject to suspension or revocation for violation of 4 A.A.C. 23.

**Historical Note**

Former Rule 9.0000. Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

**R4-23-902. Non-disciplinary Civil Penalties**

As authorized under A.R.S. § 32-1904(D), the Board may issue the following non-disciplinary civil penalties to a licensee or permittee who engages in the specified acts or omissions without posing an imminent threat to public health or safety:

1. Failing to submit a remodel application before remodeling a permitted facility: \$250;
2. Failing to provide notice before a business is relocated: \$500;
3. Failing to update contact information: \$50/occurrence to a maximum of twice;

4. Failing to update change of employment information: \$50/occurrence to a maximum of twice;
5. Failing to complete required continuing education:
  - a. Registered pharmacist: \$100/deficient hour of continuing education for the first occurrence, \$150/deficient hour for second occurrence; and
  - b. Pharmacy technician: \$25/deficient hour of continuing education for the first occurrence, \$37.50/deficient hour for second occurrence;
6. Failing to provide notice of a new pharmacist in charge: \$100/occurrence to a maximum of twice;
7. Failing to provide notice of a new designated representative: \$100/occurrence to a maximum of twice;
8. Failing to provide notice of a new criminal charge, arrest, or conviction in any jurisdiction: \$250/occurrence to a maximum of twice;
9. Failing to provide notice of disciplinary action taken against the licensee or permittee by another jurisdiction: \$250/occurrence to a maximum of twice;
10. Failing to renew a license timely and continuing to work with an expired license:
  - a. Registered pharmacist: \$100/day worked not to exceed \$1,000; and
  - b. Pharmacy technician: \$50/day worked not to exceed \$500;
11. Failing to conduct a controlled substance inventory when there is a new pharmacist in charge: \$250/occurrence to a maximum of twice;
12. Failing to obtain a permit before shipping into Arizona anything for which a permit is required: \$100/item shipped;
13. Failing to respond timely to a subpoena: \$50;
14. Failing to provide notice before there is a change in ownership: \$250; and
15. Failing to conduct required controlled substance inventories: \$250.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**ARTICLE 10. UNIFORM CONTROLLED SUBSTANCES AND DRUG OFFENSES****R4-23-1001. Repealed****Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Section repealed by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3).

**R4-23-1002. Repealed****Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Repealed effective November 4, 1998 (Supp. 98-4).

**R4-23-1003. Records and Order Forms****A. Records.**

1. If the pharmacist-in-charge of a pharmacy is replaced by another pharmacist-in-charge, the new pharmacist-in-charge shall complete an inventory of all controlled substances in the pharmacy within 10 days of assuming the responsibility. This inventory and any other required controlled substance inventory shall:
  - a. Include an exact count of all Schedule II controlled substances;



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- b. Include an exact count of all Schedule III through Schedule V controlled substances or an estimated count if the stock container contains fewer than 1001 units;
  - c. Indicate the date the inventory is taken and whether the inventory is taken before opening of business or after close of business for the pharmacy;
  - d. Be signed by:
    - i. The pharmacist-in-charge; or
    - ii. For other required inventories, the pharmacist who does the inventory;
  - e. Be kept separately from all other records; and
  - f. Be available in the pharmacy for inspection by the Board or its designee for not less than three years.
2. A loss of a controlled substance shall be reported:
- a. Within 10 days of discovery;
  - b. On a DEA form 106;
  - c. By the pharmacist-in-charge of a pharmacy or a manufacturer;
  - d. By the permittee or designated representative of a full-service wholesaler; and
  - e. To the federal Drug Enforcement Administration (DEA), the Narcotic Division of the Department of Public Safety (DPS), and the Board of Pharmacy. A copy of the DEA form 106 shall be kept on file by the pharmacy permittee. The DEA form 106 shall state whether the police investigated the loss.
3. Every person manufacturing any controlled substance, including repackaging or relabeling, shall record and retain for not less than three years the manufacturing, repackaging, or relabeling date for each controlled substance.
4. Every person receiving, selling, delivering, or disposing of any controlled substance shall record and retain for not less than three years the following information:
- a. The name, strength, dosage form, and quantity of each controlled substance received, sold, delivered, or disposed;
  - b. The name, address, and DEA registration number of the person from whom each controlled substance is received;
  - c. The name, address, and DEA registration number of the person to whom each controlled substance is sold or delivered or who disposes of each controlled substance; and
  - d. The date of each transaction.
5. A full-service drug wholesale permittee or the designated representative shall complete an inventory of all controlled substances in the manner prescribed in subsection (A)(1). The permittee or designated representative shall conduct this inventory:
- a. On May 1 of each year or as directed by the Board; and
  - b. If there is a change of ownership, or discontinuance of business, or within 10 days of a change of a designated representative.
6. A drug manufacturer permittee or the pharmacist-in-charge shall complete an inventory of all controlled substances in the manner prescribed in subsection (A)(1). The permittee or pharmacist-in-charge shall conduct this inventory:
- a. On May 1 of each year or as directed by the Board; and

- b. If there is a change of ownership, or discontinuance of business, or within 10 days of a change of a pharmacist-in-charge.

- B.** Order form. For purposes of A.R.S. § 36-2524, "Order Form" means DEA Form 222c.

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4).  
 Amended effective November 1, 1993 (Supp. 93-4).  
 Amended effective April 1, 1995; filed January 31, 1995 (Supp. 95-1). Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3). Amended by final rulemaking at 12 A.A.R. 1912, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 3670, effective November 8, 2008 (Supp. 08-3).

**R4-23-1004. Schedules of Controlled Substances**

As of the effective date of this Section and as required under A.R.S. §§ 36-2512 through 36-2516, the Board adopts the following schedules of controlled substances. The schedules adopted include no later amendments. The adopted schedules are available on the Board's website:

- 1. Schedule I. 21 CFR, Chapter II, Part 1308.11;
- 2. Schedule II. 21 CFR, Chapter II, Part 1308.12;
- 3. Schedule III. 21 CFR, Chapter II, Part 1308.13;
- 4. Schedule IV. 21 CFR, Chapter II, Part 1308.14; and
- 5. Schedule V. 21 CFR, Chapter II, Part 1308.15.

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4). Repealed effective November 4, 1998 (Supp. 98-4). New Section made by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1005. Products Excluded or Exempted from the Schedules of Controlled Substances**

The following lists of products are excluded or exempted from the schedules of controlled substances adopted in R4-23-1004. All lists are available on the Board's website and at <https://www.ecfr.gov/current/title-21/chapter-II/part-1308>:

- 1. Excluded nonnarcotic substances that may be lawfully sold over-the-counter without a prescription order. 21 CFR, Chapter II, Part 1308.22;
- 2. Exempted chemical preparations and mixtures. 21 CFR, Chapter II, Part 1308.24; and
- 3. Exempted prescription products containing a nonnarcotic controlled substance. 21 CFR, Chapter II, Part 1308.32.

**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4).  
 Amended by final rulemaking at 6 A.A.R. 3177, effective August 3, 2000 (Supp. 00-3). Amended by final rulemaking at 18 A.A.R. 2609, effective December 2, 2012 (Supp. 12-4). Amended by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1006. Substances Excepted from Drug Offenses**

The following materials, compounds, mixtures, or preparations containing any stimulant or depressant substance included in A.R.S. §§ 13-3401(6)(b) or 13-3401(6)(c) are excepted from the definition of dangerous drugs under the authority of A.R.S. § 32-1904(B)(14):

- 1. Over-the-counter drugs excepted in R4-23-1005(A).
- 2. Chemical preparations excepted in R4-23-1005(B).
- 3. Prescription-only drugs excepted in R4-23-1005(C).

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**Historical Note**

Adopted effective August 2, 1982 (Supp. 82-4).  
Amended by final rulemaking at 6 A.A.R. 3177, effective  
August 3, 2000 (Supp. 00-3).

**ARTICLE 11. PHARMACY TECHNICIANS; PHARMACY TECHNICIAN TRAINEES**

*Article 11, consisting of R4-23-1101 through R4-23-1105, made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1).*

**R4-23-1101. Repealed****Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Repealed by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1102. Pharmacy Technician Licensure**

- A.** License required. A person shall not work as a pharmacy technician in Arizona unless the person possesses a license issued by the Board. A licensed pharmacy technician shall maintain the certificate of licensure, which is in good standing, at the practice site for inspection by the Board or its designee or review by the public. A license issued by the Board is not transferable.
- B.** Eligibility. An applicant for licensure as a pharmacy technician, as defined at A.R.S. § 32-1901, shall provide the Board proof the applicant is eligible under A.R.S. § 32-1923.01(A), including documentation the applicant:
  1. Passed a Board-approved pharmacy technician examination;
  2. Passed the Foreign Pharmacy Graduate Equivalency Examination, if applicable; or
  3. Graduated from a Board-approved pharmacy school.
- C.** Application.
  1. An applicant for licensure as a pharmacy technician shall:
    - a. Submit a completed application electronically or manually on a form furnished by the Board, and
    - b. Submit with the application form:
      - i. The documents specified in the application form,
      - ii. The initial licensure fee specified in R4-23-205, and
      - iii. The wall license fee specified in R4-23-205.
  2. The Board office shall deem an application form received on the date the Board office electronically or manually date-stamps the form.
- D.** Licensure.
  1. If an applicant is found to be ineligible for pharmacy technician licensure under statute and rule, the Board office shall issue a written notice of denial to the applicant.
  2. If an applicant is found to be eligible for pharmacy technician licensure under statute and rule, the Board office shall issue a certificate of licensure and a wall license. An applicant who is assigned a license number and granted "open" or "active" status on the Board's license verification site may begin practice as a pharmacy technician. An applicant shall not practice as a pharmacy technician if the Board's license verification site indicates any status other than "open" or "active."
- E.** License renewal.
  1. To renew a license, a pharmacy technician shall submit a completed license renewal application electronically or manually on a form furnished by the Board with the biennial renewal fee specified in R4-23-205.
  2. If the biennial renewal fee is not paid by November 1 of the renewal year specified in A.R.S. § 32-1925, the pharmacy technician license is suspended and the licensee shall not practice as a pharmacy technician. The licensee shall pay a reinstatement penalty as provided in A.R.S. § 32-1925 and R4-23-205 to vacate the suspension.
  3. Continuing education requirement. Under A.R.S. § 32-1925(H), continuing professional education is mandatory for a licensee.
    - a. The Board shall accept continuing education hours awarded only by an approved provider.
    - b. The Board shall not renew a pharmacy technician license unless the licensee successfully completes 20 continuing education hours during the two years since the licensee's last renewal date and attests to that on the biennial renewal form.
    - c. Special continuing education requirements. If applicable, during each two-year license period, a pharmacy technician:
      - i. Shall not administer a vaccine under R4-23-1104(B)(5) unless the pharmacy technician has successfully completed two continuing education hours relating to administration of vaccines; and
      - ii. As described under A.R.S. § 32-1925(H), shall successfully complete two continuing education hours regarding remote dispensing site pharmacy practices.
    - d. A pharmacy technician licensee is exempt from the continuing education requirement in subsection (E)(3)(b) between the time of initial licensure and first renewal.
    - e. A pharmacy technician licensee shall maintain for five years continuing education records that indicate the number of hours successfully completed and the approved provider of each continuing education. The pharmacy technician licensee shall make the records available to the Board on request.
    - f. The Board shall deem failure to comply with the continuing education requirements as unprofessional conduct and grounds for disciplinary action under A.R.S. § 32-1927.01.
    - g. A pharmacy technician who is aggrieved by a Board decision concerning continuing education may request a hearing before the Board.
- F.** Delinquent license for five or more consecutive years. The Board shall reinstate a delinquent Arizona pharmacy technician license only if the individual furnishes satisfactory proof of fitness to be licensed as a pharmacy technician and pays all fees for the two most recent renewal periods and penalty fees. Satisfactory proof includes:
  1. For an individual who is practicing as a pharmacy technician out-of-state with a pharmacy technician license issued by another jurisdiction:
    - a. Proof of current, unrestricted pharmacy technician licensure in another jurisdiction; and
    - b. Proof of employment as a pharmacy technician during the last 12 months; or
  2. For an individual who did not practice as a pharmacy technician within the last 12 months:

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- a. Take and pass a Board-approved pharmacy technician examination, and
  - b. Complete 20 continuing education hours.
- G. Time frames for pharmacy technician licensure and license renewal. The Board office shall follow the time frames established in R4-23-202(F).
- H. Verification of license. A pharmacy permittee or pharmacist-in-charge shall not allow a person to practice as a pharmacy technician until the pharmacy permittee or pharmacist-in-charge verifies the person is currently licensed by the Board as a pharmacy technician.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1103. Pharmacy Technician Trainee Registration**

- A. Registration required. As indicated under A.R.S. § 32-1923.01, a person shall not work as a pharmacy technician trainee in Arizona unless the person has registered with the Board. A registered pharmacy technician trainee shall maintain the registration certificate at the practice site for inspection by the Board or its designee or review by the public. Registration as a pharmacy technician trainee is not transferable.
- B. Eligibility. An applicant for a 36-month, non-renewable registration as a pharmacy technician trainee shall provide the Board proof the applicant is eligible under A.R.S. § 32-1923.01(B).
- C. Application.
  - 1. An applicant for a 36-month, non-renewable registration as a pharmacy technician trainee shall:
    - a. Submit a completed application electronically on a form available on the Board's website, and
    - b. Submit with the application form:
      - i. The documents specified in the application form, and
      - ii. The registration fee specified in R4-23-205.
  - 2. The Board office shall deem an application form received on the date the Board office electronically date-stamps the form.
- D. Registration.
  - 1. If an applicant is found to be ineligible for registration as a pharmacy technician trainee under statute and rule, the Board office shall issue a written notice of denial to the applicant.
  - 2. If an applicant is found to be eligible for registration as a pharmacy technician trainee under statute and rule, the Board office shall issue a certificate of registration. An applicant who is assigned a registration number and granted "open" or "active" status on the Board's website may begin practice as a pharmacy technician trainee. An applicant shall not practice as a pharmacy technician trainee if the Board's website indicates any status other than "open" or "active."
- E. Time frames for pharmacy technician trainee registration. The Board office shall follow the time frames established in R4-23-202(F).

- F. Verification of registration. A pharmacy permittee or pharmacist-in-charge shall not allow a person to practice as a pharmacy technician trainee until the pharmacy permittee or pharmacist-in-charge verifies that the person is currently registered by the Board as a pharmacy technician trainee.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 19 A.A.R. 2911, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1104. Pharmacy Technicians and Pharmacy Technician Trainees**

- A. Permissible tasks of a pharmacy technician trainee. Acting in compliance with all applicable statutes and rules and under the supervision of a pharmacist, a pharmacy technician trainee registered under R4-23-1103 may assist an intern or pharmacist with the following when applicable to the pharmacy practice site:
  1. Record on the original prescription order the serial number of the prescription medication and date dispensed;
  2. Initiate or accept verbal or electronic refill authorization from a medical practitioner or medical practitioner's agent and record, on the original prescription order or by an alternative method approved by the Board or its designee, the medical practitioner's name, patient name, name and quantity of prescription medication, specific refill information, and name of medical practitioner's agent, if any;
  3. Record information in the refill record or patient profile;
  4. Enter information for a new or refill prescription medication as required under A.R.S. § 32-1964;
  5. Type and affix a label for the prescription medication. A pharmacist or intern working under the supervision of a pharmacist shall verify the accuracy of the label as described under R4-23-402(A)(11);
  6. Reconstitute a prescription medication, if a pharmacist checks the ingredients and procedure before reconstitution and verifies the final product after reconstitution;
  7. Retrieve, count, or pour a prescription medication, if a pharmacist verifies the contents of the prescription medication against the original prescription medication container or by an alternative drug identification method approved by the Board or its designee;
  8. Prepackage drugs in accordance with R4-23-402(A); and
  9. Measure, count, pour, or otherwise prepare and package a drug needed for hospital inpatient dispensing, if a pharmacist verifies the accuracy, measuring, counting, pouring, preparing, packaging, and safety of the drug before the drug is delivered to a patient care area.
- B. Permissible tasks of a pharmacy technician. Acting in compliance with all applicable statutes and rules and under the supervision of a pharmacist, a pharmacy technician licensed under R4-23-1102 may:
  1. Perform the tasks listed in subsection (A);
  2. After completing a pharmacy technician drug compounding training program developed by the pharmacy permittee or pharmacist-in-charge under R4-23-1105(C), assist a pharmacist or intern in compounding prescription medi-

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cations and sterile or non-sterile pharmaceuticals in accordance with written policies and procedures, if the preparation, accuracy, and safety of the final product is verified by a pharmacist before dispensing;

3. Administer a vaccine when:
  - a. Administration of the vaccine is done under an order that complies with A.R.S. § 32-1974 and R4-23-411;
  - b. Administration of the vaccine is delegated by and done under the supervision of a pharmacist on duty who is certified under A.R.S. § 32-1974 to administer vaccines; and
  - c. There is documentation by the permittee that the pharmacy technician has completed the following:
    - i. A practical training program that is approved by the Accreditation Council for Pharmacy Education and includes hands-on injection technique and recognition and treatment of emergency reactions to vaccines; and
    - ii. Current certification in basic cardiopulmonary resuscitation.
4. Perform a task not related to professional judgment if the task is delegated to the pharmacy technician by the pharmacist on duty after the pharmacist on duty ensures the pharmacy technician is trained to do the task and there is documentation by the permittee of the training; and
5. A pharmacist on duty shall not delegate or attempt to delegate the following tasks to a pharmacy technician:
  - a. Administering an emergency medication,
  - b. Counseling a patient,
  - c. Conducting a drug utilization review,
  - d. Performing any task that requires the exercise of clinical judgment,
  - e. Issuing a prescription order,
  - f. Receiving a new prescription order for a controlled substance, or
  - g. Transferring by telephone an existing prescription order for a controlled substance.

- C. Prohibited activities. A pharmacy technician or pharmacy technician trainee shall not perform a professional practice reserved for a pharmacist or intern in accordance with R4-23-402 or R4-23-653 unless otherwise allowed by rule.
- D. A pharmacy technician or pharmacy technician trainee shall wear a badge indicating name and title while on duty.
- E. Before employing a pharmacy technician or pharmacy technician trainee, a pharmacy permittee or pharmacist-in-charge shall develop, implement, review, revise, and enforce, in the manner described in R4-23-653(A), policies and procedures addressing tasks to be performed by the pharmacy technician or pharmacy technician trainee that are consistent with state and federal law and the site at which the pharmacy technician or pharmacy technician trainee will be employed.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 23 A.A.R. 3257, effective January 8, 2018 (Supp. 17-4). Amended by final rulemaking at 28 A.A.R. 994 (May 13, 2022), effective July 2, 2022 (Supp. 22-2). Section made by emergency rulemaking at 29 A.A.R. 1196 (May 26, 2023), with an immediate effective date of May 4, 2023; effective for 180 days (Supp. 23-2). Amended by final rulemaking at

29 A.A.R. 2191 (September 22, 2023), with an immediate effective date of September 6, 2023 (Supp. 23-3). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1104.01 Repealed****Historical Note**

New Section made by final rulemaking at 23 A.A.R. 3257, effective January 8, 2018 (Supp. 17-4). Repealed by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1105. Pharmacy Technician Trainee Training Program; Pharmacy Technician Drug Compounding Training Program**

- A. Nothing in this Section prevents additional offsite training of a pharmacy technician.
- B. Pharmacy technician trainee training program. A pharmacy permittee or pharmacist-in-charge shall develop, implement, review, revise, and enforce, in the manner described in R4-23-653(A), a pharmacy technician trainee training program that is based on the needs of the individual pharmacy and designed to prepare the pharmacy technician trainee to pass a Board-approved national certification examination.
- C. Pharmacy technician drug compounding training program.
  1. A pharmacy permittee or pharmacist-in-charge shall develop, implement, review, revise, and enforce, in the manner described in R4-23-653(A), a pharmacy technician drug compounding training program based on the needs of the individual pharmacy.
  2. A pharmacist-in-charge shall:
    - a. Document the date a pharmacy technician successfully completed the pharmacy technician drug compounding training program, and
    - b. Maintain the required documentation for inspection by the Board or its designee.
- D. A pharmacy technician shall perform only those tasks, listed in R4-23-1104(B), for which training and competency has been demonstrated.
- E. If a pharmacy technician trainee leaves a training program described under subsection (B) before successfully completing the training program, the pharmacist-in-charge shall provide the pharmacy technician trainee with written documentation of the hours of training completed and the tasks for which competence was demonstrated.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1192, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 3032, effective October 1, 2006 (Supp. 06-3). Amended by final rulemaking at 19 A.A.R. 102, effective March 10, 2013 (Supp. 13-1). Amended by final rulemaking at 25 A.A.R. 1015, effective June 1, 2019 (Supp. 19-2). Amended by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**R4-23-1106. Repealed****Historical Note**

New Section made by final rulemaking at 11 A.A.R. 1105, effective April 30, 2005 (Supp. 05-1). Amended by final rulemaking at 26 A.A.R. 223, effective March 14, 2020 (Supp. 20-1). Section made by emergency rulemaking at 29 A.A.R. 1196 (May 26, 2023), with an

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immediate effective date of May 4, 2023; effective for 180 days (Supp. 23-2). Amended by final rulemaking at 29 A.A.R. 2191 (September 22, 2023), with an immediate effective date of September 6, 2023 (Supp. 23-3). Repealed by final rulemaking at 30 A.A.R. 3095 (October 25, 2024), effective November 30, 2024 (Supp. 24-4).

**ARTICLE 12. DONATED MEDICINE PROGRAM****R4-23-1201. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1202. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1203. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1204. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1205. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1206. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

effective May 2, 2022 (Supp. 22-1).

**R4-23-1207. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1208. Handling Fee**

- A. The definitions at A.R.S. § 32-1909(U) apply to this Section.
- B. As specified under A.R.S. § 32-1909(N), an authorized recipient shall not sell a medicine received from a donor.
- C. An authorized recipient may charge a fee to an eligible patient to whom a donated medicine is dispensed. The authorized recipient shall ensure any fee charged to an eligible patient:
  - 1. Does not exceed the reasonable cost of receiving, handling, and dispensing the donated medicine; and
  - 2. Is consistent with the purpose of the donated medicine program. A fee consistent with the purpose of the donated medicine program includes an adjustment for the quantity and retail cost of the medicine dispensed.
- D. An authorized recipient may charge a fee to a donor or other authorized recipient for usual and customary expenses incurred in receiving and handling donated medicine.

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1209. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

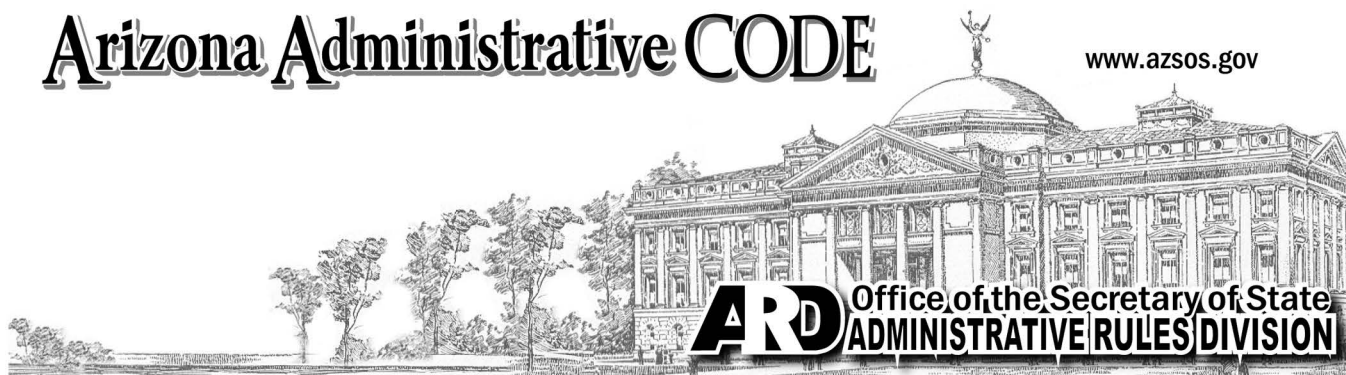
**R4-23-1210. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

**R4-23-1211. Repealed****Historical Note**

New Section made by final rulemaking at 14 A.A.R. 4320, effective January 3, 2009 (Supp. 08-4). Repealed by final rulemaking at 28 A.A.R. 611 (March 18, 2022), effective May 2, 2022 (Supp. 22-1).

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4 A.A.C. 28

Supp. 24-4

## TITLE 4. PROFESSIONS AND OCCUPATIONS CHAPTER 28. STATE REAL ESTATE DEPARTMENT

The table of contents on page one contains links to the referenced page numbers in this Chapter.  
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that expired in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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**The release of this Chapter in Supp. 24-4 replaces Supp. 19-2, 1-32 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 28. STATE REAL ESTATE DEPARTMENT

Authority: A.R.S. § 32-2107

## Supp. 24-4

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Section	
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**ARTICLE 1. GENERAL PROVISIONS**

**R4-28-101. Definitions**

In addition to the definitions listed in A.R.S. § 32-2101 the following terms apply to this Chapter:

“Active license” or “active status license” means a current license issued by the Department to a broker or salesperson that states the name of the broker that employs the broker or salesperson and the location at which the salesperson or broker is employed. If referring to an employing broker, it means a currently licensed employing broker with a currently licensed designated broker of record.

“ADEQ” means the Arizona Department of Environmental Quality.

“ADWR” means the Arizona Department of Water Resources.

“Closing” means the final step of a real estate transaction, such as when the consideration is paid, all documents relating to the transaction are executed and recorded, or the deed is delivered or placed in escrow.

“Credit hour” means 50 minutes of instruction.

“Course” means a class, seminar, or presentation.

“D.b.a.” means ‘doing business as’ and is a name, other than a person’s legal name, authorized by the Department for a licensee’s use in conducting business.

“Distance learning course” means a course of instruction outside a traditional classroom situation consisting of computer-based interactive instructional material, requiring completion in the credit hours specified. A course that requires a student to read text, listen to audio tapes, or view video material without student participation, feedback, and remedial instruction is not a distance learning course.

“Immediate family” means persons related to an individual by blood, marriage, or adoption, including spouse, siblings, parents, grandparents, children, and grandchildren.

“Individual” means a natural person.

“Material change” means any significant change in the size or character of the development, development plan, or interest being offered, or a change that has a significant effect on the rights, duties, or obligations of the developer or purchaser, or use and enjoyment of the property by the purchaser.

“Non-resident license” means a license authorized under the provisions of 32-2122(A) issued to a person who has been domiciled in this state for less than one year and who does not meet any of the following:

- Has an Arizona driver’s license;
- Has an Arizona motor vehicle registration;
- Has been employed in Arizona;
- Has an Arizona voter registration;
- Has transferred banking services to Arizona;
- Has changed permanent address on all pertinent records;
- Is a domestic corporation or limited liability company;
- Has filed an Arizona income tax return with the Department of Revenue during the previous or current tax year;
- or

Has received benefits from any Arizona public service department or agency, such as welfare, food stamps, unemployment benefits, or worker’s compensation.

“Property interest” means a person’s ownership or control of a lot, parcel, unit, share, use in a development, including any right in a subdivided or unsubdivided land, a cemetery plot, a condominium, a time-share interval, a membership camping contract, or a stock cooperative.

**Historical Note**

Former Section R4-28-01 repealed, new Section R4-28-01 adopted effective May 1, 1980 (Supp. 80-3). Amended effective August 1, 1986 (Supp. 86-4). Former Section R4-28-01 renumbered without change as Section R4-28-101 (Supp. 87-1). Former Section R4-28-101 renumbered to R4-28-102, new Section R4-28-101 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3640, effective August 6, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-102. Document Filing; Computation of Time**

- A. All documents shall be considered filed on the date received by the Department. An original or renewal application postmarked on or before the end of the application or renewal deadline shall be considered timely.
- B. In computing any period of time allowed by these rules or by an order of the Commissioner, the day of the act, event, or default from which the designated period of time begins to run is not included. The last day of the period is included unless it is Saturday, Sunday, or a legal holiday in which event the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Unless the time period is specified as calendar days, when the period of time allowed is less than 11 days, intermediate Saturdays, Sundays, and legal holidays are excluded from the computation.

**Historical Note**

Former Section R4-28-02 repealed, new Section R4-28-02 adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Former Section R4-28-02 renumbered without change as Section R4-28-102 (Supp. 87-1). Former Section R4-28-102 repealed, new Section R4-28-102 renumbered from R4-28-101 and amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-103. Licensing Time-frames**

- A. Overall time-frame. The Department shall issue or deny a license within the overall time-frames listed in Table 1 after receipt of a complete application. The overall time-frame is the total of the number of days provided for in the administrative completeness review and the substantive review.
- B. Administrative completeness review.
  1. The applicable administrative completeness review time-frame established in Table 1 begins on the date the Department receives the application. The Department shall notify the applicant in writing within the administrative completeness review time-frame whether the application is incomplete. The notice shall specify what information is missing. If the Department does not pro-

## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 28. STATE REAL ESTATE DEPARTMENT

vide notice to the applicant, the license application shall be considered complete.

2. An applicant with an incomplete license application shall supply the missing information within the completion request period established in Table 1. The administrative completeness review time-frame is suspended from the date the Department mails the notice of missing information to the applicant until the date the Department receives the information.
  3. If the applicant fails to submit the missing information before expiration of the completion request period, the Department shall close the file, unless the applicant requests an extension in writing from the Department before expiration of the Response to Completion Request period in Table 1. The Department shall grant the applicant one extension for the number of days identified as the Response to Completion Request period for the type of license. An applicant whose file has been closed may obtain a license by submitting a new application.
- C. Substantive review.** The substantive review time-frame established in Table 1 begins after the application is administratively complete.
1. The Department may schedule an inspection.
  2. If the Department makes a comprehensive written request for additional information, the applicant shall submit the additional information identified by the request within the additional information period provided in Table 1. The substantive review time-frame is suspended from the date the Department mails the request until the information is received by the Department. If the applicant fails to provide the information identified in the written request the Department shall consider the application withdrawn unless the applicant requests in writing an extension from the Department before expiration of the Response to Additional Information period in Table 1. The Department shall grant the applicant one extension for the number of days identified in the Response to Additional Information period for the type of license.
  3. If the application is denied, the Department shall send the applicant written notice explaining the reason for the denial with citations to supporting statutes or rules, the applicant's right to seek a fair hearing, and the time period for appealing the denial.

**D. Renewals.** If an applicant for renewal of a salesperson's or broker's license submits a complete renewal application:

1. Before the expiration date and there are no changes in the applicant's license or qualifications pursuant to R4-28-301(A), the Department shall send the applicant notice that the license is renewed;
2. After the expiration date, or if a substantive review is required because the applicant wishes to make changes to or has answered in the affirmative any question on the license questionnaire, the Department shall process the application as a modified or amended application.

**Historical Note**

Amended as an emergency effective June 20, 1975 (Supp. 75-1). Former Section R4-28-03 repealed, new Section R4-28-03 adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-03 renumbered without change as Section R4-28-103 (Supp. 87-1). Former Section R4-28-103 repealed, new Section R4-28-103 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-104. Development Inspection Fee**

A fee shall be charged for a development site inspection pursuant to A.R.S. §§ 32-2182, 32-2194.02, 32-2195.02, 32-2197.05, and 32-2198.04, before or after issuance of a public report. Multiple inspections and fees may be required based on development circumstances.

**Historical Note**

New Section R4-28-104 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 4917, effective January 5, 2003 (Supp. 02-4). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-105. Expired****Historical Note**

New Section R4-28-105 made by exempt rulemaking at 19 A.A.R. 201, effective January 16, 2013 (Supp. 13-1). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 971, effective March 1, 2019 (Supp. 19-2).

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**Table 1. Time-frames (Calendar Days)**

License	Authority	Administrative Completeness Review	Response to Completion Request	Substantive Review	Response to Additional Information	Overall Time-frame
Broker or Salesperson (Individual)	A.R.S. § 32-2122	30	30	30	30	60
Individual Renewal	A.A.C. R4-28-301	30	30	30	30	60
Modified/Amended (Change of Name, Address, or License Status)	A.A.C. R4-28-303	30	30	30	30	60
Individual Reinstatement	A.A.C. R4-28-303	30	30	30	30	60
Corp/LLC/Partnership/PC/PLC/Desig. Broker Status	A.R.S. § 32-2125	60	30	60	60	120
Branch Office	A.A.C. R4-28-302	60	30	60	60	120
Entity/DB status Renewal	A.R.S. § 32-2127	60	30	60	60	120
	A.A.C. R4-28-303	60	30	60	60	120
Modified/Amended (Change of Name, Address, or License Status)	A.A.C. R4-28-303	60	30	60	60	120
Entity Reinstatement	A.A.C. R4-28-303	60	30	60	60	120
Temporary Broker	A.R.S. § 32-2133	60	30	60	60	120
Temp Cemetery Salesperson	A.R.S. § 32-2134	60	30	60	60	120
Membership Camping Cert. of Convenience	A.R.S. § 32-2134.01	60	30	60	60	120
	A.A.C. R4-28-305	60	30	60	60	120
School Approval	A.R.S. § 32-2135(A)	10	15	20	15	30
	A.A.C. R4-28-404					
Course Approval: New (Live Instruction)	A.R.S. § 32-2135	10	15	20	15	30
New (Distance Learning)	A.A.C. R4-28-404	30	30	90	30	120
	A.A.C. R4-28-402, R4-28-404					
Instructor Approval	A.R.S. § 32-2135	10	15	20	15	30
	A.A.C. R4-28-404					
ADVERTISING						
Membership Campground (only for lottery or drawing)	A.R.S. § 32-2198.10(D)	15	5	0	0	15
	A.R.S. § 32-2198.14					
	A.A.C. R4-28-503(D)	15	5	0	0	15
Subdivision (only for drawing or contest)	A.R.S. § 32-2183.01(I)	15	5	0	0	15
	A.A.C. R4-28-503(D)					
Time-Share (only for drawing or contest)	A.A.C. R4-28-503(D)	15	5	0	0	15
Time-Share (the offer of a premium)	A.R.S. § 32-2197.17(I)	15	5	0	0	15
	A.A.C. R4-28-503(D)					
	A.R.S. § 32-2197.17(K)					
	A.A.C. R4-28-503(D)					
Development Application	A.R.S. § 32-2183(A)	40	40	60	40	100
	A.R.S. § 32-2195.03(A)					
	A.R.S. § 32-2197.06					
	A.R.S. § 32-2198.02					
	A.A.C. R4-28-B1203					
Amended Report	A.R.S. § 32-2184	30	30	30	30	60
	A.R.S. § 32-2195.10					
	A.R.S. § 32-2197.03					
	A.R.S. § 32-2198.01(D)					
	A.A.C. R4-28-B1203					
Certificate of Authority	A.R.S. § 32-2194.03(A)	40	40	60	40	100
Amended Certificate	A.R.S. § 32-2194.10	30	30	30	30	60
	A.A.C. R4-28-B1204					

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WAIVERS Pre-license	A.R.S. § 32-2124 A.A.C. R4-28-401	15	60	30	0	45
Continuing Education	A.R.S. § 32-2130 A.R.S. R4-28-402	5	10	7	0	12
EXEMPTIONS Subdivision	A.R.S. § 2181.01 A.A.C. R4-28-B1202	40	40	40	40	80
Unsubdivided Land	A.R.S. § 32-2195.01 A.A.C. R4-28-B1202	40	40	40	40	80
Time-Share	A.R.S. § 32-2197.13	40	40	40	40	80
Membership Camping	A.R.S. § 32-3198.03	40	40	40	40	80

**Historical Note**

New Table 1 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**ARTICLE 2. REPEALED**

**R4-28-201. Repealed**

**Historical Note**

Former Section R4-28-04 repealed, new Section R4-28-04 adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Amended effective August 1, 1986 (Supp. 86-4). Former Section R4-28-04 renumbered and amended as R4-28-201 effective February 28, 1987 (Supp. 87-1). Amended effective February 28, 1995 (Supp. 95-1). Section R4-28-201 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**ARTICLE 3. LICENSURE**

**R4-28-301. General License Requirements; Non-resident License**

A. An applicant for any Department-issued license or license renewal including, if an entity, any officer, director, member, manager, partner, owner, trust beneficiary holding 10% or more beneficial interest, stockholder owning 10% or more stock, or other person exercising control of the entity, shall submit the following information to the Department:

1. A signed original licensure or renewal questionnaire, as applicable, disclosing any:
  - a. Conviction for a misdemeanor or felony, or deferral of a judgment or sentencing for a misdemeanor or felony;
  - b. Order, judgment, or adverse decision entered against the applicant involving fraud or dishonesty, or involving the conduct of any business or transaction in real estate, cemetery property, time-share intervals, membership camping contracts, or campgrounds;
  - c. Restriction, suspension, or revocation of a professional or occupational license, or registration currently or previously held by the applicant in any state, district, or possession of the United States or under authority of any federal or state agency; any civil penalty imposed under the license, or any denial of a license; or
  - d. Order, judgment, or decree permanently or temporarily enjoining the applicant from engaging in or continuing any conduct or practice in connection with the sale or purchase of real estate or cemetery property, time-share intervals, membership camping contracts, campgrounds, securities, or involving consumer fraud or violation of the racketeering laws

by the applicant, or payment from a recovery fund or fund of last resort due to the applicant's action or inaction.

2. If the applicant discloses information under subsection (A)(1), the applicant shall provide all of the following written documentation:
  - a. A signed written statement describing in detail the circumstances surrounding the matter disclosed;
  - b. A certified copy of any police report and court record that pertains to each crime for which the applicant has been convicted or for which sentencing or judgment has been deferred. If the applicant is unable to provide documents for each crime, the applicant shall provide written documentation from the court or agency having jurisdiction, stating the reason the records are unavailable.
  - c. Three written and dated references from individuals, 18 years or older and not related by blood or marriage to the applicant, who have known the applicant for at least one year before the date of the Department's receipt of the application. Each reference shall be dated no more than one year from the date the application is submitted to the Department and include the writer's name, address, and telephone number;
  - d. A 10-year work history, stating each employer's name and address, supervisor's name and telephone number, position held, and dates of employment, specifying any periods of unemployment;
  - e. A certified copy of all documents pertaining to every reprimand, censure or sanction, order assessing a civil penalty, or denying, suspending, restricting, or revoking any professional or occupational license currently held or held by the applicant within the last 10 years;
  - f. A certified copy of any civil judgment awarded by a court of competent jurisdiction against the applicant that included findings of fraud or dishonest dealings by the applicant;
  - g. A certified copy of any document evidencing a payment of a judgment on behalf of the applicant by any recovery fund administered by any state or professional or occupational licensing board, or repayment by the applicant as a judgment debtor to any recovery fund administered by any state or professional or occupational licensing board. If an Arizona real estate or subdivision recovery fund matter, a written disclosure of the file number, approximate date, and

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approximate amount of payment and current repayment status satisfies this requirement.

- h. A certified copy of any temporary or permanent order of injunction entered against the applicant;
- i. Any other documentation that the applicant believes supports the applicant's qualifications for licensure.
- 3. A full set of fingerprints as prescribed in A.R.S. § 32-2108.01;
- 4. The appropriate license application and fee; and
- 5. Social security number, if the applicant is an individual.
- B.** In addition to the information required in subsection (A), an applicant for a salesperson's or broker's license shall provide information showing the person meet the qualifications listed in A.R.S. § 32-2124, A.A.C. R4-28-401, and R4-28-403. If disclosing censure, sanction, disciplinary action, or other order against any professional or occupational license currently or previously held by the applicant, the applicant shall submit a certified license history from each state in which the applicant holds, or has held, a professional or occupational license within the five years before the application.
- C.** The Department shall not issue a broker's license to any person who holds an active salesperson's license in this state. An active-status salesperson applying for broker's license may simultaneously submit a severance signed by the designated broker on behalf of the salesperson's employing broker under R4-28-303(E)(10) or may request to be administratively severed under R4-28-303(G).
- D.** The Department shall issue to a qualified person a license bearing the legal name of the licensee and any additional nickname, corporate, or dba name that the Commissioner finds is not detrimental to the public interest. A professional corporation or professional limited liability company licensed under A.R.S. § 32-2125(B) shall not adopt a dba name.
- E.** Every salesperson and broker holding a current license shall file with the Commissioner both the address of the salesperson's or broker's principal place of business, if any, and a current residence address.
- F.** Each salesperson, broker, school owner, director, administrator, and instructor shall, within 10 days of each occurrence, notify the Commissioner in writing of any change in information provided under subsection (A)(1)(a) through (d) and provide documentation listed in subsection (A)(2).
- G.** A licensee shall, within 14 calendar days or a later date determined by the Department, respond to a request from the Commissioner or the Commissioner's representative for any documents, electronic files, written statements, or other information required as a part of a complaint investigation, regardless of whether the licensee is named in the complaint.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Amended effective August 1, 1986 (Supp. 86-4). Former Section R4-28-05 renumbered without change as Section R4-28-301 (Supp. 87-1). Amended subsection (C) effective May 3, 1988 (Supp. 88-2). Amended subsection (J) effective February 28, 1989 (Supp. 89-1). Amended effective February 28, 1995 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-302. Employing Broker's License; Non-resident Broker**

- A.** A person applying for an employing broker's license shall provide the following information:
  - 1. The name, business address, telephone number, fax number and e-mail address, if any, and designated broker's name, license number and expiration date, and the signature of the designated broker;
  - 2. Whether the broker is an individual, a sole proprietorship, corporation, partnership, limited liability company, professional corporation or professional limited liability company;
  - 3. The mailing address, if different than the business address;
  - 4. The d.b.a. name, if applicable;
  - 5. The bank name and location of each of the broker's trust accounts, if any; and
  - 6. The name and number of the trust account.
- B.** Partnership.
  - 1. When the applicant is a partnership, the applicant shall name a broker to serve as designated broker:
    - a. The designated broker shall be a partner of the general partner if the general partner is a partnership.
    - b. The designated broker shall be a corporate officer of the corporate partner if the general partner is a corporation.
    - c. The designated broker shall be a member of the member-managed limited liability company or manager of the manager-managed limited liability company if the general partner is a limited liability company.
    - d. A limited partner of a partnership shall not be designated broker for the partnership.
  - 2. In addition to the information provided in subsection (A), an applicant for an employing broker's license as a partnership shall, if applicable, provide:
    - a. The name and address of each partner, and the name of any other person with a beneficial or membership interest in the partnership;
    - b. An agreement signed by all partners, stating the name of the partner appointed to act as the designated broker for the partnership;
    - c. A written statement signed by the designated broker stating that:
      - i. The partnership has applied for a broker's license in Arizona;
      - ii. Each partner has read the complete application on the named partnership as submitted to the Department;
      - iii. All the information contained in the application is true;
      - iv. Each general partner is qualified to do business in Arizona; and
      - v. The name of the partnership complies with A.R.S. § 29-245 and subsections (H) and (I), and is not likely to be misleading or confusing;
    - d. A copy of the partnership agreement and any amendments;
    - e. A copy of the application for partnership registration stamped "Received and Filed" by the Arizona Secretary of State; and
    - f. Any other information required by the Department to verify the applicant's qualifications.

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- C. Corporation.** In addition to the information provided in subsection (A), an applicant for an employing broker's license for a corporation shall provide:
1. The name and address of each officer and director, and the name and address of each shareholder controlling or holding more than 10% of the issued and outstanding common shares, or 10% of any other proprietary, beneficial, or membership interest in the corporation;
  2. A copy of the Articles of Incorporation and any amendments stamped "Received and Filed" by the Arizona Corporation Commission. If more than one year has elapsed between the date the Articles were stamped "Filed" by the Arizona Corporation Commission and the application for the corporate license, a Certificate of Good Standing from the Arizona Corporation Commission is required;
  3. A corporate resolution stating that the designated broker was elected or appointed as a corporate officer, naming the office held, and stating that the individual was appointed to act as designated broker for the corporation;
  4. A written statement signed by the designated broker stating that:
    - a. The corporation has applied for a broker's license in Arizona;
    - b. Each officer and director has read the complete application on the named corporation as submitted to the Department;
    - c. All the information contained in the application is true;
    - d. The name of the corporation complies with A.R.S. § 10-401 and 4 A.A.C. 28, Article 10, and is not likely to be misleading or confusing; and
    - e. Each corporation is qualified to do business in Arizona; and
  5. Any other information required by the Department to verify the applicant's qualifications.
- D. Limited liability company.** In addition to the information provided in subsection (A), an applicant for an employing broker's license for a limited liability company shall provide:
1. The name and address of each member and manager, and the name and address of any person controlling or holding more than 10% of the membership interest in the limited liability company;
  2. A copy of the Articles of Organization and any amendments stamped "Received and Filed" by the Arizona Corporation Commission. If more than one year has elapsed between the date the Articles were stamped "Filed" by the Arizona Corporation Commission and the application for the limited liability company license, a Certificate of Good Standing from the Arizona Corporation Commission is required;
  3. A company resolution signed by all members stating whether management of the limited liability company is established as manager-controlled or member-controlled and the name of the member or manager appointed to act as the designated broker;
  4. A written statement signed by the designated broker stating that:
    - a. The limited liability company has applied for a broker's license in Arizona;
    - b. Each member and manager has read the complete application on the limited liability company as submitted to the Department;
    - c. All of the information contained in the application is true;
    - d. The name of the limited liability company complies with A.R.S. § 29-602 and 4 A.A.C. 28, Article 10, and is not likely to be misleading or confusing; and
    - e. The limited liability company is qualified to do business in Arizona.
  5. A copy of the operating agreement and any amendments; and
  6. Any other information required by the Department to verify the applicant's qualifications.
- E. Foreign entity.** In addition to the requirements in this Section, the Department may require any of the following information from an entity applying for a broker's license if a partner, member, officer, or director of the entity is domiciled in another state:
1. The agreement and plan of merger;
  2. The Certificate of Good Standing;
  3. The Certificate of Merger on file in the state in which the applicant is domiciled;
  4. The Certificate of Merger on file with the Arizona Corporation Commission;
  5. A filed and stamped Articles of Merger;
  6. A filed and stamped application for registration of the foreign limited liability company, foreign corporation, or partnership;
  7. Any other information required by the Department to verify the applicant's qualifications.
- F. Self-employed broker.** In addition to the information provided in subsection (A), any person applying as a self-employed broker shall provide a sworn statement attesting that the applicant is the sole proprietor of the business.
- G.** If any information prescribed in subsections (A) through (F) changes, the designated broker shall, within 10 days after the change, file a supplemental statement in writing with the Department listing the change and include the appropriate fee, if any.
- H.** The Department shall not license an employing broker or authorize an employing broker to do business under a dba name similar to that of any employing broker already licensed if the name would cause uncertainty or confusion to the public. If there is a conflict of names between two employing brokers, the Commissioner shall require the employing broker seeking licensure to supplement or otherwise modify the broker's name.
- I.** The Department shall not license an employing broker under more than one dba name and a person shall not conduct or promote real estate business under any name other than the name under which the person is licensed.
- J.** A broker shall not employ a salesperson or associate broker and allow the salesperson or associate broker to establish and carry on a brokerage business if the broker's only interest is the receipt of a fee for the use of the license and the broker does not exercise supervision over the salesperson or associate broker.
- K. Change of designated broker.**
1. To resign as an employing broker's designated broker a broker shall submit to the Department a copy of the broker's letter of resignation and shall return the licenses issued to the designated broker and the employing broker to the Department.
  2. A licensed entity may remove its designated broker by submitting to the Department a copy of the partnership agreement, corporate or company resolution removing the broker and returning to the Department the licenses issued to the employing broker and designated broker.



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3. The employing broker whose designated broker has resigned or been removed shall cease conducting business until the employing broker has complied with subsection (K)(4).
4. An employing broker whose designated broker has resigned or been removed may continue business without interruption if the incoming designated broker on the same day as, or the next business day following, the departure or removal of the outgoing designated broker:
  - a. Completes, signs, and submits the Change Form as prescribed in R4-28-303; and
  - b. If the entity is a corporation or limited liability company, submits a resolution appointing the new broker to act on its behalf; or
  - c. If the entity is a partnership, submits an amendment to the partnership agreement naming the new broker to act on its behalf.

**L. Non-resident employing broker.**

1. An employing broker that holds a non-resident license and maintains a principal office outside this state shall:
  - a. Maintain a trust account or licensed escrow account situated in Arizona for monies received from Arizona transactions;
  - b. Maintain, in Arizona, copies of all documents pertaining to any Arizona transactions handled by the broker;
  - c. Provide a written statement to the Department identifying the name, address, and telephone number of the person residing in Arizona, such as a statutory agent or attorney, who has possession of the records; and
  - d. Identify the physical location of the records.
2. An employing broker that holds a non-resident license and employs a licensed salesperson or broker within the state shall:
  - a. Establish an office in Arizona and appoint a branch manager; and
  - b. Provide a statement describing how the licensed employee shall be supervised.
3. An employing broker who holds a non-resident license shall notify the Department within 10 days of any change to any information required under this Section.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Correction, Supp. 80-3 should read Adopted effective May 1, 1980 (Supp. 83-3). Amended subsection (B) effective August 1, 1986 (Supp. 86-4). Former Section R4-28-06 renumbered without change as Section R4-28-302 (Supp. 87-1). Amended effective February 28, 1995 (Supp. 95-1). Former Section R4-28-302 repealed, new Section R4-28-302 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-303. License Renewal; Reinstatement; Changes of Personal Information, License, or License Status; Professional Corporation or Professional Limited Liability Company License; Administrative Severance**

**A. Renewal.**

1. If a salesperson or broker makes a timely and sufficient application for license renewal or a new license with reference to any activity of a continuing nature, the existing

license does not expire until the application has been finally determined by the Department, and, in case the application is denied or the terms of the new license limited, until the last day for seeking review of the Commissioner's order or a later date fixed by order of the reviewing court.

2. Any salesperson or broker applying for a license renewal shall submit the following information on the Application for License Renewal form:

- a. Any change or correction to the applicant's licensing information;
- b. Whether the renewal application is late;
- c. If the renewal is for an active license and is filed in paper format, the Department shall require the application to include the date and signature of the designated broker, authorized branch office manager, or authorized designee under A.R.S. § 32-2127(D). If signed by a branch manager or designee, the branch manager or designee shall attach a copy of the authorization or designation;
- d. The signature of the applicant, attesting to the truthfulness of the application information;
- e. A completed certification questionnaire, providing details and supporting documents for any affirmative response not previously disclosed in writing to the Department concerning judgments, orders, professional licenses, or convictions, as required under R4-28-301(A).
- f. To renew as designated broker for an employing broker, the designated broker shall complete and submit a signed Broker Supervision & Control Audit Declaration for the sole proprietorship or entity on whose behalf the broker acts as designated broker. The completed declaration shall:
  - i. Be dated and filed before or with the broker's renewal application, and submitted to the Department no earlier than 90 days before the broker's license expiration date;
  - ii. Be in the form prescribed by the Department;
  - iii. State the broker's compliance or non-compliance with, or the non-applicability of, specified statutes and rules; and
  - iv. Identify all of the broker's property management and trust accounts.

- B. Late renewal.** In addition to the information required in subsection (A), any person applying for renewal after the date of license expiration shall specify whether the person conducted unlawful license activities as described in R4-28-306.

**C. Reinstatement.**

1. Any salesperson or broker applying for license reinstatement under A.R.S. § 32-2131 shall, in addition to the requirements in R4-28-301(A), submit the following information on the Application For Reinstatement form:
  - a. The type of license and status requested;
  - b. The applicant's legal name, business address, and telephone number;
  - c. Whether the license was suspended, canceled, terminated, or revoked, and the date of and reason for the action;
  - d. The license number of the applicant;
  - e. The mailing address, if different than the business address;
  - f. The name, address, and telephone number of the employing broker, if applicable;

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- g. The employer's trade or d.b.a. name, if any;
  - h. The date of the application; and
  - i. The signature of the applicant attesting to the above information and that the applicant is aware of the provisions in A.R.S. §§ 32-2131, 32-2153, and 32-2160.01.
2. If the license was active at the time of suspension, cancellation, revocation, or termination, the applicant shall provide the information required under R4-28-306.
- D.** A salesperson or broker shall notify the Department in writing within 10 days of any change in the individual's personal information or qualifications. The salesperson or broker shall include in the notice the individual's name, signature, license number, and:
- 1. If disclosing information required under R4-28-301, such as a criminal conviction, adverse judgment, denial or restriction of or disciplinary action against a professional or occupational license, or recovery fund payment on the person's behalf, a written statement providing detailed information and, upon request by the Department, the supporting documentation identified in R4-28-301(A)(2);
  - 2. If requesting a change of personal name, written notice stating the prior name and new name, supporting documentation for the change, and applicable fee;
  - 3. If changing residence address or residential mailing address, written notice stating the prior address, new address and the date of the change;
  - 4. If changing residence telephone number or providing an additional telephone number or e-mail address, written notice of the prior and current number or e-mail address; or
  - 5. If becoming licensed as a professional corporation or professional limited liability company, or changing licensure as a professional corporation or professional limited liability company, the information required under subsection (F).
- E.** A designated broker shall notify the Department in writing within 10 days of any change in the employing broker's qualifications under R4-28-301, and shall provide notice of any proposed change in the employing broker's business information under this Section. An employing broker shall not conduct business under information described in subsections (E)(2), (3), (7), (9), (12), or (13) until the change is approved by the Department. The designated broker shall include in the notice the designated broker's name and signature, the employing broker's legal name, and:
- 1. If disclosing information required under R4-28-301 such as an adverse judgment, denial, or restriction of or disciplinary action against a professional or occupational license, or recovery fund payment on the person's own behalf or on behalf of any officer, director, member, manager, partner, owner, trust beneficiary holding 10 percent or more beneficial interest, stockholder owning 10 percent or more stock, or other person exercising control of the employing broker, file with the Department a written statement within 10 days of the occurrence, providing detailed information and, upon request by the Department, the supporting documentation identified in R4-28-301(A)(2);
  - 2. If changing the employing broker's legal name, written notice stating the current name and proposed name, supporting documentation, and applicable fee;
  - 3. If changing the employing broker's dba name, written notice stating the current dba name, if any, the proposed dba name, and applicable fee;
  - 4. If changing the employing broker's physical address, changing or adding a business mailing address, or changing the address of any branch office, written notice within 10 days of the change stating the prior address and new address, return all current licenses issued to the former address, and pay the applicable fee;
  - 5. If changing business telephone number, written notice within 10 days of the change, providing the prior and current number. The broker may provide additional telephone numbers or e-mail addresses;
  - 6. If changing the structure or membership of the employing broker as provided in A.R.S. § 32-2125 (G), written notice within 10 days of the change including supporting documentation identified in R4-28-302;
  - 7. If changing branch office managers at an established branch office of the employing broker, or changing the authority delegated to the branch office manager, the application form, applicable fee, and letter of authority that identifies the person appointed and specifies the duties delegated as provided by R4-28-304;
  - 8. If closing a branch office, a written statement informing the Department within 10 days of the closure, accompanied by the branch office license and Department form severing the employment of or transferring to another branch office each employee at the branch;
  - 9. If hiring a salesperson or broker, or transferring a salesperson or broker employed by the employing broker to another office of the employing broker, a change form that includes the name, license number, signature of the employee, and the branch office address where the employee will work, and applicable fee;
  - 10. If severing a licensee employed by the employing broker, written notice and return of the employee's license within 10 days of the severance;
  - 11. If opening or closing a broker's trust account, written notice within 10 days of the opening or closing that provides the name of the account, the account number, and the name and address of the bank where the account is located. If relocating or changing the name of a trust account, the designated broker shall include the information for the previous and new accounts;
  - 12. If appointing a temporary broker, submit the information specified in R4-28-305 and in accordance with provisions of A.R.S. §§ 32-2127 or 32-2133, as applicable; or
  - 13. If an employing broker is changing designated brokers, the information and documentation provided in R4-28-302(K).
- F.** In addition to the applicant's name, signature, license number, the name and address of the employing broker's office where the employee will work, and the change fee, a salesperson or broker shall submit the following information to be licensed as a professional corporation or professional limited liability company, to add or remove members of a licensed professional corporation or professional limited liability company, or to change the name of a licensed professional corporation or professional limited liability company:
- 1. Professional corporation.
    - a. The name of the professional corporation that includes the full or last name of each officer, director, and shareholder of the professional corporation as it appears in the Articles of Incorporation;

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- b. The name and business address of each officer, director, and shareholder in the corporation and a written statement that each holds a current and active real estate license;
  - c. A copy of the Articles of Incorporation, as amended, stamped "Received and Filed" by the Arizona Corporation Commission;
    - i. The Articles of Incorporation shall state that the corporation's sole purpose is to provide professional real estate, cemetery, or membership camping services, or real estate, cemetery, and membership camping services.
    - ii. If more than one year has elapsed between the date the Articles of Incorporation were stamped "Filed" by the Arizona Corporation Commission and the date of the application for a license as a professional corporation, the Department shall require the salesperson or associate broker to submit a Certificate of Good Standing from the Arizona Corporation Commission; and
  - d. Evidence that membership in the professional corporation is limited to the designated broker and does not include any other person if the applicant for licensure as a professional corporation is licensed as a designated broker;
2. Professional limited liability company.
- a. The name of the professional limited liability company which includes the full or last name of each member of the professional limited liability company as it appears in the Articles of Organization;
  - b. The name and address of each member and manager in the limited liability company and a written statement that each holds a current and active real estate license;
  - c. A copy of the Articles of Organization, as amended, stamped "Received and Filed" by the Arizona Corporation Commission;
    - i. The Articles of Organization shall state that the limited liability company's sole purpose is to provide professional real estate, cemetery, or membership camping services, or real estate, cemetery, and membership camping services.
    - ii. If more than one year has elapsed between the date the Articles of Organization were stamped "Filed" by the Arizona Corporation Commission and the date of the application for a license as a professional limited liability company, the Department shall require the salesperson or associate broker to submit a certificate of Good Standing from the Arizona Corporation Commission.
  - d. A copy of the operating agreement, as amended;
  - e. Evidence that membership in the professional limited liability company is limited to the designated broker and does not include any other person if the applicant for licensure as a professional limited liability company is licensed as a designated broker.
3. To return a license from professional corporation or professional limited liability company status to individual status:
- a. The name, license number, and dated signature of the salesperson or broker;
  - b. A written statement that the salesperson or broker no longer wishes to be licensed as a professional corporation or professional limited liability company; and
  - c. The change fee.
- G. Administrative severance.**
- 1. A salesperson or broker may request that the Department sever the salesperson's or broker's license from the employing broker. The salesperson or broker shall provide the following information on a form or in the manner prescribed by the Department:
    - a. The name, license number, and dated signature of the salesperson or broker seeking the severance; and
    - b. The name of the employing broker from whom the license is being severed.
  - 2. Upon receipt of the written request for severance as provided in subsection (G)(1)(a), the Department shall administratively sever the license and provide written notice to the employing broker, who shall return the severed person's license to the Department under subsection (E)(10).
- Historical Note**
- Adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Amended effective August 1, 1986 (Supp. 86-4). Former Section R4-28-07 renumbered without change as Section R4-28-303 (Supp. 87-1). Amended by adding a new subsection (K) effective May 3, 1988 (Supp. 88-2). Amended effective February 28, 1995 (Supp. 95-1). Former Section R4-28-303 repealed, new Section R4-28-303 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Subsection (F) amended to correct a manifest clerical error, filed in the Office of the Secretary of State March 29, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).
- R4-28-304. Branch Office; Branch Office Manager**
- A.** To obtain a branch office license, the designated broker shall submit to the Department before operating the branch office the following information for each branch office of the employing broker on the Application for Branch Office form:
- 1. The name, date, and signature of the designated broker;
  - 2. The license number and license expiration date of the employing broker;
  - 3. The name, address, telephone, and license number of the main office;
  - 4. The type of employing broker's license;
  - 5. The employing broker's dba name, if applicable;
  - 6. The address, telephone number, and fax number, if any, of the branch office; and
  - 7. The name and license status of the salesperson or broker who is the branch office manager and the authority granted to the branch office manager, including any designation of authority under subsection (B).
- B.** Branch office manager. A designated broker may authorize in writing an associate broker or salesperson to act as a branch office manager to perform any of the following duties of the designated broker at the branch office. This designation does not relieve the designated broker from any responsibilities. Upon change of the branch manager, the designated broker shall submit a new authorization to the Department within 10 days of the change and shall retain a copy in the broker's main office for five years.

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1. If the branch manager is an associate broker, the associate broker may, when dealing with branch office transactions:
    - a. Review and initial contracts,
    - b. Supervise the activity of salespersons and associate brokers,
    - c. Hire or sever a salesperson or associate broker,
    - d. Sign compensation checks,
    - e. Be a signer on the branch office trust account and property management trust account,
    - f. Write checks from the broker's trust accounts, and
    - g. Be responsible for the handling of all trust account funds administered by the branch manager.
  2. If the branch manager is a salesperson, the salesperson may, when dealing with branch office transactions:
    - a. Perform office management tasks that are not statutory duties of the employing broker, and
    - b. Be a signer on the broker's trust account and property management trust account.
- C. Temporary office.** An additional license is not required for a temporary office established for the original on-site sale of properties within the immediate area of a subdivision or unsubdivided land.
1. The broker named in the application for public report shall supervise operation of the temporary office to sell or lease the subdivided or unsubdivided land.
  2. The broker shall display the subdivision or unsubdivided land name and the licensed name of the employing broker marketing the development in a prominent manner at the entrance to the temporary office.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended subsection (A) effective June 23, 1983 (Supp. 83-3). Amended subsection (A)(4) effective August 1, 1986 (Supp. 86-4). Former Section R4-28-08 renumbered and amended as Section R4-28-304 effective February 28, 1987 (Supp. 87-1). Former Section R4-28-304 repealed, new Section R4-28-304 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-305. Temporary License, Certificate of Convenience**

- A.** Any individual applying for a temporary cemetery salesperson's license, a temporary broker's license, or a membership camping salesperson's certificate of convenience shall submit the following information and applicable fee to the Department:
1. The type of license requested;
  2. The name, address, telephone number, and date of birth of the applicant;
  3. The mailing address if different from the address in subsection (A)(2);
  4. The name, business address, telephone number, fax number, if any, and license number of the employing broker; and
  5. The branch office number, address, telephone number, and fax number, if any, where employed, if different than the employing broker in subsection (A)(4).
- B.** The designated broker shall submit an affidavit under A.R.S. § 32-2134 or 32-2134.01 for:
1. An applicant for temporary cemetery license stating that the applicant has been trained in cemetery and contract law; or

2. An applicant for a membership camping certificate of convenience stating that the applicant will be trained in membership camping and contract laws.

- C.** In addition to the information required in subsection (A), an applicant for a temporary broker's license pursuant to A.R.S. § 32-2133 shall submit the following information to the Department:
1. A copy of the death certificate or notice, if applicable, or a letter advising the Department of the broker's illness or disability; and
  2. A letter from the surviving spouse, an attorney representing the broker or the broker's family, personal representative, or other responsible party, appointing an individual to serve as a temporary broker for 90 days.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended subsection (A) effective June 23, 1983 (Supp. 83-3). Amended subsection (A)(4) and (5) effective August 1, 1986 (Supp. 86-4). Former Section R4-28-09 renumbered without change as Section R4-28-305 (Supp. 87-1). Former Section R4-28-305 repealed, new Section R4-28-305 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-306. Unlawful License Activity**

- A.** Unlawful license activity is:
1. The performance of acts requiring a license under A.R.S. § 32-2122 by a person who does not hold a current and active license;
  2. The performance of acts requiring a license by a person on behalf of a broker other than the person's employing broker; or
  3. A broker's employment of a person as a salesperson or broker if the person does not hold a current and active license issued to the person under that employing broker.
- B.** A person who conducts unlawful license activity shall submit to the Department, as soon as the person becomes aware that the activity has occurred, the following:
1. A written explanation of why the unlawful license activity occurred;
  2. A signed statement from the person that the person will not conduct activities requiring licensure under A.R.S. § 32-2122 unless the person holds a current and active license to perform those acts;
  3. A signed statement from the employing broker's designated broker, identifying all unlawful activity by the person on behalf of the employing broker;
  4. Upon request by the Department:
    - a. A copy of all listing and employment agreements, offers or contract to buy, sell, lease, exchange, transfer, or manage real estate, cemetery property, or membership camping contracts prepared, negotiated or executed by the person while the person was not properly licensed under the employing broker;
    - b. Documentation listing all compensation received or to be received by the person based on transactions that occurred while the person was not properly licensed;
    - c. Documentation listing all compensation received or to be received by the person's employing broker and designated broker, if any, resulting from transactions that occurred while the person was not properly

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licensed if not provided in response to subsection (B)(4)(b); and

- d. A signed statement from the person stating that the information provided under subsection (B)(4) is true and complete and that the copies provided are true copies of all contracts, agreements, statements, and leases and no relevant documents are omitted.
- C. A person who has no prior history of engaging in unlawful license activity under this Section, who conducted unlawful license activity for not more than 30 days and against whom there are no pending complaints may apply to renew the person's license or for license change to active status. The Department shall not delay processing the application based on the unlawful licensed activity. The Department shall issue an Advisory Letter of Concern to the person.
- D. The Commissioner may take disciplinary action under A.R.S. § 32-2153 against a person who engages in unlawful license activity under this Section for longer than 30 days, has previously conducted unlawful license activity, or is the subject of a pending complaint.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**ARTICLE 4. EDUCATION****R4-28-401. Preclicensure Education Requirements; Waiver**

- A. Any individual applying for a real estate license shall either:
  - 1. Complete the required 90-hour preclicensure education as prescribed in A.R.S. § 32-2124; or
  - 2. Except for the 27-hour Arizona-specific course, apply for and be granted a waiver of the preclicensure courses.
- B. If the waiver request is based on prior education, the applicant shall submit a letter to the Commissioner that includes or demonstrates:
  - 1. The name, mailing, and business address, daytime telephone number, and signature of the applicant;
  - 2. The type of license sought;
  - 3. The name and address of the school;
  - 4. The course description or curriculum, including credit hours; and
  - 5. Completion of one or more real estate courses. Acceptable evidence includes:
    - a. A signed letter from a school representative or official transcript from a college or university, which indicates:
      - i. The starting and ending dates of the course;
      - ii. The number of semesters, quarters, and credit hours awarded per course; and
      - iii. Whether the course examination was passed.
    - b. Evidence of course completion provided as part of a certified license history from a state in which the applicant is currently or was previously licensed.
- C. If the waiver request is based on experience, or education and experience, the applicant shall submit a letter to the Commissioner that includes:
  - 1. A detailed resume covering the previous 10 years, indicating duties performed and the name and telephone number for each employer; and
  - 2. An original certified license history, including disciplinary action if any, from the real estate regulatory agency in each state in which the applicant is currently licensed and from any other state in which the applicant was licensed during the preceding 10 years; and
  - 3. One or more of the following:

- a. Completion of one or more real estate courses. Acceptable evidence includes a signed letter from a school representative, or official transcript from a college or university, which identifies:
  - i. The starting and ending dates of the course;
  - ii. The number of semesters, or quarters, and credit hours awarded per course;
  - iii. Whether the course examination was satisfactorily passed.
- b. Evidence of more than five years' experience in a real estate related field; or
- c. Evidence of course completion provided as part of a certified license history from a state in which the applicant is currently or was previously licensed.
- D. The Department shall provide a copy of the preclicensure course content to any person requesting it.
- E. A person shall not receive credit for more than 10 hours of preclicensure education classes per day.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended subsections (F) and (G) effective March 13, 1981 (Supp. 81-2). Former Section R4-28-10 renumbered without change as Section R4-28-401 (Supp. 87-1). Amended by adding a new subsection (E) and renumbering accordingly effective March 7, 1988 (Supp. 88-1). Amended subsection (G) effective June 6, 1989 (Supp. 89-2). Amended effective February 28, 1995 (Supp. 95-1). Section R4-28-401 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-402. Continuing Education Requirements; Waiver; Distance Learning**

- A. Continuing education requirements.
  - 1. To be eligible for license renewal, a real estate salesperson or broker shall complete continuing education courses approved by the Department under R4-28-404, presented by a real estate school approved under R4-28-404, and taken since the salesperson's or broker's original licensure or effective date of the preceding license, whichever is later.
  - 2. A real estate salesperson or associate broker applying for renewal shall submit proof of satisfactory completion of 24 credit hours of continuing education courses in the categories specified in subsection (A)(5). The renewal applicant shall complete a minimum of three hours in each of the mandatory categories under subsections (A)(5)(a) through (A)(5)(f). The renewal applicant shall take additional courses in the mandatory categories, or shall take courses in the business brokerage or general real estate categories described in subsection (A)(5)(g) and (A)(5)(h) to fulfill the required 24 credit hours.
  - 3. A real estate designated broker applying for renewal shall submit proof of satisfactory completion of 24 credit hours of continuing education courses. The renewal applicant shall complete a minimum of three hours in each of the mandatory categories under subsections (A)(5)(a) through (A)(5)(f) and shall complete a Broker Management Clinic under A.R.S. 32-2136 approved in the Commissioner's Standards category under subsection (A)(5)(c). The renewal applicant shall take additional courses in the mandatory categories, or shall take courses in the business brokerage or general real estate categories described in subsection (A)(5)(g) and (A)(5)(h) to fulfill the required 24 credit hours.

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4. A salesperson renewing for the first time may include credit for attendance at the Contract Writing class taken under A.R.S. § 32-2124(L) if taken within one year before the date of the salesperson's original licensure. A broker renewing for the first time may include credit for attendance at the Broker Management Clinic under A.R.S. § 32-2136 taken before the broker's original licensure date.
5. The categories for real estate continuing education courses are:
  - a. Agency law. The majority of class material concerns agency relationships and disclosure.
  - b. Contract law. The majority of class material concerns the contract formation and implementation, or the results of contract use, including:
    - i. Various contract forms and clauses, fundamentals, updates, options, offers, counter offers, first right of refusal, and exchanges;
    - ii. Contract writing;
    - iii. Required disclosures, problem-solving, and law and rule requirements;
    - iv. Recent court decisions and case law studies;
    - v. Breach of contract issues;
    - vi. Legal, ethical and agency considerations, procedures, and disclosures;
    - vii. Accommodating current financing procedures, requirements, and options.
  - c. Commissioner's standards. The majority of class material relates to license laws, including:
    - i. Article 26 of the Arizona Constitution;
    - ii. A.R.S. Title 32, Chapter 20, and A.A.C. Title 4, Chapter 28, which includes trust accounts, recordkeeping, license requirements, exemptions to licensure, commission payments, recovery fund provisions, development requirements, processes for public reports for and sale of subdivided and unsubdivided land, membership campgrounds and time-shares, cemetery regulations, and grounds for disciplinary action and hearings.
    - iii. A.R.S. Title 44, Chapter 10, Article 3.1, Trade Names and Business Practices.
  - d. Real estate legal issues. The majority of class material concerns existing real estate law, including:
    - i. Sources of real estate law (constitutions, statutes, zoning, common), and the legal system;
    - ii. Land and its elements (air, mineral rights, real and personal property);
    - iii. Land, title, and interests in land, homestead, encumbrances, and the Landlord and Tenant Act;
    - iv. Easements, fixtures, land descriptions, ownership, deeds, and building restrictions;
    - v. Escrow procedures, financing documents, and lending laws and regulations, including Regulation Z;
    - vi. Wills and estates, taxes, bankruptcy law, securities laws, title insurance, and appraisal law;
    - vii. Case law studies, real estate fraud, disclosure law, interstate and international real estate;
    - viii. Commission issues and forms of business ownership;
    - ix. Homeowners Association regulations;
    - x. Real Estate Settlement Procedures Act (RESPA); and
    - xi. Environmental issues.
  - e. Fair housing. The majority of class material concerns equal opportunities in housing, including:
    - i. Americans with Disabilities Act, ADA architectural designs (construction and development), and pertinent court cases;
    - ii. Arizona and federal fair housing laws, including advertising, marketing, information, and enforcement;
    - iii. Housing developments, deed restrictions, affordable housing, elder housing, zoning, local ordinances, and disclosures;
    - iv. Commercial and residential concerns; and
    - v. Administrative procedures and business practices.
  - f. Disclosure. The majority of class material concerns the following:
    - i. Licensee's disclosure obligations to client and others;
    - ii. Seller's and buyer's disclosure obligations to each other;
    - iii. Common material facts warranting disclosure, and liability for failure to disclose;
    - iv. Avoiding inadvertent non-disclosures;
    - v. Transaction documents that should be reviewed;
    - vi. Common "red flags" in a real estate transaction;
    - vii. Homeowner associations and buyers' obligations to homeowner associations; and
    - viii. Advising buyers and sellers of common "red flags."
  - g. Business brokerage. The majority of class material concerns business brokerage including:
    - i. Business brokerage basics including introducing licensees to business brokerage, associated terminology, marketing, prospecting, listing, pricing, closing practices, the use of contracts related to and unique to business brokerage, and the application of business brokerage contracts;
    - ii. Business valuations and appraisals, and establishing an in-depth review of proper business valuation techniques for small, medium, and large businesses;
    - iii. Tax structure and considerations, tax law, and policy including subjects such as financing tools available, options available, and tax implications;
    - iv. Accounting for business brokers;
    - v. Agency in business brokerages, the use of contracts related to and unique to business brokerage, and the application of business brokerage contracts; and
    - vi. Disclosure issues in business brokerage, including common "red flags" in a business opportunity transaction, and advising buyers and sellers of common "red flags."
  - h. General real estate. The majority of class material concerns real estate, but does not fall within any of the categories listed in subsections (A)(5)(a) through (A)(5)(g), including:

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- i. Appraisal methodology;
    - ii. General finance, use of financial calculators, mathematics, and managing cash flow;
    - iii. History of development in metropolitan areas; and
    - iv. Introduction to property management.
  - 6. The Department may require an individual applying for renewal to obtain credit hours based upon significant current issues in the real estate community. The Department shall notify licensees of a new requirement by written notice published in printed or electronic format.
  - 7. The Department may grant continuing education credit for a course that does not have a certificate of approval under R4-28-404 if the applicant demonstrates to the satisfaction of the Commissioner that the course meets the requirements prescribed in R4-28-404 and the course content requirements of this Section.
  - 8. An applicant may substitute subject matter hours within a 90-hour broker's preclicensure course that meet the criteria for credit under subsections (A)(5)(a) through (A)(5)(h), if taken since the last license renewal, for the continuing education credit required in subsection (A)(2) or (3).
  - 9. If any change in the continuing education course requirements occurs during a renewal applicant's license period and the applicant has fully complied with the continuing education requirement in effect before the change occurs, the Department shall consider the renewal applicant to be in compliance with the continuing education requirements for the license period.
- B. Continuing education waiver.** Under A.R.S. § 32-2130, the Commissioner may waive all or a portion of the continuing education requirement or grant additional time to complete a continuing education requirement when a salesperson or broker submits a written request to the Commissioner and shows good cause for the waiver or additional time.
- 1. Good cause may include:
    - a. A person employed by the state or political subdivision establishes to the satisfaction of the Commissioner that the person's employment during the prior license period involved real estate-related matters;
    - b. Any officer or employee of the state whose license is on an inactive status due to a possible conflict of interest or other employment requirement;
    - c. The person demonstrates successful completion of a course on topics specifically related to the person's field of real estate practice;
    - d. An approved real estate instructor requests a waiver for a course the instructor has taught;
    - e. The salesperson or broker demonstrates other extraordinary circumstances.
  - 2. A salesperson or broker is granted additional time by the Commissioner to complete the continuing education requirement for license renewal shall complete the continuing education hours by the deadline or be subject to disciplinary action.
- C.** The Department shall not grant a person credit for more than nine hours of continuing education per day.
- D. Distance learning.**
- 1. Only a school holding a Certificate of Approval shall offer a distance learning course. The school shall obtain course approval from the Department before advertising the course as approved by the Department for credit hours and before issuing Department credit hours for the course to students.
- 2. The Department shall not approve a distance learning course unless it contains:
    - a. Individual modules of instruction for delivery on a computer or other interactive program;
    - b. At least one learning objective for each module of instruction. The learning objective shall ensure that if all the objectives are met, the entire content of the course is understood;
    - c. A structured learning method to enable the student to attain each learning objective;
    - d. A diagnostic assessment of the student's performance during each module of instruction;
      - i. The assessment shall measure what the student learned throughout the module of instruction, and
      - ii. Assess the comprehension of each concept covered in the module;
    - e. Remediation.
      - i. Repetition of a module if a student is deficient in a diagnostic assessment; and
      - ii. Continuous repetition of the module until the student understands the content material.
  - 3. An approved instructor shall teach and an approved instructor or the school director shall grade distance learning courses. The instructor or school director shall:
    - a. Provide the student with assistance, if required;
    - b. Obtain a signed certification statement from the student indicating that the student has completed each assignment of instruction; and
    - c. Certify the student as completing a distance learning course only if the student:
      - i. Completes all required instructional modules,
      - ii. Attends any required hours of live instruction or testing, or both, for a given course; and
      - iii. Passes a final examination.
  - 4. As part of its application for approval of a distance learning course, a school shall file a plan with the Department describing how the school will deal with hardware and software failure.
- Historical Note**
- Adopted effective May 1, 1980 (Supp. 80-3). Amended subsection (F) effective March 13, 1981 (Supp. 81-2). Former Section R4-28-11 renumbered without change as Section R4-28-402 (Supp. 87-1). Amended by deleting subsections (C) and (E) and renumbering accordingly effective March 7, 1988 (Supp. 88-1). Former Section R4-28-402 renumbered to Section R4-28-403, new Section R4-28-402 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).
- R4-28-403. License Examinations**
- A.** The Department shall hold, or contract for, at least one state licensing examination each week.
  - B.** A state license examination shall not be returned to the applicant. The applicant shall be notified in person of the results of the examination by the words "passed" or "did not pass." The results notification for an applicant who did not pass the examination shall also show the score for the examination and the relative score for each content area.

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- C. Qualifying to take or passing a license examination does not constitute a waiver of the Commissioner's right to deny issuance of a license if grounds exist pursuant to A.R.S. § 32-2153 or any other applicable statute.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-12 repealed, new Section R4-28-12 adopted effective August 28, 1986 (Supp. 86-4). Former Section R4-28-12 renumbered without change as Section R4-28-403 (Supp. 87-1). Amended effective February 28, 1995 (Supp. 95-1). Former Section R4-28-403 renumbered to R4-28-404, new Section R4-28-403 renumbered from R4-28-402 and amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-404. Real Estate School Requirements, Course and Instructor Approval**

- A. Certificate of School Approval. Except for a community college or university accredited by the Council on Post Secondary Accreditation or the U.S. Department of Education offering courses in real estate, any school offering a course of study for original or renewal licensure of a real estate applicant shall apply for and possess a Certificate of School Approval from the Department. The school's authorized representative shall provide the following information on or with the Certificate of School Approval form:
1. The name, address, telephone number, and fax number, if any, of the school;
  2. The name of the owner and d.b.a. name, if any;
  3. Whether the owner is a sole proprietorship, partnership, trust, limited liability company, or corporation;
  4. The name, address, telephone number, and percentage ownership of each person, entity, or beneficiary holding or controlling 10% or more financial interest in the school;
  5. The name of each individual authorized to act on behalf of the school and sign continuing education certificates or precursure verifications, or both;
  6. The name, business address, and telephone number of all current and prospective administrators, directors, and instructors;
  7. In addition to the information required in R4-28-301(A), each school owner, administrator, director, and instructor shall provide a statement of the individual's:
    - a. Education,
    - b. Teaching experience, and
    - c. Employment history.
  8. If the owner is a partnership, a copy of the partnership agreement naming the partner authorized to act on its behalf;
  9. If the owner is a corporation or limited liability company, a copy of:
    - a. A corporate or company resolution or operating agreement naming the officer, member, or manager authorized to execute the Certificate of Approval form;
    - b. A current Certificate of Good Standing from the Arizona Corporation Commission;
    - c. The latest annual report on file with the Arizona Corporation Commission;
    - d. The Articles of Incorporation or Organization, as amended.
  10. The location of school registration and licensing certification records.
- B. Certificate of Course Approval. Any school offering a course of study for original or renewal licensure of a real estate applicant shall apply for and possess a Certificate of Course Approval for each course offered by the school. The school's authorized representative shall submit the following information:
1. The school name, address, telephone number, and fax number, if any;
  2. The authorized representative's name, title, and signature;
  3. The title of the course;
  4. A detailed outline of course material content that clearly lists the subject matter to be covered;
  5. The date, time, and location of the anticipated presentation, if known;
  6. The number of credit hours requested. The time allocated by a school for examination shall not be included in calculating credit hours if the examination is used for overall evaluation.
  7. The category of approval requested;
  8. A definition of segments if the course is to be offered in part and in its entirety;
  9. If video or audio tapes will be used as instructional aids, the percentage of the class they will comprise;
  10. The name of every instructor who will teach the course; and
  11. The date of the application.
- C. Instructor approval. Any person wishing to teach an approved real estate course shall apply for an instructors approval, and shall have at least one of the following in the proposed subject area:
1. A bachelor's or master's degree in an area traditionally associated with real estate, such as business, law, economics, marketing, and finance;
  2. An award of a generally-recognized professional real estate designation, such as Certified Commercial Investment Member, Graduate Realtor Institute, Certified Residential Specialist, Independent Fee Appraiser, or Member of the Appraisal Institute, and two years of postsecondary education from an accredited institution;
  3. Experience in real estate, and a bachelor's degree in education with a valid certificate issued within 15 years of the date of application for instructor approval;
  4. A real estate salesperson's or broker's license, and is an employee or former employee of a regulatory agency;
  5. A Distinguished Real Estate Instructor designation, with credentials in the specific subject;
  6. At least three years real estate or specific subject experience; or
  7. Other education or experience determined by the Commissioner to qualify the applicant as an instructor.
- D. The school shall maintain a record for five years of each student attending the school. The record shall include:
1. The name of each student;
  2. The dates of attendance;
  3. The title of each course taken;
  4. The course number, category, and credit hours awarded;
  5. The final grade or score in each precursure course; and
  6. The original signature roster for each course or course segment taught.
- E. The prospective student shall sign an agreement or application to enroll, presented to the student by the school representative, that includes the following, in bold type and capital letters:
1. The course or course segment title within a curriculum,
  2. The total credit hours applicable for licensure or renewal,



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3. The cost of each course,
  4. A statement of the refund policy, and
  5. A statement of any job placement service.
- F.** The Department does not consider lists of employers given to graduates to be a placement service. The school may advertise job placement services only if:
1. Student referrals result from direct contact between the school placement service and prospective employers,
  2. Documented evidence of student referrals is maintained and includes:
    - a. The number of referrals to prospective employers per student,
    - b. Results of referrals,
    - c. Final placement or other disposition.
- G.** Complaints. The Commissioner may, and upon a verified complaint in writing shall, investigate and observe the classes of any school, owner, administrator, director, or instructor acting on behalf of the school and may examine the books and records of the school in connection with the offering of approved courses.
- H.** Change in school, course, or instructor. Each school owner, operator, director, and instructor shall:
1. Provide a written notice and supporting documentation within 10 days of any:
    - a. Change of personal name or address,
    - b. Change of business address,
    - c. Change of business mailing address,
    - d. School closing, or
    - e. Disclosure of certification information pursuant to R4-28-301(A),
  2. Provide a written notice and supporting documentation within 30 days after any change in structure of a licensed entity, including any change of a:
    - a. Director, officer, or person holding or controlling 10% or more of the shares, if a corporation;
    - b. Partner, if a partnership;
    - c. Member or manager, if a limited liability company.
  3. Obtain approval from the Commissioner before conducting business when:
    - a. Changing a business name,
    - b. Establishing a school location,
    - c. Changing the course content,
    - d. Changing the course length, or
    - e. Offering a new course.
  4. Provide written notice as soon as practical of a last minute change of instructor due to illness or emergency.

**Historical Note**

Section R4-28-404 renumbered from R4-28-403 and amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-405. Expired**

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1). Section expired under A.R.S. § 41-1056(J) at 21 A.A.R. 757, effective February 28, 2015 (Supp. 15-2).

**ARTICLE 5. ADVERTISING**

**R4-28-501. Repealed**

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-13 renumbered without change as Section R-28-501 (Supp. 87-1). Former Section R4-28-501

repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-502. Advertising by a Licensee**

- A.** A salesperson or broker acting as an agent shall not advertise property in a manner that implies that no salesperson or broker is taking part in the offer for sale, lease, or exchange.
- B.** Any salesperson or broker advertising the salesperson's or broker's own property for sale, lease, or exchange shall disclose the salesperson's or broker's status as a salesperson or broker, and as the property owner by placing the words "owner/agent" in the advertisement.
- C.** A salesperson or broker shall ensure that all advertising contains accurate claims and representations, and fully states factual material relating to the information advertised. A salesperson or broker shall not misrepresent the facts or create misleading impressions.
- D.** A school shall include its name, address and telephone number in all advertising of Department-approved courses. The school owner, director, or administrator shall supervise all advertising. The school owner shall ensure that the school's advertising is accurate.
- E.** A salesperson or broker shall ensure that all advertising identifies in a clear and prominent manner the employing broker's legal name or the dba name contained on the employing broker's license certificate.
- F.** A licensee who advertises property that is the subject of another person's real estate employment agreement shall display the name of the listing broker in a clear and prominent manner.
- G.** The designated broker shall supervise all advertising, for real estate, cemetery, or membership camping brokerage services.
- H.** A licensee shall not use the term "acre," either alone or modified, unless referring to an area of land representing 43,560 square feet.
- I.** Before placing or erecting a sign giving notice that specific property is being offered for sale, lease, rent, or exchange, a salesperson or broker shall secure the written consent of the property owner, and the sign shall be promptly removed upon request of the property owner.
- J.** The provisions of subsections (E) and (G) do not apply to advertising that does not refer to specific property.
- K.** Trade Names.
  1. Any broker using a trade name owned by another person on signs displayed at the place of business shall place the broker's name, as licensed by the Department on the signs;
  2. The broker shall include the following legend, "Each (TRADE NAME or FRANCHISE) office is independently owned and operated," or a similar legend approved by the Commissioner, in a manner to attract the attention of the public.
- L.** The use of an electronic medium, such as the Internet or web site technology, that targets residents of this state with the offering of a property interest or real estate brokerage services pertaining to property located in this state constitutes the dissemination of advertising as defined in A.R.S. § 32-2101(2).

**Historical Note**

Former Section R4-28-14 repealed, new Section R4-28-14 adopted effective May 1, 1980 (Supp. 80-3). Amended subsection (D) effective August 1, 1986 (Supp. 86-4). Former Section R4-28-14 renumbered without change as Section R4-28-502 (Supp. 87-1). Section R4-28-502 amended by final rulemaking at 5 A.A.R. 650, effective

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February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-503. Promotional Activities**

- A. A licensee shall not describe a premium offered at no cost or reduced cost to promote sales or leasing as an "award," or "prize," or use a similar term.
- B. A licensee shall clearly disclose to a person in writing the terms, costs, conditions, restrictions, and expiration date of an offer of a premium before the person participates in the offer.
- C. Unless otherwise provided by law, a person shall not solicit, sell, or offer to sell an interest in a development by conducting a lottery contest, drawing, or game of chance.
- D. A subdivider, time-share developer, or membership camping operator may apply for approval to conduct a lottery, contest, drawing, or game of chance, or award a premium under A.R.S. § 32-2197.17(J), by submitting to the Department the information under A.R.S. §§ 32-2183.01(I), 32-2197.17(J) or 32-2198.10(D), the applicable fee, if any, and:
  1. The name, address, telephone number, and fax number, if any, of the subdivider, time-share developer, or operator;
  2. The legal name of the broker;
  3. The public report number;
  4. The time and location for collecting entries for the lottery, contest, or drawing;
  5. The date, time, and site for selection of a winner; and
  6. The conditions and restrictions to enter, if any.

**Historical Note**

Former Section R4-28-15 repealed, new Section R4-28-15 adopted effective May 1, 1980 (Supp. 80-3). Amended effective August 1, 1986 (Supp. 86-4). Former Section R4-28-15 renumbered without change as Section R4-28-503 (Supp. 87-1). Section R4-28-503 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-504. Development Advertising**

- A. If a developer obtains a conditional sales exemption, under R4-28-B1202, or registers a notice of intent with the Department to accept lot reservations under A.R.S. § 32-2181.03, the developer shall disclose on all advertising that only reservations or conditional sales contracts will be taken until the public report has been issued.
- B. Only a developer or the developer's authorized representative shall file advertising for a development under A.R.S. §§ 32-2183.01(A), 32-2194.05(A), 32-2195.05(A), 32-2197.17(A) or 32-2198.01(A)(6) with the Department.
- C. A developer shall ensure that advertisement of property in a development includes the name of the development as registered with the Department. The Commissioner may waive application of this subsection if the Commissioner determines that the public interest is not affected.
- D. A developer shall not advertise a monthly payment, total price, or interest rate that is not available to all prospective purchasers or is restricted, unless the lack of availability or the restriction is conspicuously disclosed to all prospective purchasers within the advertisement.
- E. A developer shall not advertise proposed or incomplete improvements unless the following requirements are met:
  1. The estimated date of completion is specified or, if there is no estimated date of completion, the developer includes a prominent disclosure in the advertisement that the improvement is proposed only and no warranty is

given or implied that the improvement will be completed; and

2. If a completion date is specified, the developer has submitted to the Department evidence to satisfactorily demonstrate to the Department that the completion and operation of the facilities are assured and that completion will be within the time represented in the advertisement or promotional material.
- F. The developer shall not reference a proposed public facility or project that purports to effect the value or utility of an interest in a development without disclosing in writing the existing status of the proposed facility. The developer shall base the disclosure upon information supplied or verified by the authority responsible for the public facility or project and shall forward the information to the Department.
- G. Pictorial or illustrative depictions, other than unmodified photographs of the property being offered, shall bear a prominent disclosure identifying the nature of the depiction, such as an artist's conception, and shall identify those improvements that are proposed and not in existence.
- H. When a pictorial representation is used in an advertisement for a specific development and is not an actual or accurate representation of the property, a statement within the advertisement shall prominently disclose the distance of the pictorial representation from the advertised property.
- I. If a map or diagram is used to show the location of the development in relation to other facilities, actual road miles from each facility to the development shall be shown on the map or diagram.
- J. A developer shall not expressly state or imply that a facility is available for the exclusive use of purchasers of lots or interests if a public right of access or public use of the facility exists.
- K. A developer shall not refer to availability for use of private clubs or facilities in which the owner will not acquire a proprietary interest through purchase of an interest in the development unless a disclosure is made in the advertisement. The disclosure shall affirmatively state the existence of the facilities and that availability for use by owners of an interest in the development is at the pleasure of the owners of the facility.
- L. When a standing body of water is described as a feature of a development, all advertising shall indicate the average surface area of the body of water. If a standing body of water or a flowing waterway described as a feature of a development is not permanent, or fluctuates substantially in size or volume, the developer shall disclose this fact in all advertisements describing the feature.
- M. At the time an incentive is offered to visit any place where a sales presentation for a development is to be made and before the recipient of the incentive makes the trip, the developer shall disclose in writing all conditions, limitations, or recipient qualifications that will be applied.
- N. A developer shall not include in advertising testimonials or endorsements that contain statements that a salesperson or broker would be precluded by law from making on the salesperson's or broker's behalf.

**Historical Note**

Editorial correction new language subsection (D)(2) (Supp. 75-1). Former Section R4-28-16 repealed, new Section R4-28-16 adopted effective May 1, 1980 (Supp. 80-3). Amended by adding subsection (T) effective March 13, 1981 (Supp. 81-2). Amended subsection (F) effective June 9, 1982 (Supp. 82-3). Amended effective August 1, 1986 (Supp. 86-4). Former Section R4-28-16 renumbered without change as Section R4-28-504 (Supp.

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87-1). Section R4-28-504 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**ARTICLE 6. REPEALED****R4-28-601. Repealed****Historical Note**

Former Section R4-28-17 repealed, new Section R4-28-17 adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-17 renumbered without change as Section R4-28-601 (Supp. 87-1). Repealed effective February 28, 1995 (Supp. 95-1).

**ARTICLE 7. COMPENSATION****R4-28-701. Compensation Sharing Disclosure**

A real estate broker shall disclose to all the parties in a transaction, in writing before closing, the name of each employing broker who represents a party to the transaction and who will receive compensation from the transaction.

**Historical Note**

Former Section R4-28-18 repealed, new Section R4-28-18 adopted effective May 1, 1980 (Supp. 80-3). Amended by adding subsection (B) effective March 13, 1981 (Supp. 81-2). Former Section R4-28-18 renumbered without change as Section R4-28-701 (Supp. 87-1). Section R4-28-701 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3640, effective August 6, 2002 (Supp. 02-3).

**ARTICLE 8. DOCUMENTS****R4-28-801. Repealed****Historical Note**

Former Section R4-28-19 repealed, new Section R4-28-19 adopted effective May 1, 1980 (Supp. 80-3). Amended effective August 28, 1986 (Supp. 86-4). Former Section R4-28-19 renumbered without change as Section R4-28-801 (Supp. 87-1). Amended subsection (A) effective November 27, 1987 (Supp. 87-4). Correction to subsection (D), from "...management shall..." to "...management agreement shall..." as certified effective August 28, 1986. Amended subsections (A), (C) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective February 28, 1995 (Supp. 95-1). Former Section R4-28-801 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-802. Conveyance Documents**

- A. Upon execution of any transaction document a salesperson or broker shall, as soon as practical, deliver a legible copy of the signed document and final agreement to each party signing the document.
- B. During the term of a listing agreement, a salesperson or broker shall promptly submit to the salesperson's or broker's client all offers to purchase or lease the listed property. Upon receiving permission from the seller or lessor, the salesperson or broker acting on behalf of the seller or lessor may disclose to all offerors or their agents the existence and terms of all additional offers on the listed property. The salesperson or broker shall submit to the client all offers made prior to closing and is not released from this duty by the client's acceptance of an offer unless the client instructs the salesperson or broker in writing

to cease submitting offers or unless otherwise provided in the listing agreement, lease, or purchase contract. The salesperson or broker may voluntarily submit offers to the seller or lessor regardless of any limitations contained in the listing agreement and may submit offers after the listing agreement is terminated.

- C. Transaction statements. In addition to the requirements of A.R.S. §§ 32-2151.01 and 32-2174, the broker shall retain true copies of all receipts and disbursements, or copies of the executed and delivered escrow closing statements that evidence all receipts and disbursements in the transaction.

**Historical Note**

Former Section R4-28-20 repealed, new Section R4-28-20 adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Former Section R4-28-20 renumbered without change as Section R4-28-802 (Supp. 87-1). Amended effective February 28, 1995 (Supp. 95-1). Section R4-28-802 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 3640, effective August 6, 2002 (Supp. 02-3).

**R4-28-803. Contract Disclosures**

- A. A developer or the developer's agent shall ensure that any agreement or contract for the sale or lease of a property interest in a development that requires a public report contains substantially the following language in bold print or print larger than the other print used in the document above the signature portion of the document:

THE DEVELOPER SHALL GIVE A PROSPECTIVE PURCHASER A COPY OF THE PUBLIC REPORT AND AN OPPORTUNITY TO READ AND REVIEW IT BEFORE THE PROSPECTIVE PURCHASER SIGNS THIS DOCUMENT.

- B. A developer or the developer's agent shall ensure that any agreement or contract for the sale or lease of a property interest in a development conspicuously discloses the nature of the document at or near the top of the document.
- C. The contract shall indicate where the earnest money or down payment, if any, will be deposited and shall include the name of the title company, the name of the broker's trust account, or other depository.
- D. Any agreement or contract for the sale or lease of a property interest in a development where a down payment, earnest money deposit, or other advanced money, if any, is paid directly to the seller and not placed in a neutral escrow depository, shall conspicuously disclose this fact within the document, and the purchaser shall sign or initial this provision indicating approval in the space adjacent to or directly below the disclosure in the purchase contract or agreement of sale. The following disclosure shall be written in large or bold print and shall be included in the public report, purchase contract, and agreement of sale.

Prospective purchasers are advised that earnest money deposits, down payments, and other advanced money will not be placed in a neutral escrow. This money will be paid directly to the seller and may be used by the seller. This means the purchaser assumes a risk of losing the money if the seller is unable or unwilling to perform under the terms of the purchase contract.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended Exhibit effective March 13, 1981 (Supp. 81-2). Former Section R4-28-21 renumbered without change as Section

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R4-28-803 (Supp. 87-1). Section R4-28-803 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-804. Rescission of Contract**

- A. Any agreement or contract for the purchase or lease of an unimproved subdivided lot, or any unsubdivided land, shall contain substantially the following language in bold print or print larger than the other print used in the document above the signature portion of the document:

The purchaser or lessee has the legal right to rescind (cancel) this agreement without cause or reason of any kind, and to the return of any money or other consideration by sending or delivering a written notice of rescission to the seller or lessor by midnight of the seventh calendar day following the day the purchaser or lessee executed the agreement. If the purchaser or lessee does not inspect the lot or parcel before the execution of the agreement, the purchaser or lessee shall have six months to inspect the lot or parcel, and at the time of inspection shall have the right to unilaterally rescind the agreement.

- B. Any agreement or contract for the purchase or lease of a time-share interval shall contain substantially the following language in bold print or print larger than the other print used in the document above the signature portion of the document:

The purchaser or lessee has the legal right to rescind (cancel) this agreement without cause or reason of any kind by sending or delivering a written notice of rescission to the seller or lessor by midnight of the seventh calendar day following the day the purchaser or lessee executed the agreement.

- C. An opportunity to exercise the seven-day right of rescission shall be provided by conspicuously disclosing the complete current name, address, and telephone number of the seller on the face of all agreements and contracts.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-22 renumbered without change as Section R4-28-804 (Supp. 87-1). Section R4-28-804 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2).

**R4-28-805. Public Report Receipt**

When a public report is required, the developer shall complete the following public report receipt and obtain the purchaser's signature to verify that the prospective purchaser has received a copy of the public report:

**PUBLIC REPORT RECEIPT**

The developer shall furnish you, as a prospective customer, with a copy of the public report required by the Arizona Department of Real Estate. It is recommended that you read the report before you make any written offer to purchase or lease an interest in the development and before you pay any money or other consideration toward the purchase or lease of an interest in the development.

**FOR YOUR PROTECTION, DO NOT SIGN THIS RECEIPT UNTIL YOU HAVE RECEIVED A COPY OF THE REPORT AND HAVE HAD THE OPPORTUNITY TO READ IT. BY SIGNING THIS RECEIPT, THE BUYER HAS ACCEPTED**

THE PUBLIC REPORT AND ACKNOWLEDGES THE INFORMATION IT CONTAINS.

Public Report Registration No. Development Name and Lot No.

I understand the report is not a recommendation or endorsement of the development by the Arizona Department of Real Estate, but is for information only.

Buyer's Name

Address

Date

**Historical Note**

New Section R4-28-805 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**ARTICLE 9. REPEALED****R4-28-901. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended by adding subsection (E) effective August 28, 1986 (Supp. 864). Former Section R4-28-23 renumbered without change as Section R4-28-901 (Supp. 87-1). Repealed effective February 28, 1995 (Supp. 95-1).

**R4-28-902. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 90-3). Amended effective March 13, 1981 (Supp. 81-2). Former Section R4-28-24 renumbered without change as Section R4-28-902 (Supp. 87-1). Repealed effective February 28, 1995 (Supp. 95-1).

**ARTICLE 10. REPEALED****R4-28-1001. Repealed****Historical Note**

Adopted effective May 31, 1980 (Supp. 80-3). Amended subsection (A) effective August 1, 1986 (Supp. 864). Former Section R4-28-26 renumbered without change as Section R4-28-1001 (Supp. 87-1). Section R4-28-1001 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-1002. Expired****Historical Note**

New Section R4-28-1002 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 1893, effective February 29, 2004 (Supp. 04-2).

**ARTICLE 11. PROFESSIONAL CONDUCT****R4-28-1101. Duties to Client**

- A. A licensee owes a fiduciary duty to the client and shall protect and promote the client's interests. The licensee shall also deal fairly with all other parties to a transaction.
- B. A licensee participating in a real estate transaction shall disclose in writing to all other parties any information the licensee possesses that materially or adversely affects the consideration to be paid by any party to the transaction, including:

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1. Any information that the seller or lessor is or may be unable to perform;
  2. Any information that the buyer or lessee is, or may be, unable to perform;
  3. Any material defect existing in the property being transferred; and
  4. The existence of a lien or encumbrance on the property being transferred.
- C.** A licensee shall expeditiously perform all acts required by the holding of a license. A licensee shall not delay performance, either intentionally or through neglect.
- D.** A licensee shall not allow a controversy with another licensee to jeopardize, delay, or interfere with the initiation, processing, or finalizing of a transaction on behalf of a client. This prohibition does not obligate a licensee to agree to alter the terms of any employment or compensation agreement or to relinquish the right to maintain an action to resolve a controversy.
- E.** A real estate salesperson or broker shall not act directly or indirectly in a transaction without informing the other parties in the transaction, in writing and before the parties enter any binding agreement, of a present or prospective interest or conflict in the transaction, including that the:
1. Salesperson or broker has a license and is acting as a principal;
  2. Purchaser or seller is a member of the salesperson's, broker's, or designated broker's immediate family;
  3. Purchaser or seller is the salesperson's or broker's employing broker, or owns or is employed by the salesperson's or broker's employing broker; or
  4. Salesperson or broker, or a member of the salesperson's or broker's immediate family, has a financial interest in the transaction other than the salesperson's or broker's receipt of compensation for the real estate services.
- F.** A salesperson or broker shall not accept compensation from or represent more than one party to a transaction without the prior written consent of all parties.
- G.** A salesperson or broker shall not accept any compensation, including rebate or other consideration, directly or indirectly, for any goods or services provided to a person if the goods or services are related to or result from a real estate transaction, without that person's prior written acknowledgement of the compensation. This prohibition does not apply to compensation paid to a broker by a broker who represents a party in the transaction.
- H.** The services that a salesperson or broker provides to a client or a customer shall conform to the standards of practice and competence recognized in the professional community for the specific real estate discipline in which the salesperson or broker engages. A salesperson or broker shall not undertake to provide professional services concerning a type of property or service that is outside the salesperson's or broker's field of competence without engaging the assistance of a person who is competent to provide those services, unless the salesperson's or broker's lack of expertise is first disclosed to the client in writing and the client subsequently employs the salesperson or broker.
- I.** A salesperson or broker shall exercise reasonable care in ensuring that the salesperson or broker obtains information material to a client's interests and relevant to the contemplated transaction and accurately communicates the information to the client. A salesperson or broker is not required to have expertise in subject areas other than those required to obtain the salesperson's or broker's license. A salesperson or broker shall take reasonable steps to assist a client in confirming the accuracy of information relevant to the transaction.
- J.** A salesperson or broker shall not:
1. Permit or facilitate occupancy in a person's real property by a third party without prior written authorization from the person; or
  2. Deliver possession prior to closing unless expressly instructed to do so by the owner of the property or property interest being transferred.
- K.** A salesperson or broker shall recommend to a client that the client seek appropriate counsel from insurance, legal, tax, and accounting professionals regarding the risks of pre-possession or post-possession of a property.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-27 renumbered without change as Section R4-28-1101 (Supp. 87-1). Section R4-28-1101 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 3640, effective August 6, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-1102. Property Negotiations**

Except for owner listed properties, negotiations shall be conducted exclusively through the principal's broker or the broker's representative unless:

1. The principal waives this requirement in writing, and
2. No licensed representative of the broker is available for 24 hours.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-28 renumbered without change as Section R4-28-1102 (Supp. 87-1). Section R4-28-1102 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1103. Broker Supervision and Control**

- A.** An employing broker and a designated broker shall exercise reasonable supervision and control over the activities of brokers, salespersons, and others in the employ of the broker. Reasonable supervision and control includes the establishment and enforcement of written policies, procedures, and systems to:
1. Review and manage:
    - a. Transactions requiring a salesperson's or broker's license; and
    - b. Use of disclosure forms and contracts and, if a real estate broker, real estate employment agreements under A.R.S. § 32-2151.02;
  2. Manage:
    - a. Filing, storing, and maintaining documents pertaining to transactions under subsection (A)(5)(a);
    - b. Handling of trust funds; and
    - c. Use of unlicensed assistants by a salesperson or broker;
  3. Oversee delegation of authority to others to act on behalf of the broker;
  4. Familiarize salespersons and associate brokers with the requirements of federal, state, and local laws relating to the practice of real estate, or the sale of cemetery property or membership camping contracts; and
  5. Review and inspect:

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- a. Documents that may have a material effect upon the rights or obligations of a party to a transaction; and
- b. Advertising and marketing by the broker and by salespersons, brokers, and others in the broker's employ.
- B.** A designated broker shall establish a system for monitoring compliance with statutes, rules, and the employing broker's policies, procedures, and systems.
- C.** A designated broker shall supervise associate brokers, salespersons, and employees of the employing broker and shall exercise reasonable supervision and control over activities by the employing broker for which a license is required.
- D.** An employing broker is responsible for the acts of all associate brokers, salespersons, and other employees acting within the scope of their employment.
- E.** A designated broker may use the services of employees to assist in administering the provisions of this Section but shall not relinquish overall responsibility for supervision and control of the acts of the employing broker's employees.
- F.** A designated broker who, upon learning of a violation of real estate statutes or rules by a salesperson or associate broker under the broker's supervision, immediately reports the violation to the Department is not subject to disciplinary action by the Department for failure to supervise the salesperson or broker.
- G.** If an employing broker maintains one office and employs a designated broker, no more than one other licensed person, and no more than one unlicensed person, the employing broker and designated broker are not required to develop and maintain written policies, procedures, and systems as described in subsection (A).

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3640, effective August 6, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 11 A.A.R. 1496, effective June 4, 2005 (Supp. 05-2).

**ARTICLE 12. DEVELOPMENTS**

**R4-28-1201. Renumbered**

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended subsection (B) effective June 9, 1982 (Supp. 82-3). Former Section R4-28-29 renumbered without change as Section R4-28-1201 (Supp. 87-1). Former Section R4-28-1201 renumbered to R4-28-B1205 by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1202. Repealed**

**Historical Note**

Former Section R4-28-30 repealed effective May 1, 1980, new Section R4-28-30 adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Former Section R4-28-30 renumbered without change as Section R4-28-1202 (Supp. 87-1). Repealed effective February 28, 1995 (Supp. 95-1).

**R4-28-1203. Renumbered**

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-31 renumbered without change as Section R4-28-1203 (Supp. 87-1). Former Section R4-28-1203 renumbered to R4-28-B1203 by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1204. Repealed**

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-32 renumbered without change as Section R4-28-1204 (Supp. 87-1). Section R4-28-1204 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**PART A. APPLICATION FOR PUBLIC REPORT,  
CERTIFICATE OF AUTHORITY, OR SPECIAL ORDER OF  
EXEMPTION**

**R4-28-A1201. Development Name; Lot Sales; Applicant**

- A.** Any person may submit a development application for a public report, a certificate of authority, or a special order of exemption, provided the applicant has a recorded ownership interest in the land, such as a deed, option, beneficial interest in a trust, or other recorded interest approved by the Commissioner. The application for a public report or certificate of authority shall contain the following information, as applicable:
  - 1. The name of the development or cemetery, as shown on the recorded map, and the marketing name if one will be used;
  - 2. The list of the lots to be offered, including the description of the sales offering;
  - 3. The name, address, telephone number, and fax number, if any, of the applicant; and
  - 4. The applicable information in this Article, Parts A and B.
- B.** If the applicant is a corporation, the application shall contain the following information:
  - 1. A Certificate of Good Standing from the Arizona Corporation Commission, dated no earlier than one year from the date of the application;
  - 2. A corporate resolution, authorizing the person signing the application on behalf of the corporation; and
  - 3. The name and address of each officer, director, and shareholder controlling or holding more than 10% of the issued and outstanding common shares, or 10% of any other proprietary, beneficial, or membership interest in the entity.
- C.** If the applicant is a partnership, the application shall contain the following information:
  - 1. A copy of all partnership agreements;
  - 2. Proof of registration with the Secretary of State if any partnership is a limited partnership, foreign or domestic;
  - 3. If the general partner is a corporation, the information requested in subsection (B);
  - 4. If the general partner is a limited liability company, the information requested in subsection (D); and
  - 5. The name and address of each partner in the partnership.
- D.** If the applicant is a limited liability company, the application shall contain the following information:
  - 1. A copy of the Articles of Organization, stamped "Received and Filed" by the Arizona Corporation Commission. If more than one year has elapsed between the original filing with the Arizona Corporation Commission and the filing date of the development application, a Certificate of Good Standing from the Arizona Corporation Commission is required;
  - 2. A copy of the operating agreement and any amendments;
  - 3. If not included in the operating agreement or Articles of Organization, a copy of the company resolution signed by all members stating whether management of the limited liability company is established as manager-controlled or member-controlled and the name of the member or man-

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- ager appointed to act on behalf of the company and sign the application;
4. The name and address of each member, manager, and managerial employee, and the name and address of any person controlling or holding more than 10% of the membership interest in the limited liability company;
  5. If a member is a corporation, the information requested in subsection (B);
  6. If a member is a partnership, the information requested in subsection (C).
- E.** If the applicant is a trust, the application shall contain the name and address of each trustee, beneficiary, and anyone in control of the trust.
- F.** If the applicant is a subsidiary corporation, the application shall contain the name and address of the parent corporation.

**Historical Note**

Section R4-28-A1201 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1202. Development Map; Location; Land Characteristics**

- A.** The applicant shall submit a legible copy, no larger than 11" x 17", of the recorded development map showing, as applicable:
1. The county recorder's recording information, including the book and page of maps and recording date;
  2. County or city approval;
  3. Applicable dedications;
  4. Monuments, distances, and bearings; and
  5. Registered land surveyor certification.
- B.** The applicant shall identify the location of the development, including the street, city, county, and state, and:
1. The miles and direction from the nearest city or town, if applicable; and
  2. The most direct route for getting to the development from a federal, state, county, or city road.
- C.** The application shall include a description of the physical characteristics of the land and any unusual factors that may affect it, such as if it has level or hilly terrain, rocky, loose, or alkaline soil, and
1. The gross acreage of the development;
  2. The total number of lots within the development, including a description of phasing, if applicable; and
  3. Whether and how lots are permanently or temporarily staked or marked for easy location.

**Historical Note**

Section R4-28-A1202 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1203. Flood and Drainage; Land Uses; Adverse Conditions**

The applicant shall state, or include as applicable:

1. Whether the development is subject to any known flooding or drainage problems and a letter bearing the signature and seal of a professional civil, city, and county engineer, or county flood district detailing the drainage conditions and flood hazards. The letter shall include the effect of any flood plain and its location, the effect of a 100 year frequency storm, and whether flood insurance is required.
2. Whether the development lots are subject to subsidence or expansive soils. If subsidence or expansive soils exist, a professional engineer's letter addressing the effects of the condition, remedies, and a buyer's on-going responsibilities in plain language;

3. A description of the existing and proposed land uses in the vicinity of the development that may cause a nuisance or adversely affect lot owners, such as freeways, airports, sewer plants, railroads, and canals, including:
  - a. Any unusual safety factors within or near the development, and
  - b. A description of all current and proposed adjacent land uses.
4. Whether the development is affected by any unusual or unpleasant odors, noises, pollutants, or other nuisances;
5. A description of any agricultural activity or condition in the area that may adversely affect a lot owner, including any odors, cultivation and related dust, agricultural burning, application of pesticides, or irrigation and drainage;
6. Whether the development lots are subject to any known geological or environmental condition that would or may be detrimental to a purchaser's health, safety, or welfare; or
7. Whether the development lots are located within the boundary of a federal, designated Superfund site or a state designated Water Quality Assurance Revolving Fund site.

**Historical Note**

Section R4-28-A1203 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1204. Utilities**

The applicant shall include information about electrical, telephone, and natural gas utilities available to the development, including:

1. The names, addresses, and telephone numbers of the electrical, telephone, and natural gas company that will provide service;
2. The location of existing electrical, telephone, and natural gas utilities in relation to the development;
3. The name of each person responsible for extending each utility to the lot lines;
4. The estimated completion date for extending each utility to the lot lines;
5. If the developer will only install conduit, a description of the arrangement made to complete operational utilities to lot lines;
6. The estimated cost a lot purchaser will be required to pay for completion of each utility to the purchaser's lot line, and, if the offer is for unimproved lots, the estimated costs to provide service from the lot line to the dwelling;
7. Upon completion of the utilities, other costs or requirements that must be addressed before the lot purchaser receives service, including the current service charges, hookup fees, turn-on fees, meter fees, and fees for pulling wire through conduit;
8. If propane gas will be used, a letter from the supplier stating that it will be providing service to the development, with a description of requirements to be met and costs to be paid by the lot purchaser for receiving the service; and
9. If street lights will be available, the person responsible for completion, the estimated completion date and the person who will pay for the electricity.

**Historical Note**

Section R4-28-A1204 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1205. Water Supply**

An applicant shall include information about any water supply to the development, including:

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1. The type of water provider such as a municipal system, improvement district, public utility, private water company, co-operative, irrigation district, private well, water hauler, or other source;
2. The name, address, and telephone number of the water provider;
3. The compliance status of the water provider with federal and state environmental laws, as of the date of the application. If in noncompliance, provide an explanation;
4. The location of the water lines closest to the development;
5. The name of the person responsible for extending the water lines to the lot lines;
6. The estimated completion date for extending the water lines to the lot lines;
7. The estimated cost a lot purchaser will be required to pay for completion of the water lines to the purchaser's lot line;
8. The estimated cost a lot purchaser will pay for completion of water lines from the lot line to a dwelling;
9. Other costs or requirements before the lot purchaser receives water service, including the current service charges, hookup fees, turn-on fees, meter fees, and development fees;
10. The name of the person responsible for maintenance of the water lines within the development, other than from lot line to dwelling;
11. The name of the person who is or will be responsible for maintenance of the water lines outside the development;
12. If a private well will be used, a description of the requirements and costs involved to install an operational domestic water system;
13. If the source of water is a private well and domestic water cannot be obtained from a private well, whether the purchaser will be offered a refund of the purchase price and if so, an explanation of any condition or restriction involving the refund;
14. The name and location of the water provider if domestic water will be transported or hauled by the lot purchaser. A cost estimate computed on a monthly basis for a four-member family, including the cost of water, cistern, and other holding tanks, pumps, or any other costs necessary to install an operational water system;
15. A water adequacy report from ADWR if the development is a subdivision or part of a subdivision located outside of a groundwater active management area;
16. A water availability report from ADWR if the development is unsubdivided land. A copy of the report or a brief summary of the report, approved by the Department, shall be displayed in all promotional material and contracts for sale; and
17. If a water provider is a public service corporation, whether a Certificate of Convenience and Necessity from the Arizona Corporation Commission has been issued and, if not, an explanation of why a Certificate has not been issued.

**Historical Note**

Section R4-28-A1205 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).  
Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2).

**R4-28-A1206. Sewage Disposal**

The applicant shall include information about sewage disposal for the development, including:

1. Whether the sewage disposal will be provided by a municipality, improvement district, public utility, private company, or individual sewage disposal system;
2. The name, address, and telephone number of the sewage disposal company;
3. The compliance status of the sewage disposal provider with the ADEQ as of the date of the application. If in noncompliance, provide an explanation;
4. The name of the person responsible for extending the sewage disposal utility to the lot lines;
5. The estimated completion date for extending the utility to the lot lines;
6. The estimated cost the lot purchaser will be required to pay for completion of the utility to the purchaser's lot line;
7. If offering an unimproved lot, the estimated cost a lot purchaser will pay for completion of the utility from the lot line to the dwelling;
8. Upon completion of the utility, other costs or requirements that must be addressed before the lot purchaser receives service, including the service charge, hookup fees, tap-in fees, and development fees;
9. The name of the person responsible for maintenance of the sewage disposal utility within the development, other than from lot line to dwelling;
10. The name of the person who is or will be responsible for maintenance of the sewage disposal utility outside the development;
11. What cost, if any, will the lot purchaser pay toward maintenance of the sewage disposal utility;
12. If a sewage disposal provider is a for-profit public service corporation, whether a Certificate of Convenience and Necessity from the Arizona Corporation Commission has been issued, and if not, an explanation of why a Certificate has not been issued;
13. A description of the type of individual sewage disposal system the lot purchaser will be required to install in accordance with the standards and requirements of ADEQ or its designee;
14. A description of all requirements and costs involved to install an operational individual sewage disposal system, including any cost for governmental licensing and permitting, equipment, and other installation, maintenance, and operation costs;
15. If an operational individual sewage disposal system cannot be installed, will the lot purchaser be offered a refund of the purchase price, and if so, an explanation of any condition or restriction involving the refund; and
16. If a dry sewer system will be installed for future connection to a future provider, the name of the future provider, all requirements and costs for lot purchasers, and the estimated connection date.

**Historical Note**

Section R4-28-A1206 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1207. Streets and Access**

A. The applicant shall include a statement attesting that:

1. Exterior streets providing access are private; or federal, state, and county highways; or municipal streets;
2. The interior streets are public or private; and



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- a. If any streets are private, a description of what provisions have been made to assure purchasers of a legal right to use the private streets;
- b. Whether the streets are completed;
- c. The standards to which the streets will be or are constructed;
- d. If the streets are not completed, the person responsible for completion and the estimated completion date;
- e. The type of existing and proposed surfacing;
- f. The cost, if any, the lot purchaser will pay toward street completion;
- g. The name of the person responsible for exterior and interior street maintenance;
- h. Whether a city or county is responsible for maintaining the streets and the approximate date when streets will be accepted for maintenance; and
- i. The cost, if any, the lot purchaser will pay toward street maintenance.

**B.** The applicant shall demonstrate that there is permanent access to the land over terrain that may be traversed by conventional 2-wheel drive automobiles and emergency vehicles by providing any of the following information or documents necessary to make the demonstration:

1. A statement from a title insurance company, signed by an authorized title officer, affirming that legal access exists to the development and lots within the development. The statement shall:
  - a. Describe the legal access by listing all recorded instruments which establish legal access,
  - b. Be accompanied by a map on which legal access is shown with accurate references to the recorded instruments,
  - c. Be accompanied by a legible copy of each recorded instrument listed in the statement.
2. A statement bearing the seal and signature of a registered land surveyor or professional engineer, affirming that legal access to and within the development, as described in the title insurance company legal access statement, is over terrain that can be traversed by conventional 2-wheel drive automobiles and emergency vehicles. The statement shall affirm that:
  - a. The legal access corresponds with the actual physical access to the development and to the lots,
  - b. The legal access is permanent and describe how that permanence is assured.
3. The recorded subdivision map which shows approval by the applicable city or county officials.
4. Recorded easements or road dedications whether public or private. If private, the applicant shall ensure that development lot owners, emergency vehicles, and utility service providers have access rights.
5. Land, on which easements and roads are provided, is traversable by conventional 2-wheel drive automobiles and emergency vehicles.
6. Road maintenance programs that assure permanent access. Road maintenance programs include those administered by city or county governments, city or county improvement districts, or private property owner associations.
7. Recorded documentation that establishes legal and permanent access for development lot owners through federal or state lands.

**Historical Note**

Section R4-28-A1207 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1208. Flood Protection and Drainage Improvements**

The applicant shall include with the application the following information about flood protection and drainage improvement:

1. A description of any current or proposed improvement;
2. The name of the person responsible for completion of the improvement;
3. The estimated completion date of the improvement;
4. The cost, if any, the lot purchaser will pay for completion of the improvement;
5. The name of the person responsible for the continuing maintenance and expense of the improvement;
6. If a city or county is responsible for maintenance, the approximate date when the improvement will be accepted for maintenance; and
7. The cost, if any, the lot purchaser will pay toward completion and maintenance of the improvement.

**Historical Note**

Section R4-28-A1208 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1209. Common, Community, or Recreational Improvements**

The applicant shall provide with the application a list of all common, community, or recreational improvements, located within the development, and include the following information:

1. The name of the person responsible for completion of each improvement;
2. The estimated completion date of each improvement;
3. The estimated cost a lot purchaser will be required to pay for the completion of each improvement;
4. The name of the person responsible for the continuing maintenance and expense of each improvement; and
5. The cost, if any, the lot purchaser will be responsible for paying toward the maintenance of each improvement.

**Historical Note**

Section R4-28-A1209 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1210. Master Planned Community**

The applicant shall include the following information about a master planned community:

1. A list of all improvements located outside the development, but included in the development offering, including all common, community and recreational improvements;
2. The name of the person responsible for completing each improvement;
3. The estimated completion date of each improvement;
4. The name of the person responsible for the continuing maintenance and expense of each improvement; and
5. The cost, if any, the lot purchaser will pay toward the completion and maintenance of each improvement.

**Historical Note**

Section R4-28-A1210 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1211. Assurances for Completion and Maintenance of Improvements**

**A.** The applicant shall identify:

1. Whether arrangements have been made to assure the completion, delivery, and continued maintenance of the

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improvements listed in subsections R4-28-A1204 through R4-28-A1210; and

2. Whether the assurances to complete and deliver the improvements have been approved by the county or city, where applicable, and if so, submit a copy of the county or city approval;
- B.** An applicant shall provide one or more of the following assurances for completion:
1. A surety or completion bond from an insurance company licensed in Arizona with a rating of good or higher from a rating agency and a copy of the rating. The bond shall specify which improvements are included and shall:
    - a. Be stipulated by and payable to a third party who is not the developer;
    - b. Be accepted and signed by all parties;
    - c. Include an expiration date not less than 90 days beyond the last improvement estimated completion date;
    - d. State when and how the third party may draw on the funds;
    - e. Be in an amount 10% greater than the estimated amount to complete all improvements; and
    - f. Include a registered engineer's, architect's, or contractor's cost estimate to complete the improvements.
  2. An irrevocable letter of credit from a financial institution licensed to do business in Arizona. The irrevocable letter of credit shall specify which improvements are included and shall:
    - a. Be stipulated by and payable to a third party who is not the developer;
    - b. Be accepted and signed by all parties;
    - c. Include an expiration date not less than 90 days beyond the last improvement estimated completion date;
    - d. State when and how the third party may draw on the funds;
    - e. Be in an amount 10% greater than the estimated amount to complete all improvements;
    - f. Include a registered engineer's, architect's, or contractor's cost estimate to complete the improvements;
    - g. State that repayment is the responsibility of the developer and not of the third party; and
    - h. State that the irrevocable letter of credit is noncancelable.
  3. A loan commitment and agreement from a lender licensed in Arizona. The loan commitment and agreement shall specify which improvements are included and shall:
    - a. Be stipulated by and payable to a third party who is not the developer;
    - b. Be accepted and signed by all parties;
    - c. Include an expiration date not less than 90 days beyond the last improvement estimated completion date;
    - d. State when and how the third party may draw on the funds;
    - e. Be in an amount 10% greater than the estimated amount to complete all improvements;
    - f. Include a registered engineer's, architect's, or contractor's cost estimate to complete the improvements; and
    - g. State that repayment is the responsibility of the developer and not of the third party even if the third party draws on the funds.
  4. A trust or escrow account with a financial institution or escrow company licensed in Arizona. The trust or escrow account shall specify which improvements are included and shall:
    - a. Be stipulated by and payable to a third party who is not the developer;
    - b. Be accepted and signed by all parties;
    - c. Include an expiration date not less than 90 Days beyond the last improvement estimated completion date;
    - d. State when and how the third party may draw on the funds;
    - e. Be in an amount 10% greater than the estimated amount to complete all improvements;
    - f. Include a registered engineer's, architect's, or contractor's cost estimate to complete the improvements; and
    - g. Directly pay for the improvements completed or release funds to the developer upon written verification from a registered engineer that the improvements have been completed in accordance with the plan.
  5. City and county trust agreement. A municipal or county government may enter into an assurance agreement with a trustee to hold a lot conveyance until improvements are completed:
    - a. The trustee is an escrow company licensed in Arizona, and
    - b. The agreement is recorded.
  6. Written escrow agreement. A developer may enter into a written escrow agreement with a title insurance company or escrow company to escrow all funds and prohibit close of escrow until all improvements are complete. The agreement shall contain the following stipulations:
    - a. The funds are not released nor the purchaser's deed or other relevant documents recorded until the developer's architect or engineer certifies to the Department and the escrow agent that the project is complete, ready for occupancy, and in compliance with all city and county requirements;
    - b. If the completion date is not met:
      - i. The developer will give purchasers notice that completion dates were not met and an updated completion schedule,
      - ii. A purchaser may, within 30 days of receiving the notice specified in subsection (B)(6)(b)(i), cancel and receive a full refund by sending written notice to the escrow agent,
      - iii. The public report is invalid and all sales are suspended; and
      - iv. The Department considers the public report valid if improvements are completed at a later date and the public report is complete and accurate.
  7. Subdivision assurances. The municipal or county government shall prohibit occupancy and an subdivider shall not close escrow on lots sold in a subdivision until all proposed or promised subdivision improvements are complete.
    - a. The subdivider shall submit an agreement or copy of the ordinance from the city or county prohibiting

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occupancy until all proposed or promised subdivision improvements are complete.

- b. If improvements are completed in phases, the subdivider shall submit complete details of the phasing program, including approval of the phasing by the city or county and the completion schedule for the phases to the Department.
- c. The subdivider shall submit a written statement that no escrow will close on any lot until all subdivision improvements are complete. If a lot is within a phase of the subdivision where all improvements are complete and can be used and maintained separately from the improvements required for the entire subdivision the escrow may be closed.
- d. The subdivider shall submit a copy of the subdivider's purchase contract containing in large or bold print the condition that escrow will not close until the city or county issues its occupancy clearance and all subdivision improvements are complete.
- e. Any improvement offered or promised to a purchaser that is scheduled for completion in a later phase of completion shall have its completion assured by an alternative method of assurance listed in this Section.
- f. If the subdivider's sales include unimproved (vacant) lots, the subdivider shall deposit all earnest money into a neutral escrow depository until escrow closes.

8. Any other assurance satisfactory to the Department that is not listed in subsections (B)(1) through (B)(7).

- C. If the construction of any improvement is completed in phases, the applicant shall provide a description of the phased schedule of completion, including the lots in each phase and estimated completion dates.

**Historical Note**

Section R4-28-A1211 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).  
Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2).

**R4-28-A1212. Schools and Services**

- A. The applicant shall include the following information about schools:
  1. The location of and distance to the nearest public elementary, junior, and high schools and whether school bus or other transportation is available;
  2. The type and location of any other school located within a 1/2 mile radius of the exterior boundaries of the development.
- B. The applicant shall include the following information about services:
  1. Community shopping. The location and distance from the development of the nearest community shopping area where food, drink, and medical supplies may be purchased;
  2. Public transportation. The type, provider, location, and distance to the nearest access point to public transportation for the development;
  3. Medical facility. The type, provider, location, and distance to the nearest medical facility;
  4. Fire protection. Whether fire protection is available to the development, the name of the provider and the cost to the lot purchaser;

5. Ambulance service. Whether ambulance service is available to the development and whether the development is in a 911 service area. If 911 service is not available, the name, address, and telephone number of the ambulance service.
6. Police service. Whether police service is available to the development, and the name of the provider;
7. Refuse collection. Whether provisions have been made for refuse collection, the name of the service provider, and the cost to the lot purchaser. If no provisions have been made, what a buyer will do to dispose of refuse.

**Historical Note**

Section R4-28-A1212 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1213. Property Owners' Association**

The applicant shall provide the following information about a property owner's association:

1. The name of the association, if any;
2. The name of the master property owners' association, if any;
3. The amount of the association assessment that property owners will be required to pay, and how it will be paid;
4. Whether the association is legally formed and operational;
5. When and under what conditions control of the association will be released to lot purchasers;
6. When and under what conditions title to the common areas will be transferred to the association;
7. Whether the common areas are subject to any lien or encumbrance. If yes, explain how purchasers' use and enjoyment of common areas will be protected in the event of default;
8. Whether all lot owners will be required to be members of the association. If not, explain;
9. Whether nonmembers will be liable for payments to the association; and
10. A copy of the Articles of Incorporation and Bylaws in effect.

**Historical Note**

Section R4-28-A1213 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1214. Development Use**

The applicant shall provide the following information about development use:

1. Whether unimproved (vacant) lots or improved (with building) lots will be sold or leased;
2. The use for which development lots will be offered and an identification of the lots and their proposed use if more than one use is contemplated;
3. Whether the development or any lot is subject to adult occupancy or age restrictions;
  - a. If yes, explain the restriction;
  - b. If yes, explain whether this restriction is in compliance with the Federal Fair Housing Act.
4. Whether all or any portion of the development is located in an open range or area in which livestock may roam at large under the laws of this State and what provisions, if any, have been made for the fencing of the development to prevent livestock from roaming within the development and on a purchaser's lot. If land is located in an open range or area in which livestock may roam at large, the purchase contract shall contain:

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- a. Any provisions for the fencing of the development to prevent livestock from roaming within the development; and
- b. Any fencing requirements for the buyers to prevent livestock from roaming on their property.
5. Whether mineral rights are, or will be, reserved from the development lots and what the effect will be on lot owners if the minerals are extracted from the development; and
6. A full written disclosure of any condition or provision not specified in subsections (1) through (5) that may limit the use or occupancy of the property.

**Historical Note**

Section R4-28-A1214 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1215. Development Sales**

The applicant shall provide a description of the sales offering and:

1. A description of how sales or leases will be made and the manner by which title, right, or other interest is to be conveyed to the purchaser, including copies of sales and lease transaction documents;
2. Indicate whether cash sales are allowed and when the purchaser takes title;
3. Indicate where the purchaser's deposit and earnest monies will be deposited and held;
4. If the deposit monies are available for use by the seller, when and under what conditions the monies will be refunded;
5. Indicate when the lot purchaser will be permitted to use and occupy the lot;
6. An explanation if the purchaser will not receive title free and clear of all liens;
7. The estimated average sales price for the lots;
8. Indicate whether any of the property will be leased, and if so;
  - a. Provide a description of any provision for increase of rental payments during the term of the lease and any provisions in the lease prohibiting assignment or subletting, or both;
  - b. Indicate whether the lease prohibits the lessee from mortgaging or otherwise encumbering the leasehold; and
  - c. Indicate whether the lessee is permitted to remove an improvement when the lease expires.
9. The name, address, and telephone number of the Arizona broker who will be responsible for sales. If none, explain why;
10. The name and telephone number of the custodian of the development records and the physical location where the records will be kept;
11. Indicate whether the property has been or will be offered for sale before the date of the development application. If yes, explain; and
12. Indicate whether the sales documents contain all contract disclosures required by rule and statute.

**Historical Note**

Section R4-28-A1215 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-A1216. Title Reports and Encumbrances**

The applicant shall provide the following information concerning title reports and encumbrances:

1. Copies of any unrecorded liens or encumbrances against the property;
2. A title report showing:
  - a. An effective date not more than 30 days before Department receipt. The Department may request that the applicant update the title report so that it is not more than 30 days old when the public report is issued;
  - b. A legal description based upon a recorded map, condominium or timeshare declaration. Metes and bounds legal descriptions shall be used only for membership camping application title reports;
  - c. The applicant's interest in the property;
  - d. The name and telephone number of the person who prepared the title report;
  - e. A requirement page, if applicable; and
  - f. The following statement after the title exceptions: "There are no further matters of record affecting the land."
3. Legible copies of all recorded and unrecorded documents reflected by the title report, or known to applicant, such as restrictions, easements, liens, encumbrances, trust agreements, options, and maps.

**Historical Note**

Section R4-28-A1216 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1217. ADEQ Approval**

The applicant shall obtain subdivision approval from ADEQ or its designee.

**Historical Note**

Section R4-28-A1217 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1218. Property Registrations in Other Jurisdictions**

The applicant shall provide a list of the jurisdictions where a property registration was filed with or accepted by another department of real estate or similar regulatory agency.

**Historical Note**

Section R4-28-A1218 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1219. Condominium Developments**

The applicant shall provide the following information about condominium developments:

1. A copy of the recorded condominium declaration, map, and amendments in effect, and
2. An opinion letter from an attorney licensed to practice in Arizona, stating that the condominium plat and declaration of condominium are in compliance with the requirements of A.R.S. §§ 33-1215 and 33-1219.

**Historical Note**

Section R4-28-A1219 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1220. Foreign Developments**

A. Unless exempt pursuant to A.R.S. § 32-2181.02, an applicant shall ensure that any development located outside the state that is advertised, promoted, or sold within the state complies with

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all Arizona laws and rules as if the land was located in the state.

- B. Any law or rule that is specific to Arizona may be waived by the Department, or the Department may request and accept the domicile state or country's equivalent form of documentation.
- C. The applicant shall provide evidence that the domicile state or country has authorized the sale of lots and that the development is in compliance and good standing. If the domicile state or country issues a public report or equivalent, the application shall include the report.

**Historical Note**

Section R4-28-A1220 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1221. Expired****Historical Note**

Section R4-28-A1221 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).  
Section R4-28-A1221 expired under A.R.S. § 41-1056(J) at 30 A.A.R. 3144 (October 25, 2024), effective October 1, 2024 (Supp. 24-4).

**R4-28-A1222. Membership Camping Developments**

The applicant shall provide the following information about a membership camping development:

1. If the interest of the operator is evidenced by a lease, license, franchise, or a reciprocal agreement, a copy of the document and any amendments;
2. A description of any lakes or streams available for recreational use; and
3. A description of any exchange network and the responsibilities, obligations, and rights of the operator and purchaser, and copies of all exchange network documents.

**Historical Note**

Section R4-28-A1222 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-A1223. Affidavit**

The applicant shall sign an affidavit attesting that the information found in the application is true and correct.

**Historical Note**

Section R4-28-A1223 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**PART B. GENERAL INFORMATION****R4-28-B1201. Expired****Historical Note**

Section R4-28-B1201 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).  
Section R4-28-B1201 expired under A.R.S. § 41-1056(J) at 30 A.A.R. 3144 (October 25, 2024), effective October 1, 2024 (Supp. 24-4).

**R4-28-B1202. Conditional Sales Exemption**

- A. Any developer applying for a special order of exemption authorizing the offer for sale of a subdivision lot or unsubdivided land before issuance of a public report shall provide the following information to the Department:
  1. The completed and executed Petition for Conditional Sales Exemption;
  2. The completed and executed subdivision or unsubdivided land application for a public report;
  3. The purchase contract containing all required contract disclosures and the Conditional Sales Addendum;

4. A current title report showing the ownership interest of the developer and acceptable condition of title;
5. A copy of the recorded development map, or if not recorded, a copy of the unrecorded map;
6. A copy of the Condominium Declaration, if applicable;
7. A Certificate of Assured Water Supply, or a letter from the ADWR or other evidence that the property is located in an area designated as having an assured water supply, if the property is located in a groundwater active management area;
8. A water adequacy report from the ADWR or evidence that the property is located in an area designated as having an adequate water supply, if the property is located outside of a groundwater active management area; and
9. Any other information revealed necessary after preliminary review.

- B. The conditional sales exemption shall expire upon issuance or denial of the public report, or upon issuance of an order to summarily suspend sales, to cease and desist, or a voluntary suspension of sales by the developer or owner.

**Historical Note**

Section R4-28-B1202 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-B1203. Material Change; Public Report Amendments**

- A. The developer shall notify the Department of all material changes in the information required by A.R.S. Title 32, Chapter 20, Articles 4, 7, 9, and 10, or 4 A.A.C. 28, Article 12, Part A.
- B. According to material changes reported in subsection (A), the Department may require the developer to amend the public report.
- C. Completion Date Extension.
  1. A developer may apply to the Department for an amendment to a public report to extend the completion date of any improvement by providing an affidavit from the developer attesting that each purchaser, owner, and the city or county officials responsible for improvements were provided written notice of the completion status of the improvement, including a list of all people who were provided notice.
  2. The Department may deny the application to extend the completion date beyond the first extension if a purchaser, owner, or city or county official opposes issuance of an amended public report to extend a completion date.
  3. If an extension is denied, the developer shall provide the Department with a written agreement to suspend sales until the improvement is complete or the Department may issue a summary suspension order as provided in A.R.S. § 32-2157(B).
- D. To amend a public report, a developer shall submit payment of the applicable amendment fee and the following information:
  1. The name and registration number of the development;
  2. The name and signature of the developer;
  3. A list of the changes to the development and sales offering or in the information previously provided to the Department;
  4. Status of sales as prescribed in subsections (C) and (E); and
  5. A purchase contract addendum, to be signed and dated by both seller and purchaser, acknowledging that the sale is conditioned upon issuance of the amended public report

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and purchaser's receipt and acceptance of the amended public report.

**E. Suspension of sales.**

1. If necessary for the protection of purchasers, the Department may suspend approval to sell or lease pending amendment of the report.
2. In lieu of issuing a suspension order under A.R.S. § 32-2157, the Department may accept a developer's written agreement to suspend sales until the amended public report has been issued by the Department.

**F.** If the Department determines that a suspension of sales is not necessary for the protection of purchasers and approves the proposed disclosure of the change, sales may continue if the prospective purchaser is provided a copy of the current public report and disclosure of all changes before signing a contract. Completion of sales is conditioned upon the developer obtaining and delivering to each purchaser under contract the amended public report.**G.** Upon obtaining the amended report, the developer shall provide a copy to prospective purchasers in place of the earlier public report and obtain a receipt for the amended public report.**H.** If an application to amend a public report is denied, the Department shall notify the developer in writing of the statutory basis for the denial and of the developer's right to a fair hearing.**Historical Note**

Section R4-28-B1203 renumbered from R4-28-1203 and amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2).

**R4-28-B1204. Cemetery Notice; Amendments**

A change to information required pursuant to the provisions of Title 32, Chapter 20, Article 6, R4-28-301(A), or any other Section, requires amendment of the notice filed pursuant to A.R.S. 32-2194.01.

**Historical Note**

Section R4-28-B1204 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-B1205. Expired****Historical Note**

Section R4-28-B1205 renumbered from R4-28-1201 and amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Section R4-28-B1205 expired under A.R.S. § 41-1056(J) at 30 A.A.R. 3144 (October 25, 2024), effective October 1, 2024 (Supp. 24-4).

**R4-28-B1206. Filing with HUD**

If the subdivider requests that a subdivision public report be certified by the Department for filing with HUD, the subdivider shall comply with the terms, conditions, and requirements of the HUD certification agreement.

**Historical Note**

Section R4-28-B1206 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-B1207. Subsequent Owner****A.** Except as provided in A.R.S. § 32-2181.02, any developer who is a successor in interest to six or more lots within a subdivision on which the Department previously issued a public

report shall file an application for and obtain a new public report before offering or selling any lot.

**B.** Any developer who is a successor in interest to six or more parcels within an unsubdivided land development on which the Department previously issued a public report shall file an application for and obtain a new public report before offering or selling any parcel.**C.** Any developer who is a successor in interest to 12 or more time-share intervals within a time-share project on which the Department previously issued a public report shall file an application for and obtain a new public report, before offering or selling any interval.**D.** The Department shall not issue a new public report to a subsequent owner of a development if the previous developer failed to complete proposed improvements in accordance with estimated completion dates specified in the previously issued public report until one of the following occurs:

1. The subsequent owner makes financial arrangements, as described in R4-28-A1211, in favor of the local governmental authority and for the benefit of purchaser, securing the owner's promise to complete the previously proposed improvements by a designated date; or
2. The subsequent owner becomes obligated to place all sales funds in a neutral escrow depository until the Department is furnished satisfactory evidence that all proposed improvements have been completed or accepted by the city or county; or
3. Permission is obtained by all previous purchasers in the development for completion of the proposed improvements by the new designated date for completion; or
4. The subsequent owner establishes to the satisfaction of the Department that adequate financial arrangements have been made to assure completion of the proposed improvements by the new designated date for completion.

**E.** A developer who is a new owner of property that is the subject of a pending application for a public report shall not replace or be substituted for the applicant of the pending application.**Historical Note**

Section R4-28-B1207 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 1886, effective May 2, 2000 (Supp. 00-2).

**R4-28-B1208. Public Report Correction**

If the public report contains an error, the Department shall correct the report at its own expense. Additional or changed information that was known to the developer before issuance of the report is not an error. The Department shall not correct the public report after it has been in effect for 10 days. After 10 days, the developer shall change the report through the development amendment process, established in R4-28-B1203, with payment of the applicable amendment fee.

**Historical Note**

Section R4-28-B1208 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-B1209. Options; Blanket Encumbrances; Releases****A.** The Department shall not issue or amend a public report for any lot held under option or subject to a blanket encumbrance if a condition precedent to the optionee's right to acquire the lot or to release from the blanket encumbrance shows that the lot shall:

1. Be acquired or released in a particular sequence,

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2. Be acquired or released only after one or more additional lots have been acquired or released, or
  3. Not be released if the encumbrance is in default because of a cross-default provision contained in the encumbrance,
- B.** The developer may require payment of a premium to permit the acquisition or release of the lot.
- C.** When a blanket encumbrance clouds title to a development, the developer shall place a written statement from the holder of the blanket encumbrance in the public report application, quoting the provisions that enable a buyer to acquire title to a lot, free of the blanket encumbrance.

**Historical Note**

Section R4-28-B1209 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-B1210. Earnest Money**

The developer shall deposit earnest money and down payments in a neutral depository if:

1. The seller is in bankruptcy;
2. The sale is conditional pursuant to R4-28-B1202; or
3. The Department perceives a risk to the buyer.

**Historical Note**

Section R4-28-B1210 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-B1211. Recordkeeping**

If real property in a development is sold or leased by a developer without the services of a listing or selling broker, the developer shall keep all records as required by A.R.S. § 32-2151.01(A) and (C).

**Historical Note**

Section R4-28-B1211 adopted by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**ARTICLE 13. ADMINISTRATIVE PROCEDURES****R4-28-1301. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Former Section R4-28-33 renumbered without change as Section R4-28-1301 (Supp. 87-1). Section R4-28-1301 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1302. Service of Pleadings Subsequent to Complaint and Notice**

- A.** Service of pleadings subsequent to complaint and notice of hearing shall be made by personal service or by mail to the last known address of record of the party or the party's counsel. If service is made by mail, response time shall be increased by five days. Service by mail is complete upon mailing.
- B.** Any person filing a pleading or brief with the Department shall also file with the Attorney General.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-34 renumbered without change as Section R4-28-1302 (Supp. 87-1). Section R4-28-1302 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1303. Information Obtained in an Investigation**

- A.** The Department shall ensure that information and documents in open audits and investigations remain confidential. Officers

and employees of the Department shall not make confidential information or documents available to anyone other than the Attorney General or the Attorney General's representative, or authorized employees of the Department, unless the Commissioner authorizes disclosure of the information or production of documents as being in the public interest.

- B.** Upon request, the Department shall disclose the existence of and make available for review audit and investigative files that were closed within five years of the request for the information, subject to redaction of confidential or privileged information such as date of birth, social security number, bank and trust account numbers, home address and telephone number of active-status licensees, criminal history reports, attorney-client privileged communications, work product, and information regarding settlement negotiations.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-35 renumbered without change as Section R4-28-1303 (Supp. 87-1). Section R4-28-1303 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-1304. Response; Default**

- A.** A response shall specifically admit, deny, or state that the party does not have, or is unable to obtain, sufficient information to admit or deny each allegation in the complaint. A statement of a lack of information shall have the effect of a denial. Any allegation not denied is deemed to be admitted. When a party intends in good faith to deny only a part of an allegation, the party shall admit so much of it as is true and shall deny the remainder.
- B.** If the party fails to file a response or after being served notice, fails to appear at a hearing within the time provided by the statute under which the hearing is commenced, the Department may file an Affidavit of Default against the party, and proceed to take action against the party based upon the allegations of the charges. This action may be taken before the hearing date established in the Notice of Hearing. The party may file a motion to vacate the default and any action taken by the Commissioner within 15 days after receiving a copy of the default and the action or order by the Commissioner. For good cause, the Commissioner may vacate a default and any action taken and reschedule a hearing.
- C.** Every response filed pursuant to this Section shall be signed by the filing party or by at least one attorney, in the attorney's individual name, who represents the party, and shall be verified.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-36 renumbered without change as Section R4-28-1304 (Supp. 87-1). Amended subsection (D) effective November 27, 1987 (Supp. 87-4). Section R4-28-1304 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1305. Notice of Appearance of Counsel**

- A.** A party may participate in the party's own behalf or be represented by a member of the State Bar of Arizona.
- B.** Any person intending to appear at a contested case hearing or appealable agency action as counsel or representative of a party shall file a Notice of Appearance which shall advise the Department of the person's intent to appear on behalf of a

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party. The notice shall be filed with the Office of Administrative Hearings and served on all parties and shall contain:

1. The title of the case,
2. The name of the agency ordering the hearing,
3. The current address and telephone number of the person appearing, and
4. The name of the party for whom the person is appearing.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-37 renumbered without change as Section R4-28-1305 (Supp. 87-1). Amended subsections (B) and (C) effective November 27, 1987 (Supp. 87-4). Section R4-28-1305 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1306. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-38 renumbered without change as Section R4-28-1306 (Supp. 87-1). Amended subsections (A), (B), and (C) effective November 27, 1987 (Supp. 87-4). Section R4-28-1306 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1307. Expired****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended subsection (E) effective March 13, 1981 (Supp. 81-2). Former Section R4-28-39 renumbered without change as Section R4-28-1307 (Supp. 87-1). Amended effective November 27, 1987 (Supp. 87-4). Section R4-28-1307 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 1893, effective February 29, 2004 (Supp. 04-2).

**R4-28-1308. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Former Section R4-28-40 renumbered without change as Section R4-28-1308 (Supp. 87-1). Amended effective November 27, 1987 (Supp. 87-4). Section R4-28-1308 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1309. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended effective June 23, 1983 (Supp. 83-3). Former Section R4-28-41 renumbered without change as Section R4-28-1309 (Supp. 87-1). Amended effective November 27, 1987 (Supp. 87-4). Section R4-28-1309 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1310. Rehearing or Review of Decision; Response; Decision**

- A.** Unless otherwise provided by statute or rule, any party to a hearing before the Office of Administrative Hearings who is aggrieved by a decision rendered in a case may, pursuant to A.R.S. § 41-1092.09, file with the Commissioner a written motion for rehearing or review of the decision. The motion shall specify the particular grounds for rehearing or review.

The moving party shall serve copies upon all other parties. A motion for rehearing or review under this Section may be amended at any time before the Commissioner rules upon the motion.

- B.** A rehearing or review of the decision may be granted for any one of the following causes that materially affect the moving party's rights:
1. Irregularity in the proceedings or any order or abuse of discretion by the administrative law judge that deprived a party of a fair hearing;
  2. Misconduct by the Department, administrative law judge, or the prevailing party;
  3. Accident or surprise that could not have been prevented by ordinary prudence;
  4. Newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original hearing;
  5. Excessive or insufficient penalties;
  6. Error in the admission or rejection of evidence or other errors of law occurring during the proceeding;
  7. That the findings of fact or decision is arbitrary, capricious, or an abuse of discretion;
  8. That the findings of fact or decision is not supported by the evidence or is contrary to law.
- C.** Presenting specific grounds for rehearing or review, affidavits and relief sought.
1. Each party filing a motion for rehearing or review shall specify in the motion which of the grounds listed in subsection (B) the motion is based upon and shall set forth specific facts and law in support of the rehearing or review. The party may cite relevant portions of testimony by reference to pages or lines of the reporter's transcript of the hearing or to the date and time range of the Office of Administrative Hearings audio record, and may cite hearing exhibits by reference to the exhibit number.
  2. When a party files a motion for rehearing or review based upon an affidavit, the person shall attach the affidavit to the motion before filing the motion unless leave for later filing of an affidavit is granted by the Commissioner. The leave may be granted ex parte.
  3. Each party filing a motion for rehearing or review shall specify the specific relief sought by the motion, such as a different decision or penalty, a new hearing, a dismissal of the complaint, or other relief. A party may seek multiple forms of relief, in the alternative.
- D.** Any party may file a written response to the motion. An affidavit may be attached to and filed with the response and shall not be later filed unless leave for later filing of affidavits is granted by the Commissioner. The original response shall be filed with the Department pursuant to R4-28-102, within 15 days after the date the motion for rehearing or review is filed, and a copy shall be served upon all other parties to the hearing.
- E.** Within 30 days after a decision is rendered, the Commissioner may, on the Commissioner's own initiative, order a rehearing or review of a decision for any reason for which a motion for rehearing or review might have been granted. The Commissioner shall specify the grounds for rehearing or review in the order.
- F.** Upon review of a motion for rehearing or review of the decision, and any response, the Commissioner shall issue a ruling granting or denying the motion. If granted, the Commissioner may modify the decision or grant a rehearing. An order granting a rehearing shall specify with particularity the grounds on which the rehearing is granted, and the rehearing shall cover



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only those matters specified. All parties to the hearing may participate as parties at any rehearing.

**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended effective March 13, 1981 (Supp. 81-2). Amended effective June 23, 1983 (Supp. 83-3). Former Section R4-28-42 renumbered without change as Section R4-28-1310 (Supp. 87-1). Amended subsections (B), (C), and (D) effective November 27, 1987 (Supp. 87-4). Section R4-28-1310 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1). Amended by final rulemaking at 11 A.A.R. 506, effective March 5, 2005 (Supp. 05-1).

**R4-28-1311. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended effective June 23, 1983 (Supp. 83-3). Former Section R4-28-43 renumbered without change as Section R4-28-1311 (Supp. 87-1). Amended subsections (A), (B), and (C) effective November 27, 1987 (Supp. 87-4). Section R4-28-1311 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1312. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Amended subsection (B) effective March 13, 1981 (Supp. 81-2). Amended effective June 23, 1983 (Supp. 83-3). Former

Section R4-28-44 renumbered without change as Section R4-28-1312 (Supp. 87-1). Section R4-28-1312 repealed by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**R4-28-1313. Correction of Clerical Mistakes**

Clerical mistakes in opinions, orders, rulings, any process issued by the Department, or other parts of the record, and errors arising from oversight or omission, may be corrected by the administrative law judge before transmission of the Department hearing file to the Commissioner, or by the Commissioner after transmission of the file, either upon the initiative of the administrative law judge or Commissioner, or upon motion of any party.

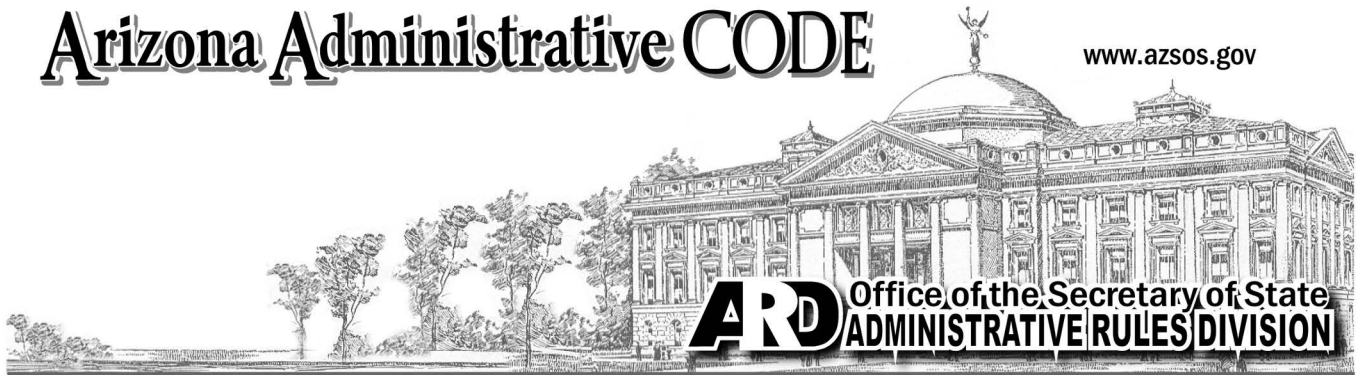
**Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-45 renumbered without change as Section R4-28-1313 (Supp. 87-1). Amended effective November 27, 1987 (Supp. 87-4). Section R4-28-1313 amended by final rulemaking at 5 A.A.R. 650, effective February 3, 1999 (Supp. 99-1).

**ARTICLE 14. REPEALED****R4-28-1401. Repealed****Historical Note**

Adopted effective May 1, 1980 (Supp. 80-3). Former Section R4-28-46 renumbered without change as Section R4-28-1401 (Supp. 87-1). Repealed effective November 27, 1987 (Supp. 87-4).

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### CHAPTER 46. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - FINANCIAL INSTITUTIONS DIVISION - REAL ESTATE APPRAISAL

The table of contents on page one contains links to the referenced page numbers in this Chapter.  
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

<a href="#">R4-46-201.01. Application for Designation as a Supervisory Appraiser; Supervision of a Registered Trainee Appraiser .....</a>	<a href="#">5</a>	<a href="#">R4-46-403. Change in Controlling Person or Agent for Service of Process; Notice of Adverse Action .....</a>	<a href="#">10</a>
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**The release of this Chapter in Supp. 24-4 replaces Supp. 22-4, 1-15 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 4. PROFESSIONS AND OCCUPATIONS

## CHAPTER 46. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - FINANCIAL INSTITUTIONS DIVISION - REAL ESTATE APPRAISAL

Authority: A.R.S. § 32-3605(A) and A.R.S. § 20-124

## Supp. 24-4

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*Under Laws 2019, Ch. 252, the name of the Department of Financial Institutions changed to the Department of Insurance and Financial Institutions. The Title of 4 A.A.C. 46 was amended at the request of the Department (Supp. 22-2).*

*Pursuant to Laws 2015, Ch. 19, § 5(C), the Title of 4 A.A.C. 46 was amended from the State Board of Appraisal to Real Estate Appraisal Division (Supp. 15-3).*

*Title 4, Chapter 46, consisting of Article 1, Sections R4-46-101 through R4-46-105; Article 2, Sections R4-46-201 through R4-46-208; Article 3, Sections R4-46-301 through R4-46-306; Article 4, Section R4-46-401; Article 5, Sections R4-46-501 through R4-46-503; and Article 6, Section R4-46-601, adopted effective December 29, 1995 (Supp. 95-4).*

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**ARTICLE 1. GENERAL PROVISIONS****R4-46-101. Definitions**

The definitions in A.R.S. §§ 32-3601, 32-3651, and 32-3661 apply to this Chapter. Additionally, unless the context otherwise requires, in this Chapter:

“Accredited” means approved by an accrediting agency recognized by the Council for Higher Education Accreditation or the U.S. Secretary of Education.

“Administrative law judge” has the meaning stated at A.R.S. § 41-1092(1).

“AMC” means appraisal management company as defined at A.R.S. § 32-3661.

“Appealable agency action” has the meaning stated at A.R.S. § 41-1092(3).

“Appraisal practice” means valuation services performed by an individual acting as an appraiser, including but not limited to an appraisal or appraisal review.

“Appraiser” means an individual, other than a property tax agent as defined at A.R.S. § 32-3651, registered, licensed, or certified by the Department to complete valuation assignments regarding real estate competently in a manner that is independent, impartial, and objective.

“AQB” means the Appraisal Qualifications Board as defined at A.R.S. § 32-3601.

“Assignment” means the valuation service that an appraiser provides as a consequence of an agreement between the appraiser and a client.

“Classroom education” means appraisal education delivered in a setting where there is no geographical separation between the instructor and student.

“Complaint” means a written allegation against a party.

“Conditional dismissal” means an agreement which allows the Director to dismiss the complaint upon the respondent’s completion of a Department specified continuing education course.

“Contested case” has the meaning stated at A.R.S. § 41-1001(6).

“Conviction” means a judgment by any state or federal court of competent jurisdiction in a criminal case, regardless of whether an appeal is pending or could be taken, and includes any judgment or order based on a plea of no contest.

“Course owner” means a person or a combination of persons that own the proprietary rights to a course. A course owner may have developed the course or may have purchased the proprietary rights to the course.

“Department” has the meaning stated at A.R.S. § 6-101(5).

“Director” has the meaning stated at A.R.S. § 6-101(7).

“Disciplinary action” means any regulatory sanction imposed by the Director, other than remedial action imposed through a letter of remedial action, and may include corrective education, a civil money penalty, restriction on the nature and scope of the respondent’s practice, monitoring, probation, mentorship, suspension, revocation, or an acceptance of surrender of a license or certificate or a combination of the above.

“Distance education” means appraisal education delivered in a setting in which the learner and instructor are geographically separated.

“Federally Regulated Appraisal Management Company” has the meaning stated at A.R.S. § 32-3661(9).

“Investigation” means a fact-finding process and review that is initiated when the Department receives a complaint.

“Investigator” means an individual who is a Department employee or operates under a contract with the Department to carry out investigations of alleged violations.

“Jurisdictional criteria” means the statutory standards of A.R.S. §§ 6-123, 6-124, and A.R.S. Title 32, Chapter 36, used by the Department to determine whether a complaint falls within its jurisdiction.

“Letter of concern” means a non-disciplinary advisory letter to notify a respondent that the finding of the Director does not warrant disciplinary action, but is nonetheless cause for concern and that its continuation may result in disciplinary action.

“Letter of remedial action” means a non-disciplinary letter that requires a respondent to take remedial action when any minor violation of A.R.S. Title 32, Chapter 36 or this Chapter is found.

“Mentor” means a certified appraiser authorized by the Department to supervise the work product of an appraiser who is subject to disciplinary action by the Director.

“Party” means each person or agency named or admitted as a party or properly seeking and entitled to participate in any proceeding.

“Person” means a natural person or any legal or commercial entity including a corporation, business trust, estate, trust, partnership, limited partnership, joint venture, association, limited liability company, limited liability partnership, or limited liability limited partnership.

“Probation” means a term of oversight by the Department, imposed upon a respondent as part of a disciplinary action, which may include submission of logs, working under the supervision of a mentor, or other conditions intended to protect the public and educate the respondent.

“Property Tax Agent” has the meaning stated at A.R.S. § 32-3651(3).

“Remedial action” means any corrective remedy that is designed to assist the respondent in improving the respondent’s professional practice.

“Respondent” means an appraiser, course owner, property tax agent, or appraisal management company against whom a complaint has been filed or any other party responding to an investigation, an action, a motion or a proceeding before the Director.

“Secondary provider” means a person that purchases or otherwise lawfully acquires the right to provide a course independently of the course owner that retains proprietary rights to the course.

“USPAP” means the Uniform Standards of Professional Appraisal Practice, issued and updated by The Appraisal Foundation and made state law under A.R.S. § 32-3610.

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“Work file” means the documentation necessary to support the analysis, opinions, and conclusions of an appraisal assignment or tax appeal.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Amended by final rulemaking at 11 A.A.R. 2018, effective July 2, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 14 A.A.R. 1434, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-102. Powers of Director**

- A. The Director may appoint advisory committees the Director deems appropriate. The committees shall make advisory recommendations which may be accepted, rejected, or modified at the Director’s discretion.
- B. Under the authority provided by A.R.S. § 32-3605(B), the Director may designate, train, and supervise volunteer licensees to conduct compliance audits of approved courses under R4-46-508.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-103. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-104. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Section repealed by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2).

**R4-46-105. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Section repealed by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2).

**R4-46-106. Fees**

- A. Under the specific authority provided by A.R.S. §§ 32-3607, 32-3619, and 32-3667, the Director establishes and shall collect the following fees:
  - 1. Application for original license or certificate: \$400.
  - 2. Application for registration as a trainee appraiser: \$300.
  - 3. Examination: The amount established by the AQB-approved examination provider.
  - 4. Biennial renewal of a license or certificate: \$425.
  - 5. Renewal of registration as a trainee appraiser: \$300.
  - 6. Delinquent renewal (in addition to the renewal fee): \$25.
  - 7. National Registry: The amount established by the Appraisal Subcommittee.
  - 8. Application for license or certificate by reciprocity: \$400.
  - 9. Application for non-resident temporary license or certificate: \$150.
  - 10. Course approval:
    - a. Core-curriculum qualifying education
      - i. Initial course approval: \$200.
      - ii. Renewal of course approval: \$200.
    - b. Continuing education
      - i. Initial course approval: \$200.
      - ii. Renewal of course approval: \$200.
  - 11. Application for initial registration as an appraisal management company: \$2,500.
  - 12. Biennial renewal of registration as an appraisal management company: \$2,500.
- B. The fees established in subsection (A) and those specified in A.R.S. § 32-3652 are not refundable unless the provisions of A.R.S. § 41-1077 apply.
- C. A person shall pay fees by cash or credit or debit card, or by certified or cashier’s check, or money order payable to the Department of Insurance and Financial Institutions.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 14 A.A.R. 225, effective March 8, 2008 (Supp. 08-1). Amended by final rulemaking at 17 A.A.R. 2605, effective December 6, 2011 (Supp. 11-4). Amended by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Amended by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-107. Procedures for Processing Applications**

- A. To comply with A.R.S. Title 41, Chapter 6, Article 7.1, the following time-frames are established for processing applications for registration, licensure, certification, and designation, including renewal applications, and applications for course approval:
  - 1. The Department shall notify the applicant within 60 days after receipt of the application that it is either administratively complete or incomplete. If the application is incomplete, the Department shall specify in the notice what information is missing.
  - 2. A final decision shall be rendered not later than 60 days after the applicant successfully completes all requirements in statute or this Chapter.
  - 3. The overall time-frame for action is 120 days, 60 days for administrative completeness review and 60 days for substantive review.



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- B.** An applicant whose application is incomplete shall supply the missing information within 60 days after the date of the notice unless the time-frame is extended by mutual agreement. The administrative completeness review time-frame stops running on the date of the Department's written notice of an incomplete application and resumes when the Department receives a complete application. If the applicant fails to submit a complete application within the specified time limit, the Department may reject the application and close the file. An applicant may reapply.
- C.** If the Director denies registration, licensure, certification, designation, or course approval to an applicant, the Department shall send the applicant written notice explaining:
1. The reason for denial, with citations to supporting statutes or rules,
  2. The applicant's right to seek a hearing to appeal the denial, and
  3. The time for appealing the denial.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**ARTICLE 2. REGISTRATION, LICENSURE, AND CERTIFICATION AS AN APPRAISER****R4-46-201. Appraiser Qualification Criteria**

- A.** Classifications. As specified in A.R.S. § 32-3612, Arizona recognizes five classifications of appraisers. These classifications are:
1. Registered trainee appraiser,
  2. State licensed real estate appraiser,
  3. State certified residential real estate appraiser,
  4. State certified general real estate appraiser, and
  5. Designated supervisory appraiser.
- B.** Qualification criteria. Except as provided elsewhere in this Article, an applicant for an original or renewal of a registration, licensure, certification, or designation shall meet the classification-specific qualification criteria established and updated January 1, 2022, by the AQB, which is incorporated by reference. A copy of the incorporated materials is on file with the Department and may be obtained from the Department or the Appraisal Foundation. This rule does not incorporate any later date or edition of this material.
- C.** Regardless of whether a transaction is federally related:
1. A state licensed residential appraiser is limited to the scope of practice in A.R.S. § 32-3612(3), and
  2. A state certified residential appraiser is limited to the scope of practice in A.R.S. § 32-3612(2).
- D.** If an applicant for registration, licensure, or certification meets the qualification criteria prescribed in A.R.S. Title 32, Chapter 36 and this Article, including evidence that the applicant has applied for a valid fingerprint clearance card pursuant to A.R.S. § 32-3620(B) and has submitted the application and the biennial National Registry fees specified in Section R4-46-106, the registration, license, or certificate that entitles the applicant to practice within the appropriate scope specified in A.R.S. § 32-3612 for the term specified in A.R.S. § 32-3616 shall be issued.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4).

Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007; subsections (D)(2)(f) and (D)(4) effective January 1, 2008 (Supp. 07-2). Amended by final rulemaking at 14 A.A.R. 1434, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-201.01. Application for Designation as a Supervisory Appraiser; Supervision of a Registered Trainee Appraiser**

- A.** An individual who wishes to act as a supervisory appraiser for a registered trainee appraiser shall:
1. Apply for and obtain designation as a supervisory appraiser before providing supervision to a registered trainee appraiser,
  2. Have been state certified for at least three years, and
  3. Apply for designation under A.R.S. § 32-3614.02.
- B.** To apply for designation as a supervisory appraiser, a certified appraiser shall submit to the Department:
1. An application for designation;
  2. A statement whether the applicant for designation has been disciplined in any jurisdiction in the last three years in a manner that affects the applicant's eligibility to engage in appraisal practice and if so, the name of the jurisdiction, date of the discipline, circumstances leading to the discipline, and date when the discipline was completed;
  3. Evidence that the applicant for designation completed a training course that complies with the course content established by the AQB and that is specifically oriented to the requirements and responsibilities of supervisory and trainee appraisers;
  4. A signed affirmation that the applicant for designation will comply with the USPAP Competency Rule for the property type and geographic location in which the supervision will be provided; and
  5. Any other information and documentation that is necessary to meet the qualification criteria established and updated by the AQB.
- C.** Supervision requirements:
1. A registered trainee appraiser may have more than one designated supervisory appraiser.
  2. A designated supervisory appraiser shall not supervise more than three registered trainee appraisers at any one time.
  3. A registered trainee appraiser shall maintain a separate appraisal log for each designated supervisory appraiser and, at a minimum, include the following in each log for each appraisal:
    - a. Type of property,
    - b. Date of report,
    - c. Address of appraised property,
    - d. Description of work performed by the registered trainee appraiser,
    - e. Scope of review and supervision provided by the designated supervisory appraiser,
    - f. Number of actual work hours worked by the registered trainee appraiser on the assignment, and

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- g. Signature and state certificate number of the designated supervisory appraiser.
- 4. A designated supervisory appraiser shall provide to the Department in writing the name and address of each registered trainee appraiser within 10 days of engagement and notify the Department in writing within 10 days when the engagement ends.
- 5. If a registered trainee appraiser or designated supervisory appraiser fails to comply with the applicable requirements of this Section:
  - a. The registered trainee appraiser or the designated supervisory appraiser may be subject to disciplinary action under A.R.S. § 32-3631(A)(8), and
  - b. The Director may decline the experience credit hours logged during any period that the registered trainee appraiser or designated supervisory appraiser failed to comply with this Section. The registered trainee appraiser and designated supervisory appraiser shall provide documentation and justification of the non-compliance for review by the Director.

**Historical Note**

Section R4-46-201.01 made by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Amended by final rulemaking at 30 A.A.R. 3515 (November 22, 2024), effective January 5, 2025 (Supp. 24-4).

**R4-46-202. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 768, effective February 3, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-202.01. Application for Licensure or Certification by Reciprocity**

- A. To be eligible to obtain a license or certificate by reciprocity in the same classification, as specified in R4-46-201(A), in which an individual is currently licensed or certified, the individual shall submit:
  - 1. Evidence that the applicant is licensed or certified in a state that meets the standards established at A.R.S. § 32-3618;
  - 2. A completed application form;
  - 3. Disclosure of the state or states in which the individual is currently licensed or certified;
  - 4. Evidence that the individual has applied for a valid fingerprint clearance card pursuant to A.R.S. § 32-3620(B); and
  - 5. The application and biennial National Registry fees specified under R4-46-106.
- B. The Department shall verify the following information:
  - 1. License or certification number;

- 2. Classification, as specified in R4-46-201(A), in which the individual is currently licensed or certified; and
- 3. Whether the license or certificate is in good standing.

**Historical Note**

Section R4-46-202.01 made by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-203. Application for Non-resident Temporary Licensure or Certification**

- A. To be eligible to obtain a non-resident temporary license or certificate, an individual shall:
  - 1. Be licensed or certified as an appraiser in a state other than Arizona;
  - 2. Not be licensed or certified as an appraiser in Arizona; and
  - 3. Have a dated and signed letter from a client that names the individual and indicates the client has engaged the individual to conduct an appraisal in Arizona, identifies the property or properties to be appraised, and specifies a date certain for completion of the assignment that is no more than one year from the date on which the Director issues a non-resident temporary license or certificate.
- B. To apply for a non-resident temporary license or certificate, an individual who meets the pre-requisites in subsection (A) shall submit:
  - 1. A completed application form;
  - 2. An irrevocable consent to service of process;
  - 3. Evidence that the applicant has applied for a valid fingerprint clearance card pursuant to A.R.S. § 32-3620(B); and
  - 4. The application fee specified under Section R4-46-106.
- C. The Director shall grant an extension of no more than 120 days to an individual to whom a non-resident temporary license or certificate has been issued if the individual provides written notice before the date specified in subsection (A)(3) that more time is needed to complete the assignment described in subsection (A)(3).
- D. An appraiser to whom a non-resident temporary license or certificate has previously been issued may, if qualified under subsection (A), apply for another non-resident temporary license or certificate by complying with subsection (B), except the applicant is not required to comply again with subsection (B)(3) unless the card has expired, or is suspended or cancelled.
- E. The Director shall issue no more than 10 non-resident temporary licenses or certificates to an individual in any 12-month period.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Section R4-46-203 renumbered to R4-46-204; new Section R4-46-203 adopted effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

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**R4-46-204. Licensure and Certification Examinations**

An applicant for licensure or certification may schedule an examination after the Department provides written notice to the applicant, to the extent written notice is required by the AQB. In such case, an applicant shall have 90 days from the written notice to successfully complete the AQB-approved examination for the classification for which application is made unless the time-frame is extended by mutual agreement.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Former Section R4-46-204 renumbered to R4-46-205; new Section R4-46-204 renumbered from R4-46-203 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-205. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-205 renumbered to R4-46-206; new Section R4-46-205 renumbered from R4-46-204 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-206. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-206 renumbered to R4-46-207; new Section R4-46-206 renumbered from R4-46-205 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Repealed by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4).

**R4-46-207. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-207 renumbered to R4-46-209; new Section R4-46-207 renumbered from R4-46-206 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-208. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-208 renumbered to R4-46-210; new Section R4-46-208 adopted effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 1880, effective May 3, 2005 (Supp. 05-2). Section repealed by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2).

**R4-46-209. Registration, License, or Certificate; Name Change; Conviction and Judgment Disclosure**

- A. If the name of an appraiser is legally changed, the appraiser shall submit written notice of the change to the Department and provide documentation showing the circumstances under which the name change occurred. A new registration, license, or certificate with the correct name shall be issued.
- B. Within 30 days after the filing date of a criminal conviction in any jurisdiction, an appraiser or property tax agent who has been convicted shall report the conviction to the Department. The report shall include a copy of the initial indictment, information or complaint filed, the final judgment entered by the court, and all other relevant legal documents.
- C. Within 30 days after the final disposition of a matter, an appraiser or property tax agent shall report to the Department any civil judgment based on fraud, misrepresentation, or deceit in the making of any appraisal entered against the appraiser or property tax agent.

**Historical Note**

R4-46-209 renumbered from R4-46-207 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-210. Repealed****Historical Note**

R4-46-210 renumbered from R4-46-208 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Section repealed by final rulemaking at 13 A.A.R. 1381, effective June 2, 2007 (Supp. 07-2).

**ARTICLE 3. COMPLAINT INVESTIGATIONS****R4-46-301. Complaints and Investigations; Complaint Resolution**

- A. Complaints and Investigations
  1. The Department shall investigate a complaint, if the complaint meets the minimum jurisdictional criteria.
  2. The Department may notify the respondent of a complaint.
  3. The Department may require that the respondent file a written response to the complaint and provide any one or more of the following:
    - a. Appraisal report,
    - b. Appraisal review,
    - c. Consulting assignment,
    - d. Property tax appeal at issue,

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- e. Work file, and
- f. Any other relevant records.
- 4. The Department may assign or contract with an investigator.
- 5. Under A.R.S. §§ 6-123(3), 6-124, 12-2212, and 32-3631(C), the Director may compel testimony or document production, regardless of whether an investigation is in process.

**B. Complaint Resolution**

- 1. Without limiting any other remedy allowed by statute, if the Director finds a violation of A.R.S. Title 32, Chapter 36, or this Chapter, the Director may:
  - a. Dismiss the matter based upon mitigating factors;
  - b. Issue a letter of concern;
  - c. Issue an order, which may include disciplinary action and/or remedial action; or
  - d. Resolve the matter by settlement.
- 2. Any time after a complaint has been filed against a respondent, the matter may be resolved by a settlement in which the respondent agrees to accept disciplinary action and/or remedial action by consent. If the Director determines that the proposed settlement will adequately protect the public, the Director may issue a letter of remedial action, or enter into another form of stipulation, agreed settlement, or consent with the respondent. The Director may also allow for a conditional dismissal.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 2018, effective July 2, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-302. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-302 repealed; new Section R4-46-302 renumbered from R4-46-303 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 2018, effective July 2, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-303. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-303 renumbered to R4-46-302; new Section R4-46-303 renumbered from R4-46-304 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 2018, effective July 2, 2005 (Supp. 05-2). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-304. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-304 renumbered to R4-46-303; new Section R4-46-304 renumbered from R4-46-305 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-305. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-305 repealed; new Section R4-46-305 renumbered from R4-46-306 and amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-306. Repealed****Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-306 renumbered to R4-46-305 effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 2018, effective July 2, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2). Repealed by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**ARTICLE 3.1. REPEALED****R4-46-301.01. Repealed****Historical Note**

New Section made by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Repealed by final rulemaking at 28 A.A.R. 3617 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R4-46-302.01. Repealed****Historical Note**

New Section made by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Repealed by final rulemaking at 28 A.A.R. 3617 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R4-46-303.01. Repealed****Historical Note**

New Section made by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Repealed by final rulemaking at 28 A.A.R. 3617 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R4-46-304.01. Repealed****Historical Note**

New Section made by final rulemaking at 25 A.A.R.

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1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Repealed by final rulemaking at 28 A.A.R. 3617 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R4-46-305.01. Repealed****Historical Note**

New Section made by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Repealed by final rulemaking at 28 A.A.R. 3617 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R4-46-306.01. Repealed****Historical Note**

New Section made by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Repealed by final rulemaking at 28 A.A.R. 3617 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R4-46-307.01. Repealed****Historical Note**

New Section made by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Repealed by final rulemaking at 28 A.A.R. 3617 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**ARTICLE 4. APPRAISAL MANAGEMENT COMPANIES****R4-46-401. Application for Initial Registration**

- A. Unless exempt under A.R.S. § 32-3663 or 12 USC § 3353(c), a person shall not engage in business as an AMC and shall not provide any appraisal management services unless registered with the Department.
- B. To register under subsection (A), a person shall submit:
  1. A registration application, which is available from the Department and on its website, and provide the information and certifications required under A.R.S. § 32-3662(B);
  2. The name and contact information of the controlling person who will be the main contact for all communication between the Department and the AMC;
  3. For the controlling person, each officer, and each individual who owns 10% or more of the AMC:
    - a. A copy of a fingerprint clearance card application under A.R.S. § 41-1758.03, and
    - b. The certification required under A.R.S. §§ 32-3668(B)(3) or 32-3669(B)(1), as applicable;
  4. Proof of the surety bond required under A.R.S. § 32-3667 and R4-46-402; and
  5. The application fee specified under R4-46-106.
- C. If an AMC operates in Arizona under more than one name, other than a DBA, the controlling person of the AMC shall ensure that a complete application, as described in subsection (B), is submitted in each name under which the AMC will operate. However, if an individual previously submitted a copy of a valid fingerprint clearance card application under subsection (B), the individual is not required to resubmit the finger-

print clearance card unless the card has expired, or is suspended, or cancelled.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). R4-46-401 amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 5 A.A.R. 2734, effective July 21, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 1577, effective April 4, 2000 (Supp. 00-2). Amended by final rulemaking at 7 A.A.R. 1373, effective March 7, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 1951, effective April 3, 2002 (Supp. 02-2). Amended by final rulemaking at 9 A.A.R. 1603, effective May 6, 2003 (Supp. 03-2). Amended by final rulemaking at 10 A.A.R. 2677, effective June 8, 2004 (Supp. 04-2). Amended by final rulemaking at 11 A.A.R. 475, effective January 4, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 2186, effective July 1, 2006 (Supp. 06-2). Amended by final rulemaking at 14 A.A.R. 31, effective December 4, 2007 (Supp. 07-4). Amended by final rulemaking at 16 A.A.R. 1992, effective September 14, 2010 (Supp. 10-3). Section amended by emergency rulemaking at 18 A.A.R. 1306, effective May 18, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 13-4). Section repealed; new Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-402. Bond Required**

- A. The surety bond required under A.R.S. § 32-3667 shall be in the amount of \$20,000 and shall be issued by a surety company authorized to do business in Arizona.
- B. The controlling person of a registered AMC shall ensure that the surety bond required under A.R.S. § 32-3667 requires the issuing surety company to provide written notice to the Department by registered or certified mail at least 30 days before the surety company cancels the bond and within 30 days after the surety company pays a loss under the bond.
- C. The surety bond required under A.R.S. § 32-3667 is to be used exclusively to ensure that a registered AMC pays:
  1. All amounts owed to persons that perform real estate appraisal services for the AMC, and
  2. All amounts adjudged against the AMC as a result of either negligent or improper real property appraisal services or appraisal management services or of a breach of contract in performing real property appraisal services or appraisal management services.
- D. The controlling person of a registered AMC shall ensure that the required surety bond is:
  1. Maintained in the amount of \$20,000;
  2. Funded to \$20,000 within seven days after being drawn down; and
  3. Maintained for at least one year after the AMC's registration expires, is revoked or surrendered, or otherwise ends.
- E. If the Department receives notice from the surety company of intent to cancel the required bond, the Department shall notify the controlling person of the AMC and require that the controlling person submit proof of a replacement bond before the existing bond is cancelled. Under A.R.S. § 32-3678, failure to maintain the required bond is grounds for disciplinary action.

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- F. If a registered AMC operates in Arizona under more than one name, other than a DBA, the controlling person shall ensure that a separate surety bond in the amount of \$20,000 is maintained in each name.
- G. If the name of a registered AMC is changed, the controlling person of the registered AMC shall ensure that a surety bond in the amount of \$20,000 is:
1. Maintained in the former name for one year after the name is changed, and
  2. Obtained in the registered AMC's new name.
- H. A person damaged by a registered AMC's failure to pay an obligation listed in subsection (C) has a right of action against the surety bond. The damaged person shall begin the action in a court of competent jurisdiction within one year after the AMC failed to pay the amount owed or the amount adjudged against the AMC.
- I. If the surety bond required under A.R.S. § 32-3667 is cancelled, liability of the issuing surety company is not limited or cancelled regarding any claim against the surety bond for actions by the AMC while the surety bond was in force.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-403. Change in Controlling Person or Agent for Service of Process; Notice of Adverse Action**

- A. If any of the information submitted under R4-46-401(B)(2) changes, the controlling person of the registered AMC shall provide to the Department written notice of the change within 10 business days.
- B. If an individual becomes the controlling person of a registered AMC and the information required under R4-46-401(B)(3) was not previously submitted for the individual, the new controlling person shall ensure that the required information is submitted to the Department within 10 business days after the change in controlling person.
- C. If a registered AMC is required under A.R.S. § 32-3662(B)(4) to provide the name and contact information for an agent for service of process in this state, the controlling person of the AMC shall provide the Department written notice of any change in the information within 10 business days.
- D. If the regulated entity, the responsible person, any controlling person, or any direct or indirect owner of the firm has ever been, or is currently, the subject of any complaint, investigation, or disciplinary action against a license, certificate, registration, or membership by any state regulatory agency, or any professional or occupational credentialing authority that resulted in an adverse judgment against them, including any denial, or voluntary surrender, withdrawal, or resignation of a credential in lieu of disciplinary action, the controlling person of the AMC shall provide the Department with written notice of such action within 10 business days after such action has been finalized.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Amended by final rulemaking at 30 A.A.R.

3515 (November 22, 2024), effective January 5, 2025 (Supp. 24-4).

**R4-46-404. Application for Renewal Registration**

- A. Under A.R.S. § 32-3665, an initial registration for an AMC expires one year after the date of issuance. A renewal registration for an AMC expires two years after the date of issuance.
- B. To renew registration for an AMC, the controlling person of the registered AMC shall, within 60 days before expiration, submit:
1. A renewal registration application,
  2. The certifications required under A.R.S. § 32-3662(B),
  3. Proof of the surety bond required under A.R.S. § 32-3667 and R4-46-402,
  4. The renewal fee under R4-46-106,
  5. Evidence that each person who has at least a 10% ownership interest in the AMC and the controlling person have applied for a valid fingerprint clearance card unless a valid fingerprint clearance card is currently on file with the Department, and
  6. Disclose any changes to the percentage of ownership.
- C. If the controlling person of a registered AMC fails to comply with subsection (B) and the registration expires, the controlling person shall ensure that the AMC immediately ceases providing all appraisal management services. The Department may accept a renewal application after the expiration date if within 90 days of the date of expiration but shall assess a delinquent renewal fee in addition to the renewal fee.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-405. Certifications; National Registry Reporting**

- A. Under A.R.S. § 32-3672, the controlling person of a registered AMC is required to make certain certifications to the Department at the time the AMC's registration is renewed.
- B. To make the certifications required under A.R.S. § 32-3672, the controlling person of a registered AMC shall use a form that is available from the Department and on its website.
- C. The controlling person of a registered AMC shall make available to the Department, upon request, evidence that the certifications are true and that the systems, processes, and records certified are effective in protecting the public.
- D. In accordance with the provisions contained in 12 U.S.C. § 3338, each authorized representative or controlling person of an AMC that is either registered with the state or federally regulated and operating in Arizona shall annually submit an AMC National Registry Report to the Department at least 15 days prior to March 1st of each year for the period from January 1 to December 31 of the previous year. The AMC National Registry Report shall include:
1. Identifying information for the AMC;
  2. The number of appraisers who have performed an appraisal for the AMC in connection with a covered transaction in the state during the previous year, or from the commencement of business for AMCs not in existence for the entire previous year; and
  3. A signed affirmation by written declaration.
- E. The AMC shall pay, at the time it submits the National Registry Report to the Department, the fee required under 12 U.S.C. § 3338(a)(4).

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- F. A registered AMC or federally regulated AMC operating in Arizona who fails to timely submit a National Registry Report to the Department and to remit the AMC National Registry fee shall not appear on the AMC National Registry.
- G. Under A.R.S. § 32-3678, failure to comply with this Section is grounds for disciplinary action.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-406. Appeal for Waiver**

- A. Under A.R.S. §§ 32-3668 and 32-3669, an AMC for which registration is sought under R4-46-401 may not have an owner, controlling person, officer, or other individual with a financial interest in the AMC who has ever had a financial, real estate, or mortgage lending industry license or certificate refused, denied, canceled, voluntarily surrendered in lieu of revocation, or revoked in any state.
- B. When an appeal is made by the individual who has had a financial, real estate, or mortgage lending industry license or certificate refused, denied, canceled, voluntarily surrendered in lieu of revocation, or revoked in any state for a non-substantive cause and reinstated by the state that revoked the license or certificate, the Director has discretion to grant the appeal.
- C. To make an appeal for waiver under subsection (B), the individual shall submit an appeal for waiver form, which is available from the Department and on its website.
- D. In deciding whether to waive the requirement under subsection (B), the Director shall consider the following factors:
  1. Whether the refusal, denial, cancellation, voluntary surrender in lieu of revocation, or revocation of a license or certificate was based on a finding of fraud, dishonesty, misrepresentation, or deceit on the part of the appellant;
  2. The amount of time that has elapsed since the refusal, denial, cancellation, voluntary surrender in lieu of revocation, or revocation of the license or certificate;
  3. Whether the act leading to the refusal, denial, cancellation, voluntary surrender in lieu of revocation, or revocation of the license or certificate was an isolated occurrence or part of a pattern of conduct;
  4. Whether the act leading to the refusal, denial, cancellation, voluntary surrender in lieu of revocation, or revocation of the license or certificate appears to have been done for a self-serving purpose;
  5. The harm caused to victims, if any;
  6. Efforts at rehabilitation, if any, undertaken by the appellant and evidence regarding whether the rehabilitation efforts were successful;
  7. Restitution made by the appellant to victims, if any; and
  8. Other factors in mitigation or aggravation that the Director determines are relevant.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2). Amended by final rulemaking at 30 A.A.R. 3515 (November 22, 2024), effective January 5, 2025 (Supp. 24-4).

**R4-46-407. Training Required**

- A. The controlling person of a registered AMC shall ensure that all employees and other individuals who work on behalf of the AMC and are responsible for selecting independent appraisers to perform real property appraisal services receive sufficient training to be qualified to comply with federal and state law regarding appraisal management services.
- B. The controlling person of a registered AMC shall ensure that the training required under subsection (A) includes at least the following:
  1. Overview of USPAP,
  2. Federal and state law applicable to real property appraisal services,
  3. Appraiser classifications and the scope of work for each classification,
  4. Factors that influence the complexity of an appraisal assignment, and
  5. Maintaining the independence of an appraiser.
- C. The controlling person of a registered AMC shall maintain a record of all training provided to an individual described under subsection (A) for one year beyond the termination of that individual's employment by or work on behalf of the AMC.
- D. The controlling person of a registered AMC shall make available to the Department, upon request, a copy of all materials used to provide the training required under this Section and the records maintained under subsection (C).

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2).

**R4-46-408. Voluntarily Relinquishing Registration**

- A. The controlling person of a registered AMC may voluntarily relinquish the AMC's registration if:
  1. No complaint is currently pending against the AMC,
  2. All amounts owed under subsection R4-46-402(C) have been paid, and
  3. The AMC is in good standing with the Department.
- B. To voluntarily relinquish an AMC's registration, the controlling person of the AMC shall enter into an agreement with the Director that provides the AMC shall:
  1. Cease engaging in business as an AMC and cease providing appraisal management services immediately, and
  2. Maintain the surety bond required under A.R.S. § 32-3667 for one year after the agreement is entered.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**ARTICLE 5. COURSE APPROVAL****R4-46-501. Course Approval Required; Definitions**

- A. Under A.R.S. §§ 32-3601(10) and 32-3625, a course must be approved by the Director, including a course presented by distance education, before the course is offered in Arizona. A course shall be approved as either qualifying or continuing education.
- B. Prior to the approval of a course as either qualifying or continuing education, the Department shall determine whether the

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course satisfies the qualification criteria under subsection R4-46-201(B).

- C. A course owner shall ensure that the course is not offered as either qualifying or continuing education until the course owner receives notice that the course has been approved unless the course owner includes notice in the offering materials that course approval is pending and no credit may be claimed for participating in the course until approval is received.
- D. The Department shall include in the notice of course approval referenced in subsection (C):
  1. An index number for the approved course,
  2. The maximum number of hours of instruction (including examination time if applicable) that may be claimed for participating in the approved course, and
  3. Whether the course is approved as qualifying or continuing education.
- E. A course owner shall ensure that the course is not advertised or represented as approved until after receipt of the notice referenced in subsection (D). After receiving notice of course approval, the course owner may represent in any materials that the course is *approved*.
- F. As used in this Article:  
 “Continuing education” means the basic education requirement for renewal of a license or certification within the meaning of A.R.S. § 32-3625.

“Qualifying education” means the basic education requirement to apply as a state-licensed appraiser under A.R.S. § 32-3613(B) or state-certified real estate appraiser under A.R.S. § 32-3614(C).

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1503, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-502. Approval of Distance-education Delivery Mechanism**

If a course is to be delivered by distance education, the course owner shall obtain approval of the course-delivery mechanism from one of the following sources if required:

1. An organization approved by the AQB that provides approval of course design and delivery;
2. An accredited institution of higher education that approves the content of the course and offers and awards academic credit for the distance-education course; or
3. An accredited institution of higher education that approves the content of the course and a distance-education approval organization that approves the course design and delivery, which includes interactivity.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Section expired under A.R.S. § 41-1056(E) at 10 A.A.R. 1893, effective January 31, 2004 (Supp. 04-2). New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final

rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-503. Course Owners**

- A. Approval of a course granted to the course owner extends to a secondary provider. However, for a course delivered by distance education:
  1. A course owner’s approval of the course-delivery mechanism, as required under R4-46-502, does not extend to a secondary provider; and
  2. Both the course owner and secondary provider shall apply for and obtain approval of the course-delivery mechanism from a source listed in R4-46-502.
- B. If a course owner allows an approved course to be offered by a secondary provider, the course owner shall ensure that the secondary provider:
  1. Uses the course owner’s materials, including the same textbook and examination, if any;
  2. Allows only the number of hours specified by the Department under subsection R4-46-501(D);
  3. Uses an instructor who is qualified under the standards specified in subsection R4-46-506(7); and
  4. Adheres to the course owner’s policies regarding student attendance, course scheduling, and prerequisites, if any.
- C. Before allowing an approved course to be offered by a secondary provider using distance education, the course owner shall comply with subsection (B) and:
  1. Ensure that the secondary provider has obtained approval of the course-delivery mechanism from a source listed in R4-46-502, and
  2. Provide evidence that the secondary provider has obtained approval of the course-delivery mechanism for the approved course.
- D. A course owner shall be held responsible if a secondary provider, authorized by the course owner under subsection (B) or (C), violates any provision of this Article.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Amended effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1503, effective June 2, 2007 (Supp. 07-2). Section repealed; new Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-504. Application for Course Approval**

Only a course owner may apply for course approval. To apply for course approval, a course owner shall submit to the Department:

1. An application for course approval, which is available from the Department and on its website;
2. Materials and other documents that demonstrate the course meets the minimum standards specified in R4-46-506;
3. If the course will be offered using distance education, evidence of approval of the course-delivery mechanism from a source listed in R4-46-502; and
4. The application fee specified under R4-46-106.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10,



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2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-505. Course Approval without Application**

The Director approves without application the following:

1. A course approved through the AQB's voluntary Course Approval Program;
2. The 15-Hour National USPAP Course or its equivalent, approved by the AQB, if the course is taught by at least one instructor who is certified by the AQB as an USPAP instructor; and
3. The 7-Hour National USPAP Update Course or its equivalent, approved by the AQB, if the course is taught by at least one instructor who is certified by the AQB as an USPAP instructor.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-506. Minimum Standards for Course Approval**

The Director shall approve a course only if the course owner submits the following materials and documents with the application for approval required under R4-46-504 and demonstrates the course, including a course presented by distance education, meets the following minimum standards:

1. Course description. Clearly describe the subject matter content of the course.
2. Summary outline. Identify major topics and the number of classroom hours devoted to each.
3. Prerequisites. Specify necessary prerequisites for any course other than a course on:
  - a. Introductory real estate appraisal principles and practices, and
  - b. Appraisal standards and ethics.
4. Learning objectives. Specific learning objectives shall:
  - a. State clearly the specific knowledge and skills students are expected to acquire by completing the course;
  - b. Be consistent with the course description required under subsection (1);
  - c. Be consistent with the instructional materials described in subsection (5);
  - d. Be achievable in the number of hours allotted for the course;
  - e. If for qualifying education, specify the required core curriculum, module subtopic, and number of course hours; and
  - f. If for continuing education, specify the appraisal topic and number of course hours.
5. Instructional materials. Instructional materials used by students shall:
  - a. Cover the subject matter in sufficient depth to achieve the learning objectives specified in subsection (4);
  - b. Reflect current knowledge and practice in the field of appraisal;
  - c. Contain no significant errors;
  - d. Use correct grammar and spelling;
  - e. Be written in a clear, concise, and understandable manner;

- f. Be in a format that facilitates learning; and
  - g. Be bound or packaged and produced in a quality manner.
6. Examinations for qualifying education courses. Qualifying education courses shall include a series of examinations or a comprehensive final examination, or both. A course examination shall:
    - a. Contain enough questions to assess adequately whether a student acquired knowledge of the subject matter covered by the course;
    - b. Contain questions directed towards assessing whether students achieved the learning objectives specified in subsection (4);
    - c. Be allotted sufficient time for students to complete;
    - d. Contain questions on information adequately addressed in the instructional material required under subsection (5);
    - e. Contain questions that are written in a clear, accurate, and unambiguous manner;
    - f. Contain questions for which the intended answer is clearly the best answer choice;
    - g. Be proctored and closed-book; and
    - h. Have a criterion for passing that is announced before the examination is given.
  7. Instructor qualifications policy. The course owner has a written policy that requires use of instructors who meet at least one of the following:
    - a. Has a baccalaureate degree in any field and at least three years of experience directly related to the subject matter to be taught,
    - b. Has a master's degree in any field and one year of experience directly related to the subject matter to be taught,
    - c. Has a master's or higher degree in a field directly related to the subject matter to be taught,
    - d. Has at least five years of real estate appraisal teaching experience directly related to the subject matter to be taught, or
    - e. Has at least seven years of real estate appraisal experience directly related to the subject matter to be taught.
  8. Required policies. The course owner shall have the following written policies:
    - a. Attendance policy that ensures student attendance is verified.
      - i. Stipulate that to receive credit, a student must be present for the entire course;
      - ii. Include the instructor's name on the attendance record; and
      - iii. Maintain attendance records for five years;
    - b. Scheduling policy.
      - i. Provide that a student may participate in a maximum of eight hours of instruction in a day, and
      - ii. Provide that appropriate breaks are included during each class session, and
    - c. Completion certificate policy.
      - i. Require that a signed and dated completion certificate be issued promptly to all students who complete a course, and
      - ii. Require that a completion certificate contain all information required on the form of certification provided by the Department.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R.

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1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-507. Secondary Providers**

The Director shall hold a course owner responsible for the activities of a secondary provider who conducts the course owner's approved course in Arizona. To protect the integrity of the approval, a course owner shall have a written agreement with a secondary provider that requires the secondary provider to:

1. Use the materials required under subsection R4-46-506(5) and the examination required under subsection R4-46-506(6) without change;
2. Conduct the course in accordance with the policies required under R4-46-506(7) and (8);
3. Clearly state in advertising materials that the course has been lawfully acquired from the course owner and that approval was provided to the course owner and not to the secondary provider;
4. Cease using the materials and examination when the course approval expires under R4-46-510; and
5. If the course is to be delivered by distance learning, obtain approval of the course-delivery mechanism from a source listed in R4-46-502.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-508. Compliance Audit of Approved Courses**

- A. To improve the quality of education available to appraisers in this state, the Department may regularly audit approved courses for compliance with this Chapter.
- B. The Director shall identify approved courses for audit using the following to establish the priority of audits:
  1. Approved courses about which a complaint has been received,
  2. Approved courses of a course owner that is new to this state, and
  3. Approved courses that have not been audited in the last five years.
- C. On request from the Director, the course owner of an approved course shall provide the dates, times, and locations at which the approved course will be taught and the name of the instructor who will teach each presentation of the approved course.
- D. The audit of an approved course may be conducted by a volunteer auditor trained by the Department.
- E. The course owner of an approved course shall allow an auditor described under subsection (D) to attend the approved course at no charge.
- F. The auditor shall be identified to the instructor before the approved course starts.
- G. On request from the auditor, the course owner shall allow the auditor to examine records, materials, and other documents relevant to the approved course audited.
- H. After review by the Director, the Department shall provide a copy of the audit report to the course owner. If the audit identifies ways in which the approved course fails to comply with this Article, the Department shall:
  1. Work with the course owner to establish a correction plan to bring the course into compliance,

2. Establish a time within which the course owner is required to complete the correction plan and bring the course into compliance, and
  3. Inform the course owner of the manner in which to report the approved course is in compliance with this Article.
- I. Failure of a course owner to comply with this Article may lead to revocation of course approval.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-509. Changes to an Approved Course**

The Director encourages revisions and updates that improve and keep an approved course current. However, if any of the information provided under R4-46-506(1), (2), (4), or (5) changes so substantially as to alter the scope of the approved course as determined at the sole discretion of the Director, the course owner of the approved course shall submit a new application for approval under R4-46-504.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-510. Renewal of Course Approval**

- A. Course approval expires a maximum of two years after approval is granted. Approval of a distance education course expires in two years or, if applicable, when the distance education delivery-mechanism approval required under R4-46-502 or approval under R4-46-505 expires, whichever is less.
- B. The Director may renew the approval of a course only if the information provided under R4-46-506(1), (2), (4), and (5) has not changed substantially.
- C. If an approved course meets the standard in subsection (B), the course owner may apply for renewal of course approval within 90 days before the course approval expires.
- D. To apply for renewal of course approval, a course owner shall submit a renewal application, which is available from the Department and on its website, and pay the renewal fee specified in subsection R4-46-106(A)(10).

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-511. Transfer of an Approved Course**

- A. A course owner that transfers the proprietary rights to an approved course shall provide written notice of the transfer to the Department. The course owner shall include in the notice the name of and contact information for the new course owner and the date of the transfer.
- B. The new course owner to which the proprietary rights to an approved course are transferred shall attach to the notice

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required under subsection (A) a certification available from the Department and on its website, that the new course owner:

1. Will adhere to the requirements in this Article, and
2. Will be responsible for the actions of all secondary providers who have an agreement under R4-46-507.

- C. If proprietary rights to an approved course are transferred under this Section, the expiration date of the course approval does not change.

**Historical Note**

New Section made by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 25 A.A.R. 1139, effective June 10, 2019 (Supp. 19-2). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**ARTICLE 6. PROPERTY TAX AGENTS**

**R4-46-601. Standards of Practice**

The Director may revoke or suspend a property tax agent's registration or otherwise discipline a property tax agent to the extent permitted by A.R.S. § 32-3654 for any of the following acts or omissions:

1. Engaging in an activity that leads to a conviction for a crime involving the tax profession;
2. Operating beyond the boundaries of an agreed relationship with an employer or a client;
3. Inferring or implying representation of a person or firm that the agent does not represent, or filing a document on behalf of a taxpayer without specific authorization of the taxpayer;
4. Violating the confidential nature of the property tax agent-client relationship, except as required by law;
5. Inappropriately offering or accepting anything of value with the intent of inducing or in return for a specific action;
6. Assigning, accepting, or performing a tax assignment that is contingent upon producing a predetermined analysis or conclusion;
7. Issuing an appraisal analysis or opinion, in the performance of a tax assignment, that fails to disclose bias or the accommodation of a personal interest;
8. Willfully furnishing inaccurate, deceitful, or misleading information, or willfully concealing material information in the performance of a tax assignment;

9. Preparing or using, in any manner, a resume or statement of professional qualifications that is misleading or false;
10. Promoting a tax agent practice or soliciting assignments by using misleading or false advertising;
11. Soliciting a tax assignment by assuring a specific result or by stating a conclusion regarding that assignment without analysis of the facts; or
12. Performing an appraisal, as defined by A.R.S. § 32-3601, unless licensed or certified by the Director as an appraiser.

**Historical Note**

Adopted effective December 29, 1995 (Supp. 95-4). Section repealed; new Section adopted effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2). Amended by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3). Amended by final rulemaking at 28 A.A.R. 893 (May 6, 2022), effective June 11, 2022 (Supp. 22-2).

**R4-46-602. Repealed**

**Historical Note**

Adopted effective October 1, 1998; filed in the Office of the Secretary of State September 10, 1998 (Supp. 98-3). Amended by final rulemaking at 13 A.A.R. 1388, effective June 2, 2007 (Supp. 07-2). Section repealed by final rulemaking at 21 A.A.R. 1675, effective October 6, 2015 (Supp. 15-3).

**ARTICLE 7. REPEALED**

**R4-46-701. Repealed**

**R4-46-702. Repealed**

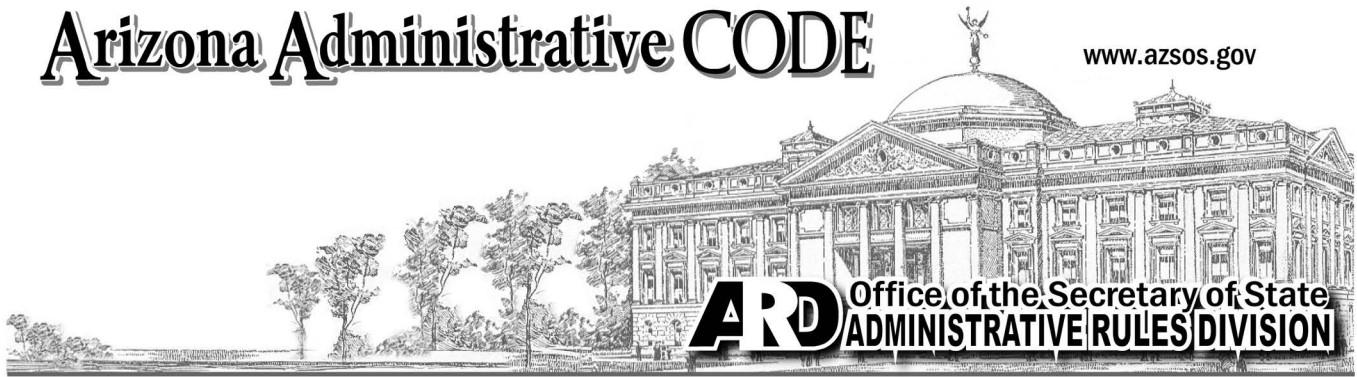
**R4-46-703. Repealed**

**R4-46-704. Repealed**

**Historical Note**

New Section made by final rulemaking at 17 A.A.R. 566, effective April 5, 2011 (Supp. 11-2). Section repealed by exempt rulemaking at 19 A.A.R. 4023, effective November 21, 2013 (Supp. 13-4).

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## TITLE 9. HEALTH SERVICES

### CHAPTER 9. DEPARTMENT OF HEALTH SERVICES - HUMAN REMAINS

The table of contents on page one contains links to the referenced page numbers in this Chapter.  
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

Articles 1 through 4 have been repealed. New Subchapter A and Articles 1 through 3 were made in supplement 24-4.

#### Questions about these rules? Contact:

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**The release of this Chapter in Supp. 24-4 replaces Supp. 23-4, 1-12 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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Administrative Rules Division

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TITLE 9. HEALTH SERVICES

CHAPTER 9. DEPARTMENT OF HEALTH SERVICES - HUMAN REMAINS

Authority: A.R.S. §§ 32-1307(A)(1). See also, Laws 2023, Ch. 194.

Supp. 24-4

*Editor's Note: The Department amended the name of this Chapter from "Department of Health Services - Procurement Organizations" to "Department of Health Services - Human Remains" by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).*

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SUBCHAPTER 9A. PROCUREMENT ORGANIZATIONS

Authority: A.R.S. § 36-851.01

*Editor's Note: The Department created a Subchapter titled "Procurement Organizations" by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).*

ARTICLE 1. PROCUREMENT ORGANIZATION  
LICENSURE

*Article 1, consisting of Sections R9-9A-101 through R9-9A-109, and Table 1.1, made by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).*

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2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-108. Repealed**

## Historical Note

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**Table 1.1. Repealed**

### Historical Note

New Table 1.1 made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Table 1.1, following Section R9-9-108 repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**ARTICLE 2. REPEALED**

**R9-9-201. Repealed**

### Historical Note

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-202. Repealed**

### Historical Note

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-203. Repealed**

### Historical Note

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-204. Repealed**

### Historical Note

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-205. Repealed**

### Historical Note

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final

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expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**ARTICLE 3. REPEALED****R9-9-301. Repealed****Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-302. Repealed****Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-303. Repealed****Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-304. Repealed****Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-305. Repealed****SUBCHAPTER 9A. PROCUREMENT ORGANIZATIONS****ARTICLE 1. PROCUREMENT ORGANIZATION LICENSURE****R9-9A-101. Applicability**

This Subchapter does not apply to a procurement organization identified in A.R.S. § 36-851.01(F).

**Historical Note**

R9-9A-101 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-102. Definitions**

In addition to the definitions in A.R.S. § 36-841, the following apply in this Subchapter, unless otherwise specified:

1. "Acceptability assessment" means the evaluation by a procurement organization of available medical and social information about a donor to determine whether the donor meets criteria for making a non-transplant anatomical donation.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**ARTICLE 4. REPEALED****R9-9-401. Repealed****Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-402. Repealed****Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). At the request of the Department a clerical error was corrected under subsection (3)(a); "and" was changed to "or" under file number R22-220 (Supp. 22-3). Amended by final expedited rulemaking at 29 A.A.R. 3429 (October 27, 2023), with an immediate effective date of October 4, 2023 (Supp. 23-4). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9-403. Repealed****Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1517 (July 1, 2022), with an immediate effective date of June 8, 2022 (Supp. 22-2). Section repealed by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

2. "Accredited" means having a current and valid certificate of accreditation as a procurement organization from a nationally recognized agency that is approved by the Department.
3. "Acquisition" means activities required to obtain a non-transplant anatomical donation.
4. "Administrator" means the individual responsible for the provision by a procurement organization of services and related activities.
5. "Applicant" means an individual or business organization requesting approval to operate a procurement organization.
6. "Application" means the information, documents, and fees required by the Department for licensure of a procurement organization.
7. "Business organization" means the same as "entity" in A.R.S. § 10-140.
8. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the

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- period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
9. "Department" means the Arizona Department of Health Services.
  10. "Distribution" means the process for release and transfer of non-transplant anatomical material to another procurement organization, an education facility, or a research facility, including the selection and evaluation of non-transplant anatomical material for the intended use.
  11. "Donor consent form" means the same as "document of gift" as defined in A.R.S. § 36-841.
  12. "Exceptional release" means the distribution of non-transplant anatomical material that:
    - a. Has been approved for usage before a donor acceptability assessment has been completed; or
    - b. Would not normally meet the established acceptability criteria, at the request of a researcher.
  13. "Final disposition" means the same as in A.R.S. § 36-301.
  14. "Licensee" means a person to whom the Department has issued a license to operate a procurement organization.
  15. "Medical director" means a physician who meets the requirements in A.R.S. § 36-851.03.
  16. "Non-transplant anatomical donation" means an anatomical gift intended to be used for education or research.
  17. "Non-transplant anatomical material" means a non-transplant anatomical donation that has been prepared, packaged, labeled, and released to distribution inventory.
  18. "Personnel member" means an individual who is identified as an employee, student, or volunteer for a procurement organization and performs activities directly related to acquisition, evaluation of a non-transplant anatomical donation, preparation, or distribution of non-transplant anatomical material.
  19. "Physical assessment" means a postmortem evaluation of a non-transplant anatomical donation to determine whether there is evidence of a condition, such as a viral or bacterial infection, that may affect the suitability of the non-transplant anatomical donation for use in education or research.
  20. "Premises" mean a facility and surrounding grounds that are designated by an applicant or a licensee and licensed by the Department as part of a procurement organization.
  21. "Preparation" means an activity:
    - a. Performed to make a non-transplant anatomical donation ready for distribution; and
    - b. Includes cleaning, preservation, disarticulation, dissection, skeletonization, plastination, packaging, and labeling of the non-transplant anatomical donation.
  22. "Procurement organization" means the same as "non-transplant anatomical donation organization," as defined in A.R.S. § 36-841, and includes both accredited and non-accredited facilities.
  23. "Quality management program" means ongoing activities designed and implemented by a procurement organization to improve acquisition, evaluation of a non-transplant anatomical donation, preparation, or distribution of non-transplant anatomical material.
  24. "Standard operating procedure" means a documented process for carrying on business, providing services, or performing activities, with instructions for performing routine or repetitive tasks.
  25. "Storage" means the process of maintaining non-transplant anatomical donations and non-transplant anatomical material in a designated area that contains relevant equipment, instruments, and supplies until distribution or final disposition.
  26. "Transfer" means to convey responsibility and oversight for non-transplant anatomical material to another person.

**Historical Note**

R9-9A-102 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-103. Individuals to Act for an Applicant or a Licensee**

When an applicant or a licensee is required by this Subchapter to provide information on or sign an application form or other document, the following shall satisfy the requirement on behalf of the applicant or licensee:

1. If the applicant or licensee is an individual, the individual; and
2. If the applicant or licensee is a business organization, the individual who the business organization has designated to act on the business organization's behalf for purposes of this Subchapter and who:
  - a. Is a U.S. citizen or legal resident;
  - b. Has an Arizona address; and
  - c. Meets one of the following, as applicable:
    - i. If the business organization is a partnership, is a general partner or is a limited partner who holds at least 10% of the voting rights of the partnership;
    - ii. If the business organization is a corporation, association, or limited liability company, is the president, the chief executive officer, the incorporator, an agent, or any individual who owns or controls at least 10% of the voting securities; or
    - iii. Holds a beneficial interest in 10% or more of the liabilities of the business organization.

**Historical Note**

R9-9A-103 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-104. Application for Licensure**

- A. A person may not act as a procurement organization in this state unless the person is licensed by the Department as a procurement organization.
- B. An applicant for a procurement organization license shall submit to the Department an application that contains:
  1. The following, according to A.R.S. § 36-851.01(A), in a Department-provided format:
    - a. The applicant's name, mailing address, email address, and telephone number;
    - b. The name or proposed name of the procurement organization, including the:
      - i. Physical address;
      - ii. Mailing address, if different from the physical address;
      - iii. Telephone number;
      - iv. Email address; and
      - v. Tax ID number;

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- c. Whether the applicant is a business organization and, if so, the type of business organization;
- d. Whether the applicant is accredited as a procurement organization;
- e. If the applicant is not accredited as a procurement organization, the name, email address, telephone number, and professional license number of the medical director;
- f. Whether the facility is ready for a licensing inspection by the Department;
- g. If the facility is not ready for a licensing inspection specified in subsection (B)(1)(f), the date the facility will be ready for a licensing inspection;
- h. The name, title, and contact information of an individual acting on behalf of the applicant, as specified in R9-9A-103;
- i. Whether the applicant complies with local zoning ordinances, building codes, and fire codes;
- j. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-9A-109; and
- k. The applicant's signature and the date signed;
- 2. If applicable, documentation that the procurement organization is accredited;
- 3. A floor plan, drawn to scale, of each building where the procurement organization will be located, showing the function of each room;
- 4. Documentation for the applicant that complies with A.R.S. § 41-1080;
- 5. Documentation that shows that the applicant is in good standing with the Arizona Corporation Commission; and
- 6. An application fee of \$2,000.
- C. Upon receipt of the application in subsection (B), the Department shall conduct an inspection of the procurement organization, if applicable.
- D. The Department shall issue or deny a license to an applicant as specified in R9-9A-109.

**Historical Note**

R9-9A-104 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-105. Application for License Renewal**

- A. A license is valid for two years from the date of issuance or renewal as specified in A.R.S. § 36-851.01(C).
- B. At least 30 calendar days before the expiration date indicated on a procurement organization's license, a licensee shall submit to the Department an application for renewal that contains:
  - 1. The following, in a Department-provided format:
    - a. The licensee's name, mailing address, email address, and telephone number;
    - b. The procurement organization's license number;
    - c. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-9A-109; and
    - d. The licensee's signature and the date signed;
  - 2. If applicable, documentation that the procurement organization is accredited; and
  - 3. An application fee of \$2,000.
- C. The Department shall renew or deny renewal of a license as specified in R9-9A-109.

**Historical Note**

R9-9A-105 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-106. Changes Affecting a License**

- A. A licensee shall notify the Department in writing at least 30 calendar days before the effective date of termination of procurement organization operations, including the following information, in a Department-provided format:
  - 1. The name and license number of the licensee;
  - 2. The name, email address, and telephone number of an individual who may be contacted by the Department;
  - 3. The proposed termination date; and
  - 4. The address and contact information for the location where the procurement organization records will be retained, according to R9-9A-201(B)(1)(b).
- B. A licensee of an accredited procurement organization, whose certificate of accreditation has expired or has been revoked, suspended, or denied, shall notify the Department in writing no later than 14 calendar days after expiration or the receipt of a revocation, suspension, or denial.
- C. A licensee shall:
  - 1. Notify the Department in writing at least 30 calendar days before a change in the legal name of a procurement organization that does not affect the structure or ownership of the business organization, including the following information:
    - a. The name and license number of the licensee;
    - b. The current name of the procurement organization;
    - c. The proposed name of the procurement organization; and
    - d. The name, email address, and telephone number of an individual who may be contacted by the Department; and
  - 2. Within seven calendar days after the effective date of the name change, submit to the Department documentation of the name change from the Arizona Corporation Commission that indicates no change in structure or ownership of the procurement organization.
- D. A licensee shall:
  - 1. Notify the Department in writing at least 30 calendar days before a change in the legal name of the licensee, which does not affect the structure or ownership of the business organization if the licensee is a business organization, including the following information:
    - a. The current name and license number of the licensee,
    - b. The proposed name of the licensee, and
    - c. The name, email address, and telephone number of an individual who may be contacted by the Department; and
  - 2. Within seven calendar days after the effective date of the name change, submit to the Department either:
    - a. If the licensee is an individual, documentation of the individual's legal name change; or
    - b. If the licensee is a business organization, documentation of the name change from the Arizona Corporation Commission that indicates no change in structure or ownership of the business organization.
- E. A licensee shall notify the Department in writing no later than 30 calendar days after a change in any of the following, including the name and license number of the procurement organization:

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1. The email address or mailing address of the procurement organization, including the new email address or mailing address;
  2. The email address or telephone number of the licensee, including the new email address or telephone number;
  3. An administrator, including the name, telephone number, and email address of the new administrator;
  4. A medical director, including the name, email address, and professional license number of the new medical director; or
  5. The name, telephone number, and email address of the individual acting on behalf of the licensee specified in R9-9A-103.
- F.** A licensee shall notify the Department in writing at least 30 calendar days before the effective date of a proposed modification, which includes a substantial improvement, enlargement, reduction, alteration, or other substantial change in the facility or another structure on the premises at the procurement organization, including:
1. The following information:
    - a. The name and license number of the licensee;
    - b. A description of the proposed modification;
    - c. Whether the modification will comply with local zoning ordinances, building codes, and fire codes;
    - d. The estimated date of completion of the modification;
    - e. The date the facility will be ready for a licensing inspection; and
    - f. The name, email address, and telephone number of an individual who may be contacted by the Department;
  2. A floor plan, drawn to scale, of each building in which a change will be made:
    - a. Showing the function of each room, and
    - b. Indicating the changes to be made; and
  3. A plan for ensuring the quality and security of non-transplant anatomical donations and non-transplant anatomical material are maintained during the modification.
- G.** For an anticipated change in the address of a procurement organization, a licensee shall:
1. Notify the Department in writing at least 30 calendar days before the anticipated change in the address, including:
    - a. The name and license number of the licensee;
    - b. The new address of the procurement organization;
    - c. The estimated date that the procurement organization plans to suspend acquisition, preparation, and distribution at the current address in anticipation of the change of address; and
    - d. The estimated date that the procurement organization plans to be ready to begin operations at the new address;
  2. Submit to the Department:
    - a. The application information, documentation, and fee required in R9-9A-104(B);
    - b. A plan for ensuring the quality and security of non-transplant anatomical donations and non-transplant anatomical material are maintained during the change of location; and
    - c. Documentation from the Arizona Corporation Commission that shows the change of address and indicates no change in structure or ownership of the procurement organization;
3. Ensure that the quality and security of non-transplant anatomical donations and non-transplant anatomical material are maintained during the change of address; and
  4. Not begin procurement organization activities at the new address until a new license has been issued according to subsection (M).
- H.** For an anticipated change of ownership of a procurement organization:
1. A licensee shall:
    - a. Notify the Department in writing at least 30 calendar days before the anticipated change of ownership, including the following information, in a Department-provided format:
      - i. The name and license number of the licensee;
      - ii. The name, email address, and telephone number of the person who is anticipated to assume ownership of the procurement organization;
      - iii. The estimated date that the procurement organization plans to suspend acquisition, preparation, and distribution in anticipation of the change of ownership;
      - iv. The estimated date that the change of ownership will occur;
      - v. The address and contact information for the location where the procurement organization records will be retained, according to R9-9A-201(B)(1)(b); and
      - vi. The name, email address, and telephone number of an individual who may be contacted by the Department;
    - b. If the licensee anticipates that any non-transplant anatomical donations or non-transplant anatomical material in the possession of the licensee will be transferred to the new owner, submit to the Department a plan for ensuring that the quality and security of the non-transplant anatomical donations and non-transplant anatomical material are maintained during the change of ownership; and
    - c. If the licensee anticipates that any non-transplant anatomical donations or non-transplant anatomical material in the possession of the licensee will not be transferred to the new owner, submit to the Department a plan for final disposition of the non-transplant anatomical donations and non-transplant anatomical material, consistent with the standard operating procedure for the final disposition of non-transplant anatomical donations and non-transplant anatomical material, according to R9-9A-201(B)(8); and
  2. The person identified in subsection (H)(1)(b) shall:
    - a. Submit to the Department the application information, documentation, and fee required in R9-9A-104(B);
    - b. Ensure that the quality and security of non-transplant anatomical donations and non-transplant anatomical material transferred from the licensee are maintained during the change of ownership; and
    - c. Not begin procurement organization activities until a license has been issued by the Department to the person according to R9-9A-109(C)(4).
- I.** If the Department receives the notification of termination of operation in subsection (A) or notice of a change in ownership in subsection (H)(1), the Department shall void the licensee's

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license to operate a procurement organization as of the termination date specified by the licensee.

- J. If the Department receives a notification in subsection (B) of a procurement organization's loss of accreditation, the Department may conduct an inspection of the procurement organization to ensure compliance with the requirements in A.R.S. § 36-851.03 and this Subchapter.
- K. If the Department receives a notification in subsection (C) or (D) of a change in the legal name of the procurement organization or licensee, the Department shall:
  - 1. Determine whether the change affects the structure or ownership of the business organization;
  - 2. If the change does not affect the structure or ownership of the business organization, issue to the licensee an amended license showing the new legal name of the procurement organization or licensee and keeping the current license expiration date; and
  - 3. If the change affects the structure or ownership of the business organization:
    - a. Notify the licensee that the procurement organization is required to suspend acquisition, preparation, and distribution as of the date of the documentation required in subsection (C)(2) or (D)(2)(b), as applicable;
    - b. Require the licensee to specify the address and contact information for the location where the procurement organization records will be retained, according to R9-9A-201(B)(1)(b);
    - c. Notify the licensee that the licensee is responsible for ensuring that the quality and security of non-transplant anatomical donations and non-transplant anatomical material are maintained until:
      - i. A new license is issued under the new structure or ownership of the business organization; or
      - ii. The licensee no longer possesses any non-transplant anatomical donations or non-transplant anatomical material;
    - d. If the procurement organization plans to continue operations under the new structure or ownership of the business organization:
      - i. Require the submission of the application information, documentation, and fee required in R9-9A-104(B);
      - ii. Conduct an inspection of the procurement organization if appropriate; and
      - iii. Specify that procurement organization activities may not resume until a new license has been issued by the Department according to R9-9A-109(C)(4); and
    - e. Terminate the licensee's current license when the Department:
      - i. Issues a new license to the procurement organization under the new structure or ownership of the business organization, or
      - ii. Receives notification that the licensee no longer possesses any non-transplant anatomical donations or non-transplant anatomical material.
- L. If the Department receives a notification in subsection (F) of a proposed modification, the Department:
  - 1. May conduct an inspection of the premises; and
  - 2. If the procurement organization is compliant with A.R.S. Title 36, Chapter 7, Article 3, and this Subchapter, shall issue to the licensee an amended license that incorporates

the modification and retains the expiration date of the existing license.

- M. If the Department receives a notification, information, and documentation in subsection (G) for a change of address, regardless of whether the change affects the structure or ownership of the business organization, or a notification in subsection (H) that indicates a change in ownership, the Department:
  - 1. Shall notify the licensee that:
    - a. The procurement organization is required to suspend acquisition, preparation, and distribution as of the date specified in subsection (G)(1)(c) or (H)(1)(a)(iii), as applicable;
    - b. The licensee is responsible for ensuring that the quality and security of non-transplant anatomical donations and non-transplant anatomical material are maintained until:
      - i. A new license is issued to the licensee at the new address or to the new owner, as applicable; or
      - ii. The licensee no longer possesses any non-transplant anatomical donations or non-transplant anatomical material; and
    - c. Procurement organization activities may not occur after the date specified in subsection (G)(1)(c) or (H)(1)(a)(iii), as applicable, until a new license has been issued by the Department according to R9-9A-109(C)(4);
  - 2. May conduct an inspection of the procurement organization;
  - 3. If the application is compliant with A.R.S. Title 36, Chapter 7, Article 3, and this Subchapter, shall issue a new license to the applicant according to R9-9A-109(C)(4); and
  - 4. Shall terminate the licensee's current license when the Department:
    - a. Issues a new license to the procurement organization at the new address or to the new owner, as applicable; or
    - b. Receives notification that the licensee no longer possesses any non-transplant anatomical donations or non-transplant anatomical material.

**Historical Note**

R9-9A-106 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-107. Inspections**

- A. A non-accredited procurement organization is subject to inspection by the Department at any time to evaluate compliance with A.R.S. Title 36, Chapter 7, Article 3, and this Subchapter according to A.R.S. § 36-851.03(A)(5)(a) and (C).
- B. An accredited procurement organization is subject to inspection by the Department at any time to evaluate compliance with requirements in A.R.S. § 36-851.02(2) and the rules adopted pursuant to A.R.S. § 36-851.02(2).
- C. If the Department determines that a procurement organization is not in compliance with the applicable requirements in A.R.S. Title 36, Chapter 7, Article 3, and the rules in this Subchapter, the Department may:
  - 1. Take an enforcement action as described in R9-9A-108; or
  - 2. Require that the licensee submit to the Department, within 30 calendar days after written notice from the

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Department, a plan of correction acceptable to the Department to address issues of compliance that:

- a. Describes how each identified instance of noncompliance will be corrected and reoccurrence prevented,
- b. Includes a date for correcting each instance of noncompliance that is appropriate to the actions necessary to correct the instance of noncompliance, and
- c. Includes the signature of the individual acting for the licensee according to R9-9A-102 and date signed.

**Historical Note**

R9-9A-107 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-108. Denial, Suspension, Revocation, Enforcement**

- A. The Department may:
  1. Deny a license as specified in subsection (B),
  2. Suspend or revoke a license under A.R.S. § 36-851.01(E) and subsection (B), or
  3. Assess or impose a civil penalty under A.R.S. § 36-851.01(E) and subsection (B).
- B. The Department may impose civil penalties, deny an application, or suspend or revoke a license to operate a procurement organization, if:
  1. An applicant or a licensee does not meet the application requirements contained in R9-9A-104 or R9-9A-105, as applicable;
  2. A licensee does not comply with applicable requirements in A.R.S. §§ 36-851.01 through 36-851.03 and this Subchapter;
  3. A licensee does not correct the deficiencies identified during an inspection according to the plan of correction;
  4. An applicant or a licensee provides false or misleading information to the Department; or
  5. The nature or number of violations revealed by any type of inspection or investigation of a procurement organization poses a direct risk to the life, health, or safety of a personnel member or member of the public.
- C. In determining which action in subsection (A) is appropriate, the Department shall consider:
  1. Repeated violations of statutes or rules,
  2. The pattern of violations,
  3. The severity of violations, and
  4. The number of violations.
- D. If the Department receives notice that a previously accredited procurement organization's accreditation has expired or has been suspended or revoked, the Department may suspend or revoke the procurement organization's license if the procurement organization does not comply with A.R.S. § 36-851.03 and this Subchapter.
- E. An applicant or a licensee may appeal the Department's determination in this Section according to A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

R9-9A-108 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-109. Time-frames**

- A. The overall time-frame, as defined in A.R.S. § 41-1072, for a license granted by the Department under this Subchapter is set

forth in Table 1.1. The applicant or licensee and the Department may agree in writing to extend the substantive review time-frame, as defined in A.R.S. § 41-1072, and the overall time-frame. An extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.

- B. The administrative completeness review time-frame, as defined in A.R.S. § 41-1072, for a license granted by the Department under this Subchapter is set forth in Table 1.1 and begins on the date that the Department receives an application from an applicant or a licensee.
  1. The Department shall send a notice of administrative completeness or deficiencies to the applicant or licensee within the administrative completeness review time-frame:
    - a. A notice of deficiencies shall list each deficiency and the information or items needed to complete the application;
    - b. The administrative completeness review time-frame and the overall time-frame are suspended from the date that the notice of deficiencies is sent until the date that the Department receives all of the missing information or items from the applicant or licensee; and
    - c. If an applicant or a licensee fails to submit to the Department all of the information or items listed in the notice of deficiencies within the time-frame in Table 1.1 after the date that the Department sent the notice of deficiencies or within a time period the applicant or licensee and the Department agree upon in writing, the Department shall:
      - i. Consider the application withdrawn, and
      - ii. Send to the applicant or licensee a written notice setting forth the information required by A.R.S. § 41-1092.03.
  2. If the Department issues a license during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.
- C. The substantive review time-frame is set forth in Table 1.1 and begins on the date of the notice of administrative completeness.
  1. As part of the substantive review of an application for a license, the Department may conduct an inspection that may require more than one visit to complete.
  2. The Department shall issue a license or send a written notice of denial of a license within the substantive review time-frame.
  3. During the substantive review time-frame, the Department may make one comprehensive written request for additional information, unless the applicant or licensee has agreed in writing to allow the Department to submit supplemental requests for information:
    - a. The Department shall send a comprehensive written request for additional information that includes a written statement of deficiencies, stating each statute and rule upon which noncompliance is based, if the Department determines that an applicant or a licensee, or the procurement organization, including the premises, are not in substantial compliance with A.R.S. Title 36, Chapter 7, Article 3, or this Subchapter;
    - b. An applicant or a licensee shall submit to the Department all of the information requested in a

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comprehensive written request for additional information or a supplemental request for information, including, if applicable, documentation of the corrections required in a statement of deficiencies, within the time-frame in Table 1.1 after the date of the comprehensive written request for additional information or the supplemental request for information or within a time period the applicant or licensee and the Department agree upon in writing;

- c. The substantive review time-frame and the overall time-frame are suspended from the date that the Department sends a comprehensive written request for additional information or a supplemental request for information until the date that the Department receives all of the information requested, including, if applicable, documentation of corrections required in a statement of deficiencies; and
- d. If an applicant or a licensee fails to submit to the Department all of the information requested in a comprehensive written request for additional infor-

mation or a supplemental request for information, including, if applicable, documentation of corrections required in a statement of deficiencies, within the time-frame in Table 1.1, the Department shall:

- i. Deny the license, and
  - ii. Send to the applicant or licensee a written notice of denial setting forth the reasons for denial and all other information required by A.R.S. §§ 41-1076 and 41-1092.03.
4. The Department shall issue a license if the Department determines that the applicant or licensee and the procurement organization, including the premises, are in substantial compliance with A.R.S. Title 36, Chapter 7, Article 3, and this Subchapter.

**Historical Note**

R9-9A-109 made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).



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**Table 1.1. Time-frames (in calendar days)**

Type of approval	Authority (A.R.S. § or A.A.C.)	Overall Time-frame	Time-frame for applicant to complete application	Administrative Completeness Time-frame	Substantive Review Time-frame	Response Time for Request in R9-9A-603(X)
Application for an initial procurement organization license	A.R.S. § 36-851.01 and R9-9A-104	90	90	30	60	30
Renewal of a procurement organization license	A.R.S. § 36-851.01 and R9-9A-105	30	30	10	20	30
Application for a facility or licensee name change	A.R.S. § 36-851.01 and R9-9A-106(C)	60	30	30	30	30
Application for another change affecting licensure	A.R.S. § 36-851.01 and R9-9A-106(C)	90	90	30	60	30

**Historical Note**

New Table 1.1. made under Subchapter A, Article 1, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**ARTICLE 2. ADMINISTRATION AND OPERATIONS FOR A PROCUREMENT ORGANIZATION****R9-9A-201. General Administration Requirements for a Procurement Organization****A. A licensee of a procurement organization:**

1. Is responsible for all issues of liability, ethical considerations, fiduciary issues, and compliance with applicable laws and regulations;
2. Shall comply with:
  - a. A.R.S. § 36-325 and, as applicable, A.A.C. R9-19-303 or A.A.C. R9-19-304 related to death certificate registration; and
  - b. A.R.S. § 36-326, A.A.C. R9-19-301, A.A.C. R9-19-308, and, if applicable, A.A.C. R9-19-311 related to the movement of non-transplant anatomical donations and non-transplant anatomical material; and
3. Shall adopt, maintain, and implement standard operating procedures, as applicable to the procurement organization.

**B. A licensee of a procurement organization shall ensure that standard operating procedures are established, documented, and implemented that cover:**

1. The proper use and maintenance of donor consent forms, including that a donor consent form:
  - a. Includes:
    - i. The intended use of the non-transplant anatomical material,
    - ii. How the non-transplant anatomical material may be used,
    - iii. A statement that the non-transplant anatomical material will be treated with dignity at all times, and
    - iv. A statement that the non-transplant anatomical material may require international export to an end-user; and
  - b. Is maintained in the donor's record and retained for at least 10 years beyond the date of final disposition;
2. An electronic identification system for donors, which is established and maintained for non-transplant anatomical donations and non-transplant anatomical material, that:
  - a. Assigns a unique identification number to the donor and the associated non-transplant anatomical donation and non-transplant anatomical material,
  - b. Tracks the complete history of all non-transplant anatomical material, and
  - c. Records the date and staff member involved in each significant step of the operation from the time of

acquisition of the non-transplant anatomical donation through final disposition;

**3. The screening of end-users prior to release and transfer of non-transplant anatomical material that:**

- a. Require a written request for non-transplant anatomical material, containing:
  - i. The name and address of the educational or research establishment making the request;
  - ii. The name, title, and contact information of the individual at the educational or research establishment who will be accepting responsibility for the receipt, use, and disposition of the non-transplant anatomical material;
  - iii. A description of the intended use;
  - iv. The date and the approximate duration of use of the non-transplant anatomical material;
  - v. A description of the venue in which the non-transplant anatomical material will be used and the environmental and security measures of the venue to ensure the safe and ethical utilization of the non-transplant anatomical material;
  - vi. An assurance that universal precautions will be used when handling the non-transplant anatomical material;
  - vii. The proposed final disposition of the non-transplant anatomical material;
  - viii. An outline of proposed descriptive materials to be disseminated in connection with the use of the non-transplant anatomical material; and
  - ix. Other supporting documentation that is relevant to the request; and
- b. Include the criteria for approving requested non-transplant anatomical material for use, including:
  - i. The standards for acceptability of the educator or researcher for the use of non-transplant anatomical material;
  - ii. The appropriateness of the intended use;
  - iii. The types of venues in which the non-transplant anatomical material may be used;
  - iv. What final disposition of the non-transplant anatomical material may be proposed, unless the non-transplant anatomical material is returned to the procurement organization; and
  - v. The suitability of the proposed descriptive materials;

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4. The process for requesting and criteria for approving the exceptional release of non-transplant anatomical material;
  5. The labeling of non-transplant anatomical donations and non-transplant anatomical material with:
    - a. The unique identification number specified in subsection (B)(2)(a),
    - b. That the non-transplant anatomical donation or non-transplant anatomical material is not for transplant or clinical use,
    - c. Any condition or limitation regarding the use of the non-transplant anatomical donation or non-transplant anatomical material,
    - d. That universal precautions must be used in handling the non-transplant anatomical donation or non-transplant anatomical material,
    - e. A disclosure of any disease state in the non-transplant anatomical donation or non-transplant anatomical material, and
    - f. The name and contact information for the procurement organization;
  6. The packaging and transport of non-transplant anatomical donations and non-transplant anatomical material to:
    - a. Preserve the quality of the non-transplant anatomical donation or non-transplant anatomical material,
    - b. Prevent potential cross-contamination between non-transplant anatomical donations or non-transplant anatomical material, and
    - c. Protect the health and safety of personnel members and the public;
  7. The distribution of non-transplant anatomical donations and non-transplant anatomical material, including methods for:
    - a. Ensuring the quality and suitability of non-transplant anatomical donations and non-transplant anatomical material;
    - b. Handling non-transplant anatomical donations and non-transplant anatomical material that do not meet quality control standards;
    - c. Ensuring the eligibility of an end-user or other person to which non-transplant anatomical donations and non-transplant anatomical material may be transferred;
    - d. Handling an end-user request that does not meet the criteria in subsection (B)(3)(b);
    - e. The release of:
      - i. Non-transplant anatomical donations to use, and
      - ii. Non-transplant anatomical material to an end-user or other person to which non-transplant anatomical material may be transferred; and
    - f. The exceptional release of the non-transplant anatomical material; and
  8. The final disposition of non-transplant anatomical donations or non-transplant anatomical material, consistent with requirements in:
    - a. A.R.S. Title 32, Chapter 12; A.R.S. Title 36, Chapter 7; and Subchapter B, related to funeral arrangements, cremation, or other final dispositions;
    - b. A.R.S. Title 36, Chapter 3, and 9 A.A.C. 19, related to the movement of non-transplant anatomical donations or non-transplant anatomical material and reporting of the final disposition; and
    - c. A.R.S. Title 36, Chapter 6, Articles 1, 2, and 4, related to non-transplant anatomical donations or non-transplant anatomical material infected with an agent causing a communicable disease.
- C.** A licensee of a procurement organization shall ensure that copies of standard operating procedures are:
1. Maintained at the procurement organization, and
  2. Available for review by the Department within two hours of the Department's request.

**Historical Note**

R9-9A-201 made under Subchapter A, Article 2, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-202. Additional Administrative Requirements for an Accredited Procurement Organization**

- A.** A licensee of an accredited procurement organization shall provide a copy of a renewed accreditation to the Department within 30 calendar days after the date of issuance.
- B.** A licensee of an accredited procurement organization shall ensure that a procurement organization facility is in a building that provides a separate and designated area for tissue recovery, according to A.R.S. § 36-851.02(3).

**Historical Note**

R9-9A-202 made under Subchapter A, Article 2, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-203. Additional Administrative Requirements for a Non-accredited Procurement Organization**

- A.** A licensee of a non-accredited procurement organization shall:
1. Appoint an administrator who:
    - a. Has at least a bachelor's degree in a health science or other science-related field,
    - b. Has at least three years of experience in tissue banking or other related fields, and
    - c. Is responsible for all services and activities at the procurement organization;
  2. Appoint a medical director who:
    - a. Is licensed under A.R.S. Title 32, Chapter 13 or 17;
    - b. Provides medical guidance to determine donor eligibility; and
    - c. May be the same individual as the administrator, if the individual's qualifications satisfy the requirements in both subsections (A)(1) and (2)(a);
  3. Adopt a quality management program that, at a minimum, includes:
    - a. A method to identify, document, and evaluate incidents;
    - b. A method to collect data to evaluate the provision of procurement organization services;
    - c. A method to evaluate the data collected to identify a concern about the provision of procurement organization services;
    - d. A method to make changes or take action as a result of the identification of a concern about the provision of procurement organization services; and
    - e. The frequency of submitting a documented report required in subsection (A)(4) to the licensee;
  4. Ensure that a documented report of quality management program activities is:
    - a. Submitted to the licensee that includes:

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- i. An identification of each concern about the provision of procurement organization services, and
      - ii. Any changes made or actions taken as a result of the identification of a concern about the provision of procurement organization services; and
    - b. Maintained by the procurement organization for at least 12 months after the date of the report;
  - 5. Review and evaluate the effectiveness of the quality management program in subsection (A)(3) at least once every 12 months;
  - 6. If any instance of use of a non-transplant anatomical donation or non-transplant anatomical material for a purpose other than for research, education, or another use specified in the donor consent form is detected:
    - a. Report the incident to the Department within seven calendar days after the incident is detected,
    - b. Maintain documentation of the report in a donor record, and
    - c. Ensure that the incident is reviewed through the quality assurance process with any steps taken to prevent a reoccurrence;
  - 7. Unless otherwise specified in this Subchapter, ensure that any records or documentation required by this Subchapter are maintained for at least three years after the latest date entered on the report or document; and
  - 8. Ensure that the following information is conspicuously posted on the premises:
    - a. The procurement organization's current license,
    - b. The names of the administrator and medical director,
    - c. The hours of operation, and
    - d. The evacuation plan listed in R9-9A-302(A)(5).
- B.** An administrator of a non-accredited procurement organization:
- 1. Is directly accountable to the licensee for the operations of the procurement organization, including all services and activities provided by or at the procurement organization;
  - 2. Has the authority and responsibility to manage the procurement organization, as specified in standard operating procedures; and
  - 3. Shall designate, in writing, an individual who is on the procurement organization's premises and is available and responsible for procurement organization operations when the administrator is not present on the premises.
- C.** A licensee of a non-accredited procurement organization shall ensure that the medical director:
- 1. Establishes, reviews, and approves standard operating procedures related to:
    - a. Donor eligibility, including:
      - i. The content and conducting of an acceptability assessment;
      - ii. The content and conducting of a physical assessment; and
      - iii. Screening for a condition, such as a viral or bacterial infection, that may affect the suitability of the non-transplant anatomical donation for use in education or research;
    - b. The criteria for and methods of verifying the suitability of a non-transplant anatomical donation for release for preparation;
    - c. The criteria and processes for the exceptional release of non-transplant anatomical material; and
    - d. Pre-established criteria for release of non-transplant anatomical material to an end-user;
  - 2. Reviews and, if necessary, revises all standard operating procedures of a medical nature at least every three years;
  - 3. Establishes a process for determining the eligibility of a donor, based on a comparison of the non-transplant anatomical donation with predetermined donor criteria;
  - 4. Prior to release for use or distribution, signs the donor eligibility statement and non-transplant anatomical material disposition or release statement;
  - 5. If designating another individual to perform tasks or functions assigned by the medical director, ensures that the individual:
    - a. Has the required training and education for performing the tasks or functions;
    - b. Has oversight when performing the tasks or functions assigned by the medical director; and
    - c. Performs the tasks or functions assigned by the medical director according to standard operating procedures, including, if applicable, the functions described in subsections (C)(3) and (4);
  - 6. Reviews activities performed by a designee at least once every three months according to standard operating procedures established by the licensee; and
  - 7. Establishes the criteria for ensuring that all appropriate parties are notified of confirmed positive infectious disease test results.
- D.** A licensee of a non-accredited procurement organization shall ensure that:
- 1. The following are established, maintained, and implemented in compliance with applicable state and federal laws and regulations:
    - a. A safety awareness and blood-borne pathogen training program, and
    - b. A cleaning program that mitigates potential cross-contamination between non-transplant anatomical donations; and
  - 2. The medical director reviews and approves standard operating procedures related to the programs in subsections (D)(1)(a) and (b).
- E.** A licensee of a non-accredited procurement organization shall ensure that the administrator:
- 1. Specifies activities involving non-transplant anatomical donations and non-transplant anatomical material that a technician may provide;
  - 2. Specifies the methods used to provide clinical oversight and training to personnel members, including when clinical oversight and training are provided to an individual or a group; and
  - 3. Creates and maintains a technician's personnel record that includes:
    - a. Documentation of all completed training and education; and
    - b. A written job description, including all primary duties.
- F.** A licensee of a non-accredited procurement organization shall ensure that a technician:
- 1. Is only assigned duties described in a written job description;
  - 2. Has the educational background, experience, and training sufficient to ensure that assigned tasks will be performed in accordance with the applicable standard operating procedures;

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3. Provides a copy of a transcript or diploma in health science or other field of science for which the technician received a degree or certificate, if applicable; and
  4. Demonstrates competency to perform assigned tasks.
- G.** A licensee of a non-accredited procurement organization shall ensure that:
1. The qualifications, skill, and knowledge required for each type of personnel member is based on the activities and services the personnel member may provide, as established in the personnel member's job description; and
  2. A personnel member's qualifications, skills, and knowledge are verified and documented:
    - a. Before the personnel member provides procurement organization services, and
    - b. According to standard operating procedures.
- H.** A licensee of a non-accredited procurement organization shall ensure that a personnel member does not have direct interaction with non-transplant anatomical donations or non-transplant anatomical material unless specifically authorized by the licensee or administrator.
- I.** A licensee of a non-accredited procurement organization shall ensure a personnel record is established for the administrator, technicians, and other personnel members that includes:
1. The individual's name, date of birth, home address, and contact telephone number;
  2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
  3. Documentation applicable to an individual's duties, as required by standard operating procedures, including the individual's:
    - a. Education and experience;
    - b. In-service education and continuing education, if applicable; and
    - c. Evidence of Hepatitis B vaccination or refusal of Hepatitis B vaccine for individuals whose job-related responsibilities involve the potential exposure to blood-borne pathogens.
- J.** A licensee of a non-accredited procurement organization shall ensure that a personnel record is:
1. Maintained throughout an individual's period of employment or volunteer service in or for the procurement organization,
  2. Maintained for at least three years after the last date that an individual's employment or volunteer service in or for the procurement organization, and
  3. Provided to the Department when requested.
- K.** A licensee of a non-accredited procurement organization shall ensure that a donor record:
1. Includes:
    - a. A copy of the donor consent form and any amendment to the consent form;
    - b. The name and contact information of the person responsible for the donor's anatomical gift; if applicable;
    - c. The donor's unique identifying number specified in R9-9A-201(B)(2)(a);
    - d. Documentation for registering the donor's death, as specified in A.A.C. R9-19-303 or A.A.C. R9-19-304, as applicable;
    - e. A disposition-transit permit specified in A.A.C. R9-19-308;
    - f. Any information from the donor referral source, including, as applicable:
      - ii. Donor eligibility;
- L.** A technician or other personnel member of a non-accredited procurement organization shall report to the administrator or medical director:
1. Any concern related to receiving, preparing, packaging, distributing, or transporting non-transplant anatomical donations or non-transplant anatomical material that may adversely affect the health and safety of others; and
- g.** All documents and permits that establish the chain of custody and identification of the individuals and organizations that had physical custody of the non-transplant anatomical donation or non-transplant anatomical material;
- h.** Medical records, including as applicable:
- i. The donor's physical assessment,
  - ii. Pathology and laboratory testing and reports,
  - iii. Physician summaries,
  - iv. Serological results,
  - v. Transfusion or infusion information, and
  - vi. Plasma dilution calculations;
- i.** Documentation related to activities involved in:
- i. Recovery of the non-transplant anatomical donation,
  - ii. Preparation and storage of the non-transplant anatomical material, and
  - iii. Distribution of the non-transplant anatomical material; and
- j.** Final disposition documentation, including all records related to chain of custody;
- 2.** Includes, if applicable:
- a. A human remains release form specified in A.A.C. R9-19-301;
  - b. Information for transporting human remains, as defined in A.R.S. § 36-301, into the state, as specified in A.A.C. R9-19-311;
  - c. The release of information by a medical examiner, as specified in A.R.S. § 36-861;
  - d. Cremation authorization documents; and
  - e. Documentation related to the use of the non-transplant anatomical donation or non-transplant anatomical material for a purpose other than for research, education, or another use specified in the donor consent form; and
- 3.** Is:
- a. Confidential and kept in a location with controlled access;
  - b. Stored in a manner to prevent unauthorized access;
  - c. Maintained in a manner to preserve the donor record's completeness and accuracy; and
  - d. Made available to:
    - i. The donor's known consentor;
    - ii. An agent legally authorized by the donor or other individual designated at the time a donor gives consent;
    - iii. An individual appointed by a court or authorized by state laws;
    - iv. An individual of a procurement organization as identified by standard operating procedures;
    - v. An individual from an approving accrediting body, if applicable; and
    - vi. An individual from the Department or other regulatory agency authorized by state and federal laws or regulations.

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2. Any personal health condition experienced by the technician or other personnel member related to receiving, preparing, packaging, distributing, or transporting non-transplant anatomical donations or non-transplant anatomical material.
- M. If an administrator or medical director of a non-accredited procurement organization receives a report specified in subsection (L), the administrator or medical director shall:
  1. Follow standard operating procedures to secure the area and eliminate exposure to others;
  2. Notify appropriate health and law enforcement agencies, as applicable; and
  3. Report the incident to the Department within seven calendar days after determining that a health condition in subsection (L) has occurred.
- N. If a non-accredited procurement organization owns or maintains a vehicle for transporting non-transplant anatomical donations and non-transplant anatomical material, an administrator shall ensure the vehicle is:
  1. Not used for a purpose other than transporting non-transplant anatomical donations and non-transplant anatomical material or conducting procurement organization business, and
  2. Only operated by a procurement organization technician or designated and authorized individual when transporting non-transplant anatomical donations or non-transplant anatomical material.
- O. If using another vehicle or type of transport for non-transplant anatomical donations or non-transplant anatomical material, an administrator of a non-accredited procurement organization shall ensure that the other vehicle or type of transport:
  1. Is properly equipped for the transportation of non-transplant anatomical donations or non-transplant anatomical material;
  2. Is compliant with all state laws and rules pertaining to transporting human remains; and
  3. If transport is by air, complies with applicable standards established by the International Air Transport Association and Transport Security Administration.
2. Has premises that are:
  - a. Sufficient to provide for a procurement organization's services and activities;
  - b. Cleaned and disinfected according to the procurement organization's standard operating procedures to prevent, minimize, and control illness and infection and mitigate potential cross-contamination between non-transplant anatomical donations and non-transplant anatomical material;
  - c. Clean and free from accumulations of dirt, garbage, and rubbish; and
  - d. Free from a condition or situation that may cause an individual to suffer physical injury;
3. Provides a restroom for clients that:
  - a. Is free from contamination from a non-transplant anatomical donation or non-transplant anatomical material;
  - b. Does not contain any items, materials, or devices associated with the preparation of non-transplant anatomical donations or non-transplant anatomical material; and
  - c. Is not used by technicians or other personnel members unless personal protective equipment is removed before entering; and
4. If the non-accredited procurement organization owns or maintains a vehicle for transporting non-transplant anatomical donations and non-transplant anatomical material:
  - a. Maintains the vehicle in a clean and sanitary condition,
  - b. Ensures that the floor of the vehicle or other locations on which non-transplant anatomical donations and non-transplant anatomical material are placed during transport have a surface capable of being cleaned and sanitized or disinfected, and
  - c. Requires that the vehicle is locked and secured at all times during transport of non-transplant anatomical donations or non-transplant anatomical material.
- B. A licensee of a non-accredited procurement organization shall ensure that:
  1. A pest control program is implemented and documented that requires:
    - a. A pest control service that uses certified applicators as specified in 3 A.A.C. 8, Article 2; and
    - b. Annual pest control service records to be retained for at least 12 months after the date of service; and
  2. The procurement organization does not engage in any practice or create any condition that would constitute a public health nuisance, as specified in A.R.S. § 36-601, or is contrary to the health laws of this state.
- C. A licensee of a non-accredited procurement organization shall ensure that:
  1. Areas used to receive or prepare non-transplant anatomical donations or to label or package non-transplant anatomical material:
    - a. Are properly ventilated;
    - b. Have sanitary flooring and drainage;
    - c. Are protected from dust, dirt, flies, and other contamination;
    - d. Are only used, as applicable, for examining and preparing non-transplant anatomical donations or for labeling or packaging non-transplant anatomical material;

**Historical Note**

R9-9A-203 made under Subchapter A, Article 2, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

### **ARTICLE 3. ENVIRONMENTAL AND PHYSICAL PLANT STANDARDS FOR A NON-ACCREDITED PROCUREMENT ORGANIZATION**

#### **R9-9A-301. Environmental and Physical Plant Standards**

- A. A licensee of a non-accredited procurement organization shall ensure that the procurement organization:
  1. Is in a building that:
    - a. Has a commercial occupancy according to the local zoning jurisdiction;
    - b. Is free of any plumbing, electrical, ventilation, mechanical, or structural hazard that may jeopardize:
      - i. The security or quality of non-transplant anatomical donations or non-transplant anatomical material, or
      - ii. The health or safety of a personnel member or the public; and
    - c. Provides a separate and designated area for tissue recovery;

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- e. Are thoroughly cleansed and disinfected with a 1% solution of chlorinated soda, or other suitable and effective disinfectant, immediately after an obvious spill of blood or other potentially infectious bodily fluid or material;
  - f. Contain the equipment, instruments, and supplies necessary for accomplishing the tasks for which the areas are used that are:
    - i. Sufficient to accomplish the tasks;
    - ii. Maintained in working condition;
    - iii. Maintained in a clean and sanitary condition and disinfected or sanitized, as applicable, after each use;
    - iv. Used according to the manufacturer's recommendations; and
    - v. If applicable, tested and calibrated according to the manufacturer's recommendations or, if there are no manufacturer's recommendations, as specified in standard operating procedures;
  - g. Are disinfected after each use to protect the health and safety of technicians and other personnel members;
  - h. Are maintained in a clean and sanitary condition at all times; and
  - i. Have proper and convenient receptacles for refuse, bandages, and all other waste materials; and
2. All refuse and waste products produced from receiving, preparing, packaging, distributing, and transporting non-transplant anatomical donations or non-transplant anatomical material are removed from the premises as needed.
- D.** A licensee of a non-accredited procurement organization shall ensure that the procurement organization has refrigerated areas for storing non-transplant anatomical donations and non-transplant anatomical material that:
1. Are only used for non-transplant anatomical donations or non-transplant anatomical material;
  2. Are maintained in working order;
  3. Are kept in a clean and sanitary condition;
  4. If a walk-in cooler, maintains a temperature between 36°F and 45°F;
  5. If a freezer, maintains a temperature at or below 32°F; and
  6. Are monitored by a temperature sensor system that:
    - a. Measures temperatures continuously and documents when a unit is out of the required temperature range, and
    - b. Alerts technicians or other designated individuals when temperatures are outside of the acceptable limits.
- E.** A licensee of a non-accredited procurement organization shall maintain documentation of equipment tests, calibrations, and repairs for at least 12 months after the date of testing, calibration, or repair.
- F.** A licensee of a non-accredited procurement organization shall ensure that:
1. Biohazardous material or medical waste and other potentially hazardous materials are removed and disposed of by a facility licensed by the Arizona Department of Environmental Quality pursuant to 18 A.A.C. 8 and 13; and
  2. Combustible or flammable liquids are stored in labeled containers or safety containers in a secured area and properly identified to ensure the health and safety of personnel members and the public.

**Historical Note**

R9-9A-301 made under Subchapter A, Article 3, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-302. Emergency and Safety Standards**

- A.** An administrator of a non-accredited procurement organization shall ensure that:
1. Standard operating procedures are developed, documented, and maintained for the emergency transfer of non-transplant anatomical donations and non-transplant anatomical material to a designated back-up storage facility when the quality or security of non-transplant anatomical donations or non-transplant anatomical material may be compromised, including:
    - a. The situations that would require an emergency transfer, including time limits and temperature tolerance for loss of refrigeration capability;
    - b. The location of the back-up storage facility;
    - c. The actions to be taken by the administrator and personnel members;
    - d. The methods to be used for the emergency transfer;
    - e. Specific labeling indicating that the transported non-transplant anatomical donations and non-transplant anatomical material must remain untouched until returned to the licensed non-accredited procurement facility after the situation has been resolved; and
    - f. Requirements for the situation that resulted in an emergency transfer to be reviewed through the quality management program in R9-9A-203(A)(3) to prevent a recurrence;
  2. A first aid kit is available at the procurement organization;
  3. Smoke detectors are:
    - a. Installed according to building size and the requirements of the local zoning jurisdiction;
    - b. Maintained in an operable condition; and
    - c. Either battery operated or, if hard-wired into the electrical system of the procurement organization, have a back-up battery;
  4. A portable fire extinguisher that is labeled 2A-10-BC by the Underwriters Laboratory:
    - a. Is readily available for use;
    - b. For a disposable fire extinguisher, is replaced when the fire extinguisher's indicator reaches the red zone; and
    - c. For a non-disposable fire extinguisher, is serviced at least every 12 months and has a tag attached to the fire extinguisher that includes the date of service; and
  5. A written fire and evacuation plan is established and maintained.
- B.** An administrator of a non-accredited procurement organization shall:
1. Obtain a fire inspection conducted according to the time-frame established by the local fire department or the State Fire Marshal,
  2. Make any repairs or corrections stated on the fire inspection report, and
  3. Maintain documentation of a current fire inspection.

**Historical Note**

R9-9A-302 made under Subchapter A, Article 3, by final expedited rulemaking at 30 A.A.R. 3657 (November 29,

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2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

**R9-9A-303. Security Standards; Inventory Controls**

- A. A licensee of a non-accredited procurement organization shall ensure that access to the enclosed-locked areas where non-transplant anatomical donations and non-transplant anatomical material are located is limited to individuals authorized by the licensee or administrator.
- B. An administrator of a non-accredited procurement organization shall ensure that:
1. Standard operating procedures are developed, documented, and maintained to prevent unauthorized access to non-transplant anatomical donation or non-transplant anatomical material inventory that:
    - a. Restricts access to the areas of the building that contain non-transplant anatomical donations or non-transplant anatomical material inventory and donor records,
    - b. Provides for identification of authorized individuals, and
    - c. Specifies the methods for conducting electronic monitoring;
  2. Personnel or security equipment to deter and prevent unauthorized entrance into limited access areas are present and operational and include:
    - a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio-frequency device or other mechanical or electronic devices;
    - b. Exterior lighting to facilitate surveillance; and
    - c. Electronic monitoring using video cameras to provide coverage of:
      - i. Entrances to and exits from limited access areas, and
      - ii. Entrances to and exits from the buildings;
  3. Video recordings from the video cameras required in subsection (B)(2)(c) are retained for at least 30 calendar days;
  4. The electronic monitoring system in subsection (B)(2)(c) has a failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; and
5. Battery backup is present and operational to ensure the functioning of video cameras and recording equipment in the event of a power outage.
- C. A licensee of a non-accredited procurement organization shall establish and implement an inventory tracking system for non-transplant anatomical donations and non-transplant anatomical material that:
1. Contains information about all non-transplant anatomical donations received and non-transplant anatomical material released for distribution;
  2. Includes release documentation related to requirements in R9-9A-201(B), and R9-9A-203(C) and (K), for each item of non-transplant anatomical material prior to transferring the item of non-transplant anatomical material to inventory;
  3. Documents the date, time, and location for non-transplant anatomical material transferred for use, including:
    - a. The name of the individual performing the transfer, and
    - b. The name and contact information for an end-user or other person to which non-transplant anatomical material may be transferred;
  4. Documents the date, time, and location for items of non-transplant anatomical material that are moved between locations controlled by the procurement organization, including the name of the individual overseeing the move; and
  5. Ensures non-transplant anatomical material that can no longer be used is removed from inventory and disposed of according to applicable standard operating procedures for final disposition.

**Historical Note**

R9-9A-303 made under Subchapter A, Article 3, by final expedited rulemaking at 30 A.A.R. 3657 (November 29, 2024), with an immediate effective date of November 5, 2024 (Supp. 24-4).

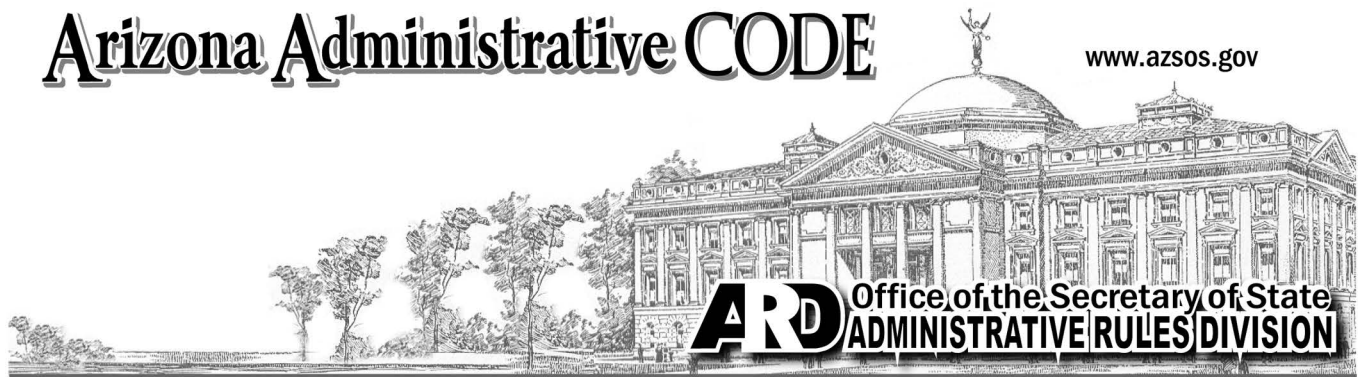
**SUBCHAPTER B. RESERVED**

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## TITLE 9. HEALTH SERVICES

### CHAPTER 17. DEPARTMENT OF HEALTH SERVICES - MEDICAL MARIJUANA PROGRAM

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

<a href="#">R9-17-317.</a>	<a href="#">Product Labeling and Packaging .....</a>	<a href="#">34</a>	<a href="#">R9-17-324.</a>	<a href="#">Dual Licensees .....</a>	<a href="#">43</a>
<a href="#">R9-17-318.</a>	<a href="#">Security .....</a>	<a href="#">39</a>			

#### Questions about these rules? Contact:

Department: Department of Health Services  
Address: Public Health Licensing Services  
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Website: <https://www.azdhs.gov>  
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**The release of this Chapter in Supp. 24-4 replaces Supp. 23-3, 1-63 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 9. HEALTH SERVICES

## CHAPTER 17. DEPARTMENT OF HEALTH SERVICES - MEDICAL MARIJUANA PROGRAM

Authority: A.R.S. §§ 36-136(G), 36-2803 and 36-2854

## Supp. 24-4

*Editor's Note: Under A.R.S. 41-1011(C) Table 3.1 referenced in this Chapter now includes the table name Analytes for clarity. This change did not alter the sense, meaning or effect of any rule in this Chapter (Supp. 21-2).*

*Editor's Note: To assist with compliance of exempt rules filed and effective January 15, 2021, the Administrative Rules Division has expedited the publication of this Chapter and released it in Supp. 20-4. Multiple notice filings were received with amendments to the same Sections in this supplement release. For versioning of these Sections, refer to the published notice in the Arizona Administrative Register (Supp. 20-4).*

*Editor's Note: Section R9-17-102 and its historical note were inadvertently removed in Supp. 20-2; the Section and historical note have been restored as last amended in Supp. 19-3 (Supp. 20-3).*

*Editor's Note: This Chapter was adopted under a one-year exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Proposition 203 passed by the voters in November 2010. Although exempt from certain provisions of the rulemaking process, Section 6 of the Proposition required the Department to provide the public with an opportunity to comment on these rules before publishing the exempted rules. The Department posted proposed rules for comment on its web site, conducted statewide public meetings and also posted public comments received on its web site. (Supp. 11-2).*

*Editor's Note: 9 A.A.C. 17, formerly contained the rules of the Department of Health Services - Pure Food Control. This Chapter expired under A.R.S. § 41-1056(E) at 13 A.A.R. 3531, effective August 31, 2007 (Supp. 07-3).*

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## ARTICLE 1. GENERAL

**R9-17-101. Definitions**

In addition to the definitions in A.R.S. § 36-2801, the following definitions apply in this Chapter unless otherwise stated:

1. "Accreditation" means being deemed as technically competent under ISO 17025 by the:
  - a. American Association of Laboratory Accreditation,
  - b. Perry Johnson Laboratory Accreditation,
  - c. ANSI National Accreditation Board,
  - d. International Accreditation Services, or
  - e. Commission on Office Laboratory Accreditation.
2. "Acquire" means to obtain through any type of transaction and from any source.
3. "Activities of daily living" means ambulating, bathing, dressing, grooming, eating, toileting, and getting in and out of bed.
4. "Amend" means adding or deleting information on an individual's registry identification card that affects the individual's ability to perform or delegate a specific act or function.
5. "Analyte" means a specific substance for which testing is performed by a laboratory.
6. "Applicant" means:
  - a. An individual submitting an application for a registry identification card or to amend, change, or replace a registry identification card for a qualifying patient, designated caregiver, dispensary agent, or laboratory agent;
  - b. An entity submitting an application for a dispensary registration certificate or approval to operate a dispensary; or
  - c. An individual or entity submitting an application for a laboratory registration certificate, approval to test, or approval to change parameters.
7. "Batch" means:
  - a. When referring to cultivated medical marijuana, a specific lot of medical marijuana that is uniform in strain, grown from one or more seeds or cuttings that are planted and harvested at the same time, and cultivated under the same conditions;
  - b. When referring to marijuana products, a specific amount of a marijuana product infused, manufactured, or prepared for sale from the same set of ingredients at the same time; and
  - c. When referring to a laboratory testing medical marijuana or a marijuana product according to R9-17-404.03, a specific set of no more than 20 samples prepared and tested during the same run using the same equipment.
8. "Batch number" means a unique numeric or alphanumeric identifier assigned to a batch by a dispensary when:
  - a. The batch of medical marijuana is planted, or
  - b. The batch of a marijuana product is infused, manufactured, or prepared for sale.
9. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
10. "Change" means:
  - a. When used in relation to a registry identification card, adding or deleting information on an individual's registry identification card that does not substantively affect the individual's ability to perform or delegate a specific act or function;
  - b. When used in relation to a place, moving to a different location;
  - c. When used in relation to an individual, selecting a different individual to perform specific actions;
  - d. When used in relation to parameters, revising a laboratory's standard operating procedures or quality assurance plan, required in R9-17-404.06, due to:
    - i. Adding or removing a parameter,
    - ii. Altering a testing method, or
    - iii. Using a different instrument for performing a test; and
  - e. When used in relation to testing results, altering the testing results in any way and for any reason.
11. "Commercial device" means a "commercial device," as defined in A.R.S. § 3-3401, that is licensed or certified according to A.R.S. § 3-3451.
12. "Contaminant" means matter, pollutant, hazardous substance, or other substance that is not intended to be part of dispensed medical marijuana or a marijuana product.
13. "Cultivation site" means the one additional location where marijuana may be cultivated, infused, or prepared for sale by and for a dispensary.
14. "Current photograph" means an image of an individual, taken no more than 60 calendar days before the submission of the individual's application, in a Department-approved electronic format capable of producing an image that:
  - a. Has a resolution of at least 600 x 600 pixels but not more than 1200 x 1200 pixels;
  - b. Is 2 inches by 2 inches in size;
  - c. Is in natural color;
  - d. Is a front view of the individual's full face, without a hat or headgear that obscures the hair or hairline;
  - e. Has a plain white or off-white background; and
  - f. Has between 1 and 1 3/8 inches from the bottom of the chin to the top of the head.
15. "Denial" means the Department's final decision not to issue a registry identification card, a dispensary registration certificate, a laboratory registration certificate, or an approval of a change of dispensary or a dispensary's cultivation site location, to an applicant because the applicant or the application does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.
16. "Dispensary" means the same as "nonprofit medical marijuana dispensary" as defined in A.R.S. § 36-2801.
17. "Dispensary agent" means the same as "nonprofit medical marijuana dispensary agent" as defined in A.R.S. § 36-2801.
18. "Dual licensee" means the same as in A.R.S. § 36-2850.
19. "Edible food product" means a substance, beverage, or ingredient used or intended for use or for sale in whole or in part for human oral consumption.
20. "Enclosed area" when used in conjunction with "enclosed, locked facility" means outdoor space surrounded by solid, 10-foot walls, constructed of metal, concrete, or stone that prevent any viewing of the marijuana plants, and a 1-inch thick metal gate.
21. "Entity" means the same as in A.R.S. § 29-2102.
22. "Generally accepted accounting principles" means the set of financial reporting standards established by the Finan-

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- cial Accounting Standards Board, the Governmental Accounting Standards Board, or another specialized body dealing with accounting and auditing matters.
23. "Geographic area" means the same as in A.R.S. § 36-2803.01.
  24. "In-state financial institution" means the same as in A.R.S. § 6-101.
  25. "Inhalable" means intended for use through intake into the lungs of an individual.
  26. "Laboratory" means the same as "independent third-party laboratory" as defined in A.R.S. § 36-2801.
  27. "Laboratory agent" means the same as "independent third-party laboratory agent" as defined in A.R.S. § 36-2801.
  28. "Legal guardian" means an adult who is responsible for a minor:
    - a. Through acceptance of guardianship of the minor through a testamentary appointment or an appointment by a court pursuant to A.R.S. Title 14, Chapter 5, Article 2; or
    - b. As a "custodian" as defined in A.R.S. § 8-201.
  29. "Manufacture" or "manufactured" means the same as in A.R.S. § 36-2850.
  30. "Marijuana establishment" means the same as in A.R.S. § 36-2850.
  31. "Marijuana facility agent" means the same as in A.R.S. § 36-2850.
  32. "Marijuana product" means the same as in A.R.S. § 36-2850.
  33. "Matrix" means the specific components of a sample, other than the analyte being tested for.
  34. "Medical record" means the same as:
    - a. "Adequate records" as defined in A.R.S. § 32-1401,
    - b. "Adequate medical records" as defined in A.R.S. § 32-1501,
    - c. "Adequate records" as defined in A.R.S. § 32-1800, or
    - d. "Adequate records" as defined in A.R.S. § 32-2901.
  35. "Out-of-state financial institution" means the same as in A.R.S. § 6-101.
  36. "Parameter" means the combination of a particular type of sample with a specific instrument or equipment by which the sample will be tested for a specific analyte or characteristic.
  37. "Proficiency testing" means a mechanism to determine a laboratory agent's ability to analyze samples within specific acceptance criteria in which the characteristics of the samples are known by the source of the samples but are unknown to a laboratory receiving the samples from the source.
  38. "Proficiency testing service" means an independent company or other person acceptable to the Department, based on ISO/IEC 17043:2010 certification, that:
    - a. Is the source for samples with known characteristics for proficiency testing, and
    - b. Assesses the acceptability of a laboratory agent's results from the samples with known characteristics during proficiency testing.
  39. "Private school" means the same as in A.R.S. § 15-101.
  40. "Public school" means the same as "school" as defined in A.R.S. § 15-101.
  41. "Registry identification number" means the random 20-digit alphanumeric identifier generated by the Department, containing at least four numbers and four letters, issued by the Department to a qualifying patient, designated caregiver, dispensary, dispensary agent, laboratory, or laboratory agent.
  42. "Revocation" means the Department's final decision that an individual's registry identification card, a dispensary registration certificate, or a laboratory registration certificate is rescinded because the individual, the dispensary, or the laboratory does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.
  43. "Sample" means:
    - a. A representative portion of a larger quantity of medical marijuana or a marijuana product,
    - b. A specific quantity of a substance or set of substances to be used for testing purposes, or
    - c. To collect the representative portion in subsection (39)(a).
  44. "Time/temperature control for safety food" means the same as in the Food Code: 2017 Recommendations of the United States Public Health Service, Food and Drug Administration, § 1-201.10.
  45. "Topical" means intended for use through application to the surface of the skin of an individual.
  46. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a state-wide furlough day.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Subsection reference to (39)(a) in subsection (41)(c) corrected to (41)(a); Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-102. Fees**

- A. An applicant submitting an application to the Department shall submit the following nonrefundable fees:
  1. For registration of a dispensary, \$4,000;
  2. To renew the registration of a dispensary, \$1,000;
  3. To change the location of a dispensary, \$2,500;
  4. To change the location of a dispensary's cultivation site or add a cultivation site, \$2,500;
  5. To change activities conducted at the current location of a dispensary or add activities at a new location for a dispensary, \$2,500;
  6. For a registry identification card for a:
    - a. Qualifying patient, except as provided in subsection (B), \$150;
    - b. Designated caregiver, \$200;
    - c. Dispensary agent, \$500; and
    - d. Laboratory agent, \$500;
  7. For renewing a registry identification card for a:

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- a. Qualifying patient, except as provided in subsection (B), \$150;
- b. Designated caregiver, \$200;
- c. Dispensary agent, \$500; and
- d. Laboratory agent, \$500;
8. For amending or changing a registry identification card, \$10;
9. For requesting a replacement registry identification card, \$10;
10. For registration of a laboratory, \$5,000; and
11. To renew the registration of a laboratory, \$1,000.

**B.** A qualifying patient may pay a reduced fee of \$75 if the qualifying patient submits, with the qualifying patient's application for a registry identification card or the qualifying patient's application to renew the qualifying patient's registry identification card, a copy of an eligibility notice or electronic benefits transfer card demonstrating current participation in the U.S. Department of Agriculture, Food and Nutrition Services, Supplemental Nutrition Assistance Program.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Section R9-17-102 and its historical note were inadvertently removed in Supp. 20-2; the Section and historical note have been restored as last amended in Supp. 19-3 (Supp. 20-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-103. Repealed****Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Repealed by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-104. Changing Information on a Registry Identification Card**

Except as provided in R9-17-203(B) and (C), to make a change to a cardholder's name or address on the cardholder's registry identification card, the cardholder shall submit to the Department, within 10 working days after the change, a request for the change that includes:

1. The cardholder's name and the registry identification number on the cardholder's current registry identification card;
2. The cardholder's new name or address, as applicable;
3. For a change in the cardholder's name, one of the following with the cardholder's new name:
  - a. An Arizona driver's license,
  - b. An Arizona identification card, or
  - c. The photograph page in the cardholder's U.S. passport or a U.S. passport card;

4. For a change in address, the county where the new address is located;
5. The effective date of the cardholder's new name or address; and
6. The applicable fee in R9-17-102 for changing a registry identification card.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-105. Requesting a Replacement Registry Identification Card**

To request a replacement card for a cardholder's registry identification card that has been lost, stolen, or destroyed, the cardholder shall submit to the Department, within 10 working days after the cardholder's registry identification card was lost, stolen, or destroyed, a request for a replacement card that includes:

1. The cardholder's name and date of birth;
2. If known, the registry identification number on the cardholder's lost, stolen, or destroyed registry identification card;
3. If the cardholder cannot provide the registry identification number on the cardholder's lost, stolen, or destroyed registry identification card, a copy of one of the following documents that the cardholder submitted when the cardholder obtained the registry identification card:
  - a. Arizona driver's license,
  - b. Arizona identification card,
  - c. Arizona registry identification card, or
  - d. Photograph page in the cardholder's U.S. passport or a U.S. passport card; and
4. The applicable fee in R9-17-102 for requesting a replacement registry identification card.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-106. Adding a Debilitating Medical Condition**

**A.** An entity may request the addition of a medical condition to the list of debilitating medical conditions in R9-17-201 by submitting to the Department, at the times specified in subsection (C), the following in writing:

1. The entity's name;
2. The entity's mailing address, name of contact individual, telephone number, and, if applicable, e-mail address;
3. The name of the medical condition the entity is requesting be added;
4. A description of the symptoms and other physiological effects experienced by an individual suffering from the medical condition or a treatment of the medical condition that may impair the ability of the individual to accomplish activities of daily living;
5. The availability of conventional medical treatments to provide therapeutic or palliative benefit for the medical condition or a treatment of the medical condition;
6. A summary of the evidence that the use of marijuana will provide therapeutic or palliative benefit for the medical condition or a treatment of the medical condition; and
7. Articles, published in peer-reviewed scientific journals, reporting the results of research on the effects of mari-



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juana on the medical condition or a treatment of the medical condition supporting why the medical condition should be added.

**B.** The Department shall:

1. Acknowledge in writing the Department's receipt of a request for the addition of a medical condition to the list of debilitating medical conditions listed in R9-17-201 within 30 calendar days after receiving the request;
2. Review the request to determine if the requester has provided evidence that:
  - a. The specified medical condition or treatment of the medical condition impairs the ability of the individual to accomplish activities of daily living, and
  - b. Marijuana usage provides a therapeutic or palliative benefit to an individual suffering from the medical condition or treatment of the medical condition;
3. Within 90 calendar days after receiving the request, notify the requester that the Department has determined that the information provided by the requester:
  - a. Meets the requirements in subsection (B)(2) and the date the Department will conduct a public hearing to discuss the request; or
  - b. Does not meet the requirements in subsection (B)(2), the specific reason for the determination, and the process for requesting judicial review of the Department's determination pursuant to A.R.S. Title 12, Chapter 7, Article 6;
4. If applicable:
  - a. Schedule a public hearing to discuss the request;
  - b. Provide public notice of the public hearing by submitting a Notice of Public Information to the Office of the Secretary of State, for publication in the *Arizona Administrative Register* at least 30 calendar days before the date of the public hearing;
  - c. Post a copy of the request on the Department's web site for public comment at least 30 calendar days before the date of the public hearing; and
  - d. Hold the public hearing no more than 150 calendar days after receiving the request; and
5. Within 180 calendar days after receiving the request:
  - a. Add the medical condition to the list of debilitating medical conditions, or
  - b. Provide written notice to the requester of the Department's decision to deny the request that includes:
    - i. The specific reasons for the Department's decision; and
    - ii. The process for requesting judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

**C.** The Department shall accept requests for the addition of a medical condition to the list of debilitating medical conditions in R9-17-201 in January and July of each calendar year starting in January 2012.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2).

**R9-17-107. Time-frames**

- A.** Within the administrative completeness review time-frame for each type of approval in Table 1.1, the Department shall:
1. Issue a registry identification card, a dispensary registration certificate, an approval to operate a dispensary, an approval of a change to a dispensary registration certificate,

a laboratory registration certificate, an approval for testing, or an approval to add a parameter;

2. Provide a notice of administrative completeness to an applicant; or
  3. Provide a notice of deficiencies to an applicant, including a list of the information or documents needed to complete the application.
- B.** An application for approval to operate a dispensary or for a change to a dispensary registration certificate is not complete until the date the applicant states on a written notice provided to the Department according to R9-17-305 or R9-17-307, as applicable, that the dispensary is ready for an inspection by the Department.
- C.** A laboratory's application for approval for testing or to add a parameter is not complete until the date the applicant states on a written notice provided to the Department according to R9-17-402.01 or R9-17-404.07, as applicable, that the laboratory is ready for an inspection by the Department.
- D.** If the Department provides a notice of deficiencies to an applicant:
1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant; and
  2. The Department shall consider the application withdrawn if the applicant does not submit the missing information or documents to the Department within the time-frame in Table 1.1.
- E.** Within the substantive review time-frame for each type of approval in Table 1.1, the Department:
1. According to subsection (H), shall issue or deny:
    - a. A registry identification card, dispensary registration certificate, or laboratory registration certificate; or
    - b. Approval to operate a dispensary, approval for a change to a dispensary registration certificate, approval for testing, or approval to add a parameter;
  2. May complete an inspection that may require more than one visit to a dispensary and, if applicable, the dispensary's cultivation site;
  3. May complete an inspection that may require more than one visit to a laboratory; and
  4. May make one written comprehensive request for more information, unless the Department and the applicant agree in writing to allow the Department to submit supplemental requests for information.
- F.** If the Department issues a written comprehensive request or a supplemental request for information:
1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives all of the information requested, and
  2. The applicant shall submit to the Department all of the information and documents listed in the written comprehensive request or supplemental request for information within the time-frame in Table 1.1.
- G.** If an applicant for an initial dispensary registration certificate is allocated a dispensary registration certificate as provided in R9-17-303, the Department shall provide a written notice to the applicant of the allocation of the dispensary registration certificate and issue the dispensary registration certificate.



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- H.** If an application for an initial laboratory registration certificate is approved, the Department shall review the information and documents submitted according to R9-17-402(A)(4) and:
1. If the information and documents for at least one of the owners comply with the A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue:
    - a. A laboratory agent registry identification card to any owner who complies with A.R.S. Title 36, Chapter 28.1 and this Chapter; and
    - b. The laboratory registration certificate; and
  2. If the information and documents submitted according to R9-17-402(A)(4) for an owner do not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall deny the owner a laboratory agent registry identification card and provide notice to the owner and to the laboratory that includes:
    - a. The specific reasons for the denial; and
    - b. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
- I.** The Department shall issue:
1. A registry identification card, renewal of a dispensary registration certificate, an approval to operate a dispensary, an approval for a change to a dispensary registration certificate, a renewal of a laboratory registration certificate, an approval for testing, or an approval to add a parameter, as applicable, if the Department determines that the applicant complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;
  2. For an applicant for a registry identification card, a denial that includes the reason for the denial and the process for requesting judicial review if:
    - a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter; or
    - b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information;
  3. For an applicant for an initial dispensary registration certificate, if the Department determines that the dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter:
    - a. A dispensary registration certificate, if not all available dispensary registration certificates have been allocated according to the criteria and processes in R9-17-303; or
    - b. Written notice that:
      - i. The dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;
      - ii. The applicant was not allocated a dispensary registration certificate according to the criteria and processes in R9-17-303 because all available dispensary registration certificates have been allocated according to the criteria and processes in R9-17-303; and
      - iii. The written notice is not a denial and is not considered a final decision of the Department subject to administrative review; or
  4. For an applicant for a dispensary registration certificate, an approval to operate, an approval for a change to a dispensary registration certificate, a laboratory registration certificate, an approval for testing, or an approval to add a parameter, a denial that includes the reason for the denial and the process for administrative review if:
    - a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter; or
    - b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 968, effective April 20, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**Table 1.1 Time-frames**

Type of approval	Authority (A.R.S. § or A.A.C.)	Overall Time-frame (in working days)	Time-frame for applicant to complete application (in working days)	Administrative Completeness Time-frame (in working days)	Substantive Review Time-frame (in working days)	Response Time for Request in R9-17-107(F)(2) (in working days)
Changing a registry identification card	§ 36-2808	10	10	5	5	10
Requesting a replacement registry identification card	§ 36-2804.06	5	5	2	3	10

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Applying for a registry identification card for a qualifying patient or a designated caregiver	§ 36-2804.02(A)	15	30	5	10	10
Amending a registry identification card for a qualifying patient or a designated caregiver	§ 36-2808	10	30	5	5	10
Renewing a qualifying patient's or designated caregiver's registry identification card	§§ 36-2804.02(A) and 36-2804.06	15	30	5	10	10
Applying for a dispensary registration certificate	§ 36-2804	30	10	5	25	10
Applying for approval to operate a dispensary	R9-17-305	45	90	15	30	60
Changing a dispensary registration certificate	§ 36-2804 and R9-17-307	90	90	30	60	60
Renewing a dispensary registration certificate	§ 36-2804.06	15	30	5	10	10
Applying for a dispensary agent registry identification card	§§ 36-2804.01 and 36-2804.03	15	30	5	10	10
Renewing a dispensary agent's registry identification card	§ 36-2804.06	15	30	5	10	10
Applying for a laboratory registration certificate	§ 36-2804.07	90	90	30	60	60
Applying for approval for testing	R9-17-402.01	90	90	30	60	120
Renewing a laboratory registration certificate	§ 36-2804.06	15	30	5	10	60
Applying to add a parameter	R9-17-404.07	90	90	30	60	120
Applying for a laboratory agent registry identification card	§ 36-2804.01	15	30	5	10	10
Renewing a laboratory agent's registry identification card	§ 36-2804.06	15	30	5	10	10

**Historical Note**

New Table 1.1 made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Table 1.1 amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired; Table 1.1 amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Section symbols added to A.R.S. citations (Supp. 17-2). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 968, effective April 20, 2020 (Supp. 20-2). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

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**R9-17-108. Expiration of a Registry Identification Card, Dispensary Registration Certificate, or Laboratory Registration Certificate**

- A. Except as provided in subsection (B), a registry identification card issued to a qualifying patient, designated caregiver, dispensary agent, or laboratory agent is valid for two years after the date of issuance.
- B. If the Department issues a registry identification card to a qualifying patient, designated caregiver, dispensary agent, or laboratory agent based on a request for a replacement registry identification card or an application to change or amend a registry identification card, the replacement, changed, or amended registry identification card shall have the same expiration date as the registry identification card being replaced, changed, or amended.
- C. Except as provided in subsection (D), a dispensary registration certificate is valid for two years after the date of issuance.
- D. If the Department issues an amended dispensary registration certificate based on a change of location or an addition of a cultivation site, the dispensary registration certificate shall have the same expiration date as the dispensary registration certificate previously held by the dispensary.
- E. An approval to operate a dispensary shall have the same expiration date as the dispensary registration certificate associated with the approval to operate the dispensary.
- F. A laboratory registration certificate is valid for two years after the original date of issuance.
- G. A laboratory's approval for testing shall have the same expiration date as the laboratory registration certificate associated with the laboratory's approval to test.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3).

**R9-17-109. Notifications and Void Registry Identification Cards**

- A. The Department shall provide written notice that a cardholder's registry identification card is void and no longer valid under A.R.S. Title 36, Chapter 28.1 and this Chapter to a:
  - 1. Qualifying patient when the Department receives notification from:
    - a. The qualifying patient that the qualifying patient no longer has a debilitating medical condition, or
    - b. The physician who provided the qualifying patient's written certification that the:
      - i. Qualifying patient no longer has a debilitating medical condition,
      - ii. Physician no longer believes that the qualifying patient would receive therapeutic or palliative benefit from the medical use of marijuana, or
      - iii. Physician believes that the qualifying patient is not using the medical marijuana as recommended;
  - 2. Designated caregiver when:
    - a. The Department receives notification from the designated caregiver's qualifying patient that the designated caregiver no longer assists the qualifying patient with the medical use of marijuana, or

- b. The registry identification card for the qualifying patient that is listed on the designated caregiver's registry identification card is no longer valid;
  - 3. Dispensary agent when:
    - a. The Department receives the written notification, required in R9-17-310(A)(10), that the dispensary agent:
      - i. No longer serves as a principal officer, board member, or medical director for the dispensary;
      - ii. Is no longer employed by the dispensary; or
      - iii. No longer provides volunteer service at or on behalf of the dispensary; or
    - b. The registration certificate for the dispensary that is listed on the dispensary agent's registry identification card is no longer valid; or
  - 4. Laboratory agent when:
    - a. The Department receives the written notification, required in R9-17-404(10), that the laboratory agent no longer:
      - i. Serves as an owner for the laboratory,
      - ii. Is employed by the laboratory, or
      - iii. Provides volunteer service at or on behalf of the laboratory; or
    - b. The registration certificate for the laboratory that is listed on the laboratory agent's registration identification card is no longer valid.
- B. The Department shall void a qualifying patient's registry identification card:
  - 1. When the Department receives notification that the qualifying patient is deceased; or
  - 2. For a qualifying patient under 18 years of age, when the qualifying patient's designated caregiver's registry identification card is revoked.
- C. The written notice required in subsection (A) that a registry identification card is void is not a revocation and is not considered a final decision of the department subject to judicial review.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS****R9-17-201. Debilitating Medical Conditions**

An individual applying for a qualifying patient registry identification card shall have a diagnosis from a physician of at least one of the following debilitating medical conditions:

- 1. Cancer;
- 2. Glaucoma;
- 3. Human immunodeficiency virus;
- 4. Acquired immune deficiency syndrome;
- 5. Hepatitis C;
- 6. Amyotrophic lateral sclerosis;
- 7. Crohn's disease;
- 8. Agitation of Alzheimer's disease;
- 9. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or med-

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- ical condition that produces cachexia or wasting syndrome;
10. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe and chronic pain;
  11. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe nausea;
  12. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces seizures, including those characteristic of epilepsy;
  13. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe or persistent muscle spasms, including those characteristic of multiple sclerosis;
  14. Post-traumatic stress disorder for which the individual is receiving treatment; or
  15. A debilitating medical condition approved by the Department under A.R.S. § 36-2801.01 and R9-17-106.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver**

- A. Except for a qualifying patient who is under 18 years of age, a qualifying patient is not required to have a designated caregiver.
- B. A qualifying patient may have only one designated caregiver at any given time.
- C. Except for a qualifying patient who is under 18 years of age, if the information submitted for a qualifying patient complies with A.R.S. Title 36, Chapter 28.1 and this Chapter but the information for the qualifying patient's designated caregiver does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue the registry identification card for the qualifying patient separate from issuing a registry identification card for the qualifying patient's designated caregiver.
- D. If the Department issues a registry identification card to a qualifying patient under subsection (C), the Department shall continue the process for issuing or denying the qualifying patient's designated caregiver's registry identification card.
- E. The Department shall not issue a designated caregiver's registry identification card before the Department issues the designated caregiver's qualifying patient's registry identification card.
- F. Except as provided in subsection (G), to apply for a registry identification card, a qualifying patient shall submit to the Department the following:
  1. An application in a Department-provided format that includes:
    - a. The qualifying patient's:
      - i. First name; middle initial, if applicable; last name; and suffix, if applicable;
      - ii. Date of birth; and
      - iii. Gender;
    - b. Except as provided in subsection (F)(1)(i), the qualifying patient's Arizona residence address and Arizona mailing address;
  2. A copy of the qualifying patient's:
    - a. Arizona driver's license issued on or after October 1, 1996;
    - b. Arizona identification card issued on or after October 1, 1996;
    - c. Arizona registry identification card;
    - d. Photograph page in the qualifying patient's U.S. passport or a U.S. passport card; or
    - e. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the qualifying patient:
      - i. Birth certificate verifying U.S. citizenship,
      - ii. U.S. Certificate of Naturalization, or
      - iii. U.S. Certificate of Citizenship;
  3. A current photograph of the qualifying patient;
  4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  5. A physician's written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's application that includes:
    - a. The physician's:
      - i. Name,
      - ii. License number including an identification of the physician license type,
      - iii. Office address on file with the physician's licensing board,
      - iv. Telephone number on file with the physician's licensing board, and
      - v. Email address;
    - b. The qualifying patient's name and date of birth;
    - c. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;

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- d. An identification, initialed by the physician, of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
  - e. If the debilitating medical condition identified in subsection (F)(5)(d) is a condition in:
    - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
    - ii. R9-17-201(14), the debilitating medical condition;
  - f. A statement, initialed by the physician, that the physician:
    - i. Has established a medical record for the qualifying patient, and
    - ii. Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;
  - g. A statement, initialed by the physician, that the physician has conducted a physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
  - h. The date the physician conducted the physical examination of the qualifying patient;
  - i. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
    - i. Medical records including medical records from other treating physicians from the previous 12 months,
    - ii. Response to conventional medications and medical therapies, and
    - iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
  - j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;
  - k. A statement, initialed by the physician, that, in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
  - l. A statement, initialed by the physician, that, if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
  - m. A statement, initialed by the physician, that the physician has provided information to the qualifying patient, if the qualifying patient is female, that warns about:
    - i. The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
    - ii. The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;
  - n. An attestation that the information provided in the written certification is true and correct; and
  - o. The physician's signature and the date the physician signed;
6. If the qualifying patient is designating a caregiver, the following in a Department-provided format:
    - a. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
    - b. The designated caregiver's date of birth;
    - c. The designated caregiver's Arizona residence address and Arizona mailing address;
    - d. The county where the designated caregiver resides;
    - e. The identifying number on the applicable card or document in subsection (F)(6)(h)(i) through (v);
    - f. An attestation signed and dated by the designated caregiver that the designated caregiver:
      - i. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
      - ii. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
    - g. A statement signed by the designated caregiver:
      - i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
      - ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
    - h. A copy of the designated caregiver's:
      - i. Arizona driver's license issued on or after October 1, 1996;
      - ii. Arizona identification card issued on or after October 1, 1996;
      - iii. Arizona registry identification card;
      - iv. Photograph page in the designated caregiver's U.S. passport or a U.S. passport card; or
      - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
        - (1) Birth certificate verifying U.S. citizenship,
        - (2) U.S. Certificate of Naturalization, or
        - (3) U.S. Certificate of Citizenship;
    - i. A current photograph of the designated caregiver; and
    - j. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
      - i. The designated caregiver's fingerprints on a fingerprint card that includes:
        - (1) The designated caregiver's first name; middle initial, if applicable; and last name;
        - (2) The designated caregiver's signature;
        - (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver's fingerprints;
        - (4) The designated caregiver's address;
        - (5) If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
        - (6) The designated caregiver's date of birth;
        - (7) The designated caregiver's Social Security number;
        - (8) The designated caregiver's citizenship status;

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- (9) The designated caregiver's gender;
      - (10) The designated caregiver's race;
      - (11) The designated caregiver's height;
      - (12) The designated caregiver's weight;
      - (13) The designated caregiver's hair color;
      - (14) The designated caregiver's eye color; and
      - (15) The designated caregiver's place of birth;
    - ii. If the designated caregiver's fingerprints and information required in subsection (F)(6)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; or
    - iii. Documentation that the designated caregiver has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
  - 7. The applicable fees in R9-17-102 for applying for:
    - a. A qualifying patient registry identification card; and
    - b. If applicable, a designated caregiver registry identification card.
- G.** To apply for a registry identification card for a qualifying patient who is under 18 years of age, the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient shall submit to the Department the following:
- 1. An application in a Department-provided format that includes:
    - a. The qualifying patient's:
      - i. First name; middle initial, if applicable; last name; and suffix, if applicable;
      - ii. Date of birth; and
      - iii. Gender;
    - b. The qualifying patient's Arizona residence address and Arizona mailing address;
    - c. The county where the qualifying patient resides;
    - d. The qualifying patient's custodial parent's or legal guardian's first name; middle initial, if applicable; last name; and suffix, if applicable;
    - e. The identifying number on the applicable card or document in subsection (G)(5)(a) through (e);
    - f. The qualifying patient's custodial parent's or legal guardian's Arizona residence address and Arizona mailing address;
    - g. The county where the qualifying patient's custodial parent or legal guardian resides;
    - h. The qualifying patient's custodial parent's or legal guardian's email address;
    - i. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;
    - j. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the patient's medical record, maintained by other treating physicians, and is providing a written certification for medical marijuana for the qualifying patient;
  - k. The qualifying patient's custodial parent's or legal guardian's date of birth;
  - l. Whether the qualifying patient's custodial parent or legal guardian is requesting authorization for cultivating medical marijuana plants for the qualifying patient's medical use because the qualifying patient's custodial parent or legal guardian believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
  - m. Whether the qualifying patient's custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
  - n. Whether the individual submitting the application on behalf of the qualifying patient under 18 years of age is the qualifying patient's custodial parent or legal guardian;
  - o. An attestation that the information provided in the application is true and correct; and
  - p. The signature of the qualifying patient's custodial parent or legal guardian and the date the qualifying patient's custodial parent or legal guardian signed;
- 2. A current photograph of the:
    - a. Qualifying patient, and
    - b. Qualifying patient's custodial parent or legal guardian serving as the qualifying patient's designated caregiver;
  - 3. An attestation in a Department-provided format signed and dated by the qualifying patient's custodial parent or legal guardian that the qualifying patient's custodial parent or legal guardian:
    - a. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
    - b. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
  - 4. A statement in a Department-provided format signed by the qualifying patient's custodial parent or legal guardian who is serving as the qualifying patient's designated caregiver:
    - a. Allowing the qualifying patient's medical use of marijuana;
    - b. Agreeing to assist the qualifying patient with the medical use of marijuana; and
    - c. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  - 5. A copy of one of the following for the qualifying patient's custodial parent or legal guardian:
    - a. Arizona driver's license issued on or after October 1, 1996;
    - b. Arizona identification card issued on or after October 1, 1996;
    - c. Arizona registry identification card;
    - d. Photograph page in the qualifying patient's custodial parent or legal guardian U.S. passport or a U.S. passport card; or
    - e. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the qualifying patient's custodial parent or legal guardian:
      - i. Birth certificate verifying U.S. citizenship,
      - ii. U. S. Certificate of Naturalization, or

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- iii. U. S. Certificate of Citizenship;
  - 6. If the individual submitting the application on behalf of a qualifying patient is the qualifying patient's legal guardian, a copy of documentation establishing the individual as the qualifying patient's legal guardian;
  - 7. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
    - a. The qualifying patient's custodial parent or legal guardian's fingerprints on a fingerprint card that includes:
      - i. The qualifying patient's custodial parent or legal guardian's first name; middle initial, if applicable; and last name;
      - ii. The qualifying patient's custodial parent or legal guardian's signature;
      - iii. If different from the qualifying patient's custodial parent or legal guardian, the signature of the individual physically rolling the qualifying patient's custodial parent's or legal guardian's fingerprints;
      - iv. The qualifying patient's custodial parent's or legal guardian's address;
      - v. If applicable, the qualifying patient's custodial parent's or legal guardian's surname before marriage and any names previously used by the qualifying patient's custodial parent or legal guardian;
      - vi. The qualifying patient's custodial parent's or legal guardian's date of birth;
      - vii. The qualifying patient's custodial parent's or legal guardian's Social Security number;
      - viii. The qualifying patient's custodial parent's or legal guardian's citizenship status;
      - ix. The qualifying patient's custodial parent's or legal guardian's gender;
      - x. The qualifying patient's custodial parent's or legal guardian's race;
      - xi. The qualifying patient's custodial parent's or legal guardian's height;
      - xii. The qualifying patient's custodial parent's or legal guardian's weight;
      - xiii. The qualifying patient's custodial parent's or legal guardian's hair color;
      - xiv. The qualifying patient's custodial parent's or legal guardian's eye color; and
      - xv. The qualifying patient's custodial parent's or legal guardian's place of birth;
    - b. If the qualifying patient's custodial parent's or legal guardian's fingerprints and information required in subsection (G)(7)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the qualifying patient's custodial parent or legal guardian as a result of the application;
    - c. Documentation that the qualifying patient's custodial parent or legal guardian has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
  - 8. A written certification from the physician in subsection (G)(1)(i) and a separate written certification from the physician in (G)(1)(j) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's application that includes:
    - a. The physician's:
      - i. Name,
      - ii. License number including an identification of the physician license type,
      - iii. Office address on file with the physician's licensing board,
      - iv. Telephone number on file with the physician's licensing board, and
      - v. Email address;
    - b. The qualifying patient's name and date of birth;
    - c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
    - d. If the debilitating medical condition identified in subsection (G)(9)(c) is a condition in:
      - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
      - ii. R9-17-201(14), the debilitating medical condition;
    - e. For the physician listed in subsection (G)(1)(i):
      - i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
      - ii. A statement, initialed by the physician, that the physician:
        - (1) Has established a medical record for the qualifying patient, and
        - (2) Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;
      - iii. A statement, initialed by the physician, that the physician has conducted a physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
      - iv. The date the physician conducted the physical examination of the qualifying patient;
      - v. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
        - (1) Medical records, including medical records from other treating physicians from the previous 12 months,
        - (2) Response to conventional medications and medical therapies, and
        - (3) Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
      - vi. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of medical marijuana to the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient; and
      - vii. A statement, initialed by the physician, that the physician has provided information to the qualifying patient's custodial parent or legal guard-

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ian responsible for health care decisions for the qualifying patient, if the qualifying patient is female, that warns about:

- (1) The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
  - (2) The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;
- f. For the physician listed in subsection (G)(1)(j), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient's medical records from other treating physicians;
  - g. A statement, initialed by the physician, that, in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
  - h. A statement, initialed by the physician, that, if the physician has referred the qualifying patient's custodial parent or legal guardian to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
  - i. An attestation that the information provided in the written certification is true and correct; and
  - j. The physician's signature and the date the physician signed; and
9. The applicable fees in R9-17-102 for applying for a:
    - a. Qualifying patient registry identification card, and
    - b. Designated caregiver registry identification card.
- H.** For purposes of this Article, "25 miles" includes the area contained within a circle that extends for 25 miles in all directions from a specific location.
- I.** For purposes of this Article, "residence address" when used in conjunction with a qualifying patient means:
1. The street address including town or city and zip code assigned by a local jurisdiction; or
  2. For property that does not have a street address assigned by a local jurisdiction, the legal description of the property on the title documents recorded by the assessor of the county in which the property is located.
- Historical Note**
- New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by final rulemaking 23 A.A.R. 970, effective June 6, 2017 (Supp. 17-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).
- R9-17-203. Amending a Qualifying Patient's or Designated Caregiver's Registry Identification Card**
- A. To add a designated caregiver or to request a change of a qualifying patient's designated caregiver, the qualifying patient shall submit to the Department, within 10 working days after the addition or the change, the following:
    1. An application in a Department-provided format that includes:
      - a. The qualifying patient's name and the registry identification number on the qualifying patient's current registry identification card;
      - b. If applicable, the name of the qualifying patient's current designated caregiver and the date the designated caregiver last provided or will last provide assistance to the qualifying patient;
      - c. The name of the individual the qualifying patient is designating as caregiver; and
      - d. The signature of the qualifying patient and date the qualifying patient signed;
    2. For the caregiver the qualifying patient is designating:
      - a. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
      - b. The designated caregiver's date of birth;
      - c. The designated caregiver's Arizona residence address and Arizona mailing address;
      - d. The county where the designated caregiver resides;
      - e. The identifying number on the applicable card or document in subsection (A)(2)(h)(i) through (v);
      - f. An attestation in a Department-provided format signed and dated by the designated caregiver that the designated caregiver has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;
      - g. A statement in a Department-provided format signed by the designated caregiver:
        - i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
        - ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
      - h. A copy the designated caregiver's:
        - i. Arizona driver's license issued on or after October 1, 1996;
        - ii. Arizona identification card issued on or after October 1, 1996;
        - iii. Arizona registry identification card;
        - iv. Photograph page in the designated caregiver's U.S. passport or a U.S. passport card; or
        - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
          - (1) Birth certificate verifying U.S. citizenship,
          - (2) U.S. Certificate of Naturalization, or
          - (3) U.S. Certificate of Citizenship;
      - i. A current photograph of the designated caregiver; and
      - j. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
        - i. The designated caregiver's fingerprints on a fingerprint card that includes:
          - (1) The designated caregiver's first name; middle initial, if applicable; and last name;
          - (2) The designated caregiver's signature;
          - (3) If different from the designated caregiver, the signature of the individual physically



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- rolling the designated caregiver's fingerprints;
- (4) The designated caregiver's address;
  - (5) If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
  - (6) The designated caregiver's date of birth;
  - (7) The designated caregiver's Social Security number;
  - (8) The designated caregiver's citizenship status;
  - (9) The designated caregiver's gender;
  - (10) The designated caregiver's race;
  - (11) The designated caregiver's height;
  - (12) The designated caregiver's weight;
  - (13) The designated caregiver's hair color;
  - (14) The designated caregiver's eye color; and
  - (15) The designated caregiver's place of birth;
- or
- ii. If the designated caregiver's fingerprints and information required in subsection (A)(2)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; and
3. The applicable fee in R9-17-102 for applying for a designated caregiver registry identification card.
- B.** To amend a qualifying patient's address on the qualifying patient's registry identification card when the qualifying patient or the qualifying patient's designated caregiver is authorized to cultivate marijuana, the qualifying patient shall submit to the Department, within 10 working days after the change in address, the following:
1. The qualifying patient's name and the registry identification number on the qualifying patient's current registry identification card;
  2. The qualifying patient's new address;
  3. The county where the new address is located;
  4. The name of the qualifying patient's designated caregiver, if applicable;
  5. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
  6. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient's designated caregiver to cultivate marijuana plants for the qualifying patient's medical use;
  7. The effective date of the qualifying patient's new address; and
  8. The applicable fee in R9-17-102 for applying to:
    - a. Amend a qualifying patient's registry identification card; and
    - b. If the qualifying patient is designating a designated caregiver for cultivation authorization, amend a designated caregiver's registry identification card.
- C.** To request authorization to cultivate marijuana based on a qualifying patient's current address or a new address, the qualifying patient shall submit to the Department, if applicable within 10 working days after the change in address, the following:
1. The qualifying patient's name and the registry identification number on the qualifying patient's current registry identification card;
  2. If the qualifying patient's address is a new address, the qualifying patient's:
    - a. Current address,
    - b. New address,
    - c. The county where the new address is located, and
    - d. The effective date of the qualifying patient's new address;
  3. The name of the qualifying patient's designated caregiver, if applicable;
  4. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
  5. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient's designated caregiver to cultivate marijuana plants for the qualifying patient's medical use; and
  6. The applicable fee in R9-17-102 for applying to:
    - a. Amend a qualifying patient's registry identification card; and
    - b. If the qualifying patient is designating a designated caregiver for cultivation authorization, amend a designated caregiver's registry identification card.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). The Department made a clerical error to R19-17-203(A)(1)(c) when promulgating rules in Supp. 12-4. Remediateor clarity "that" has been moved after "individual" at the request of the Department at file number R19-242 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-204. Renewing a Qualifying Patient's or Designated Caregiver's Registry Identification Card**

- A.** Except for a qualifying patient who is under 18 years of age, to renew a qualifying patient's registry identification card, the qualifying patient shall submit the following to the Department at least 30 calendar days before the expiration date of the qualifying patient's registry identification card:
1. An application in a Department-provided format that includes:
    - a. The qualifying patient's first name; middle initial, if applicable; last name; and suffix, if applicable;
    - b. The qualifying patient's date of birth;
    - c. Except as provided in subsection (A)(1)(j), the qualifying patient's Arizona residence address and Arizona mailing address;
    - d. The county where the qualifying patient resides;

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- e. The qualifying patient's email address;
  - f. The registry identification number on the qualifying patient's current registry identification card;
  - g. The name, address, and telephone number of the physician providing the written certification for medical marijuana for the qualifying patient;
  - h. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
  - i. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient's designated caregiver to cultivate marijuana plants for the qualifying patient's medical use;
  - j. If the qualifying patient is homeless, an address where the qualifying patient can receive mail;
  - k. Whether the qualifying patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
  - l. An attestation that the information provided in the application is true and correct; and
  - m. The signature of the qualifying patient and the date the qualifying patient signed;
2. If the qualifying patient's name in subsection (A)(1)(a) is not the same name as on the qualifying patient's current registry identification card, one of the following with the qualifying patient's new name:
    - a. An Arizona driver's license,
    - b. An Arizona identification card, or
    - c. The photograph page in the qualifying patient's U.S. passport or a U.S. passport card;
  3. A current photograph of the qualifying patient;
  4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  5. A physician's written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's renewal application that includes:
    - a. The physician's:
      - i. Name,
      - ii. License number including an identification of the physician license type,
      - iii. Office address on file with the physician's licensing board,
      - iv. Telephone number on file with the physician's licensing board, and
      - v. Email address;
    - b. The qualifying patient's name and date of birth;
    - c. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
    - d. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
    - e. If the debilitating medical condition identified in subsection (A)(5)(d) is a condition in:
      - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
      - ii. R9-17-201(14), the debilitating medical condition;
  - f. A statement, initialed by the physician, that the physician:
    - i. Has established a medical record for the qualifying patient, and
    - ii. Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;
  - g. A statement, initialed by the physician, that the physician has conducted a physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
  - h. The date the physician conducted the physical examination of the qualifying patient;
  - i. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
    - i. Medical records including medical records from other treating physicians from the previous 12 months,
    - ii. Response to conventional medications and medical therapies, and
    - iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
  - j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;
  - k. A statement, initialed by the physician, that, in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
  - l. A statement, initialed by the physician, that, if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
  - m. A statement, initialed by the physician, that the physician has provided information to the qualifying patient, if the qualifying patient is female, that warns about:
    - i. The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
    - ii. The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;
  - n. An attestation that the information provided in the written certification is true and correct; and
  - o. The physician's signature and the date the physician signed;
6. If the qualifying patient is designating a caregiver or if the qualifying patient's designated caregiver's registry identification card has the same expiration date as the qualifying patient's registry identification card, the following in a Department-provided format:
    - a. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
    - b. The designated caregiver's date of birth;

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- c. The designated caregiver's Arizona residence address and Arizona mailing address;
  - d. The county where the designated caregiver resides;
  - e. If the qualifying patient is renewing the designated caregiver's registry identification card, the registry identification number on the designated caregiver's registry identification card associated with the qualifying patient;
  - f. If the qualifying patient is designating an individual not previously designated as the qualifying patient's designated caregiver, the identification number on and a copy of the designated caregiver's:
    - i. Arizona driver's license issued on or after October 1, 1996;
    - ii. Arizona identification card issued on or after October 1, 1996;
    - iii. Arizona registry identification card;
    - iv. Photograph page in the designated caregiver's U. S. passport or a U.S. passport card; or
    - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
      - (1) Birth certificate verifying U.S. citizenship,
      - (2) U. S. Certificate of Naturalization, or
      - (3) U. S. Certificate of Citizenship;
  - g. A current photograph of the designated caregiver;
  - h. An attestation signed and dated by the designated caregiver that the designated caregiver:
    - i. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
    - ii. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
  - i. A statement in a Department-provided format signed by the designated caregiver:
    - i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
    - ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and
  - j. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
    - i. The designated caregiver's fingerprints on a fingerprint card that includes:
      - (1) The designated caregiver's first name; middle initial, if applicable; and last name;
      - (2) The designated caregiver's signature;
      - (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver's fingerprints;
      - (4) The designated caregiver's address;
      - (5) If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
      - (6) The designated caregiver's date of birth;
      - (7) The designated caregiver's Social Security number;
      - (8) The designated caregiver's citizenship status;
      - (9) The designated caregiver's gender;
      - (10) The designated caregiver's race;
      - (11) The designated caregiver's height;
      - (12) The designated caregiver's weight;
      - (13) The designated caregiver's hair color;
      - (14) The designated caregiver's eye color; and
      - (15) The designated caregiver's place of birth; or
    - ii. If the designated caregiver's fingerprints and information required in subsection (A)(6)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; or
    - iii. Documentation that the designated caregiver has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
7. If the qualifying patient's designated caregiver's registry identification card has the same expiration date as the qualifying patient's registry identification card and the designated caregiver's name in subsection (A)(6)(a) is not the same name as on the designated caregiver's current registry identification card, one of the following with the designated caregiver's new name:
- a. An Arizona driver's license,
  - b. An Arizona identification card, or
  - c. The photograph page in the designated caregiver's U.S. passport or a U.S. passport card; and
8. The applicable fees in R9-17-102 for applying to:
- a. Renew a qualifying patient's registry identification card; and
  - b. If applicable, issue or renew a designated caregiver's registry identification card.
- B.** To renew a registry identification card for a qualifying patient who is under 18 years of age, the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient shall submit to the Department the following:
- 1. An application in a Department-provided format that includes:
    - a. The qualifying patient's:
      - i. First name; middle initial, if applicable; last name; and suffix, if applicable; and
      - ii. Date of birth;
    - b. The qualifying patient's Arizona residence address and Arizona mailing address;
    - c. The county where the qualifying patient resides;
    - d. The registry identification number on the qualifying patient's current registry identification card;
    - e. The qualifying patient's custodial parent's or legal guardian's first name; middle initial, if applicable; last name; and suffix, if applicable;
    - f. The qualifying patient's custodial parent's or legal guardian's Arizona residence address and Arizona mailing address;
    - g. The county where the qualifying patient's custodial parent or legal guardian resides;
    - h. The qualifying patient's custodial parent's or legal guardian's email address;

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- i. The registry identification number on the qualifying patient's custodial parent's or legal guardian's current registry identification card;
- j. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;
- k. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the qualifying patient's medical record maintained by other treating physicians, and is providing a written certification for medical marijuana for the qualifying patient;
- l. Whether the qualifying patient's custodial parent or legal guardian is requesting approval for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient's custodial parent or legal guardian believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
- m. Whether the qualifying patient's custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
- n. A statement in a Department-provided format signed by the qualifying patient's custodial parent or legal guardian who is serving as the qualifying patient's designated caregiver:
  - i. Allowing the qualifying patient's medical use of marijuana;
  - ii. Agreeing to assist the qualifying patient with the medical use of marijuana; and
  - iii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
- o. An attestation that the information provided in the application is true and correct; and
- p. The signature of the qualifying patient's custodial parent or legal guardian and the date the qualifying patient's custodial parent or legal guardian signed;
2. If the qualifying patient's custodial parent's or legal guardian's name in subsection (B)(1)(e) is not the same name as on the qualifying patient's custodial parent's or legal guardian's current registry identification card, one of the following with the custodial parent's or legal guardian's new name:
  - a. An Arizona driver's license,
  - b. An Arizona identification card, or
  - c. The photograph page in the qualifying patient's custodial parent's or legal guardian's U.S. passport or a U.S. passport card;
3. A current photograph of the qualifying patient;
4. A written certification from the physician in subsection (B)(1)(j) and a separate written certification from the physician in subsection (B)(1)(k) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's renewal application that includes:
  - a. The physician's:
    - i. Name,
    - ii. License number including an identification of the physician license type,
  - iii. Office address on file with the physician's licensing board,
  - iv. Telephone number on file with the physician's licensing board, and
  - v. Email address;
  - b. The qualifying patient's name and date of birth;
  - c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition;
  - d. If the debilitating medical condition identified in subsection (B)(4)(c) is a condition in:
    - i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
    - ii. R9-17-201(14), the debilitating medical condition;
  - e. For the physician listed in subsection (B)(1)(j):
    - i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
    - ii. A statement, initialed by the physician, that the physician:
      - (1) Has established a medical record for the qualifying patient, and
      - (2) Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;
    - iii. A statement, initialed by the physician, that the physician has conducted a physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient's presenting symptoms and the qualifying patient's debilitating medical condition diagnosed or confirmed by the physician;
    - iv. The date the physician conducted the physical examination of the qualifying patient;
    - v. A statement, initialed by the physician, that the physician reviewed the qualifying patient's:
      - (1) Medical records including medical records from other treating physicians from the previous 12 months,
      - (2) Response to conventional medications and medical therapies, and
      - (3) Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
    - vi. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of medical marijuana to the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient; and
    - vii. A statement, initialed by the physician, that the physician has provided information to the qualifying patient's custodial parent or legal guardian responsible for health care decisions for the qualifying patient, if the qualifying patient is female, that warns about:
      - (1) The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and

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- (2) The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;
  - f. For the physician listed in subsection (B)(1)(k), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient's medical records from other treating physicians;
  - g. A statement, initialed by the physician, that, in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition;
  - h. A statement, initialed by the physician, that, if the physician has referred the qualifying patient's custodial parent or legal guardian to a dispensary, the physician has disclosed to the qualifying patient's custodial parent or legal guardian any personal or professional relationship the physician has with the dispensary;
  - i. An attestation that the information provided in the written certification is true and correct; and
  - j. The physician's signature and the date the physician signed; and
5. A current photograph of the qualifying patient's custodial parent or legal guardian;
  6. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
    - a. The qualifying patient's custodial parent's or legal guardian's fingerprints on a fingerprint card that includes:
      - i. The qualifying patient's custodial parent's or legal guardian's first name; middle initial, if applicable; and last name;
      - ii. The qualifying patient's custodial parent's or legal guardian's signature;
      - iii. If different from the qualifying patient's custodial parent or legal guardian, the signature of the individual physically rolling the qualifying patient's custodial parent's or legal guardian's fingerprints;
      - iv. The qualifying patient's custodial parent's or legal guardian's address;
      - v. If applicable, the qualifying patient's custodial parent's or legal guardian's surname before marriage and any names previously used by the qualifying patient's custodial parent or legal guardian;
      - vi. The qualifying patient's custodial parent's or legal guardian's date of birth;
      - vii. The qualifying patient's custodial parent's or legal guardian's Social Security number;
      - viii. The qualifying patient's custodial parent's or legal guardian's citizenship status;
      - ix. The qualifying patient's custodial parent's or legal guardian's gender;
      - x. The qualifying patient's custodial parent's or legal guardian's race;
      - xi. The qualifying patient's custodial parent's or legal guardian's height;
      - xii. The qualifying patient's custodial parent's or legal guardian's weight;
    - xiii. The qualifying patient's custodial parent's or legal guardian's hair color;
    - xiv. The qualifying patient's custodial parent's or legal guardian's eye color; and
    - xv. The qualifying patient's custodial parent's or legal guardian's place of birth; or
  - b. If the qualifying patient's custodial parent's or legal guardian's fingerprints and information required in subsection (B)(6)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the patient's custodial parent or legal guardian serving as the qualifying patient's designated caregiver as a result of the application; or
  - c. Documentation that the custodial parent or legal guardian has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
7. The applicable fees in R9-17-102 for applying to renew a:
  - a. Qualifying patient's registry identification card, and
  - b. Designated caregiver's registry identification card.
- C. Except as provided in subsection (A)(6), to renew a qualifying patient's designated caregiver's registry identification card, the qualifying patient shall submit to the Department, at least 30 calendar days before the expiration date of the designated caregiver's registry identification card, the following:
  1. An application in a Department-provided format that includes:
    - a. The qualifying patient's first name; middle initial, if applicable; last name; and suffix, if applicable;
    - b. The registry identification number on the qualifying patient's current registry identification card;
    - c. The designated caregiver's first name; middle initial, if applicable; last name; and suffix, if applicable;
    - d. The designated caregiver's date of birth;
    - e. The designated caregiver's Arizona residence address and Arizona mailing address;
    - f. The county where the designated caregiver resides;
    - g. The registry identification number on the designated caregiver's current registry identification card;
  2. If the designated caregiver's name in subsection (C)(1)(a) is not the same name as on the designated caregiver's current registry identification card, one of the following with the designated caregiver's new name:
    - a. An Arizona driver's license,
    - b. An Arizona identification card, or
    - c. The photograph page in the designated caregiver's U.S. passport or a U.S. passport card;
  3. A current photograph of the designated caregiver;
  4. A statement in a Department-provided format signed by the designated caregiver:
    - a. Agreeing to assist the qualifying patient with the medical use of marijuana; and
    - b. Pledging not to divert marijuana to any individual or person who is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and
  5. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
    - a. The designated caregiver's fingerprints on a fingerprint card that includes:

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- i. The designated caregiver's first name; middle initial, if applicable; and last name;
- ii. The designated caregiver's signature;
- iii. If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver's fingerprints;
- iv. The designated caregiver's address;
- v. If applicable, the designated caregiver's surname before marriage and any names previously used by the designated caregiver;
- vi. The designated caregiver's date of birth;
- vii. The designated caregiver's Social Security number;
- viii. The designated caregiver's citizenship status;
- ix. The designated caregiver's gender;
- x. The designated caregiver's race;
- xi. The designated caregiver's height;
- xii. The designated caregiver's weight;
- xiii. The designated caregiver's hair color;
- xiv. The designated caregiver's eye color; and
- xv. The designated caregiver's place of birth; or
- b. If the designated caregiver's fingerprints and information required in subsection (C)(1)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; or
- c. Documentation that the designated caregiver has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
6. The applicable fee in R9-17-102 for renewing a designated caregiver's registry identification card.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 23 A.A.R. 970, effective June 6, 2017 (Supp. 17-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-205. Denial or Revocation of a Qualifying Patient's or Designated Caregiver's Registry Identification Card**

- A. The Department shall deny a qualifying patient's application for or renewal of the qualifying patient's registry identification card if the qualifying patient does not have a debilitating medical condition.
- B. The Department shall deny a designated caregiver's application for or renewal of the designated caregiver's registry identification card if the designated caregiver does not meet the definition of "designated caregiver" in A.R.S. § 36-2801.
- C. The Department may deny a qualifying patient's or designated caregiver's application for or renewal of the qualifying patient's or designated caregiver's registry identification card if the qualifying patient or designated caregiver:
  1. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or this Chapter; or
  2. Provides false or misleading information to the Department.

- D. The Department shall revoke a qualifying patient's or designated caregiver's registry identification card if the qualifying patient or designated caregiver diverts medical marijuana to an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1.
- E. The Department shall revoke a designated caregiver's registry identification card if the designated caregiver has been convicted of an excluded felony offense.
- F. The Department may revoke a qualifying patient's or designated caregiver's registry identification card if the qualifying patient or designated caregiver knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.
- G. If the Department denies or revokes a qualifying patient's registry identification card, the Department shall provide written notice to the qualifying patient that includes:
  1. The specific reason or reasons for the denial or revocation; and
  2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
- H. If the Department denies or revokes a qualifying patient's designated caregiver's registry identification card, the Department shall provide written notice to the qualifying patient and the designated caregiver that includes:
  1. The specific reason or reasons for the denial or revocation; and
  2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3).

**ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS****R9-17-301. Principal Officers and Board Members**

- A. For the purposes of this Chapter, in addition to the individual or individuals identified in the dispensary's by-laws or other organizational governing documents as principal officers of the dispensary, if applicable, the following individuals are considered principal officers:
  1. If a corporation is applying for a dispensary registration certificate, two individuals who are officers of the corporation, including, but not limited to, the president or chief executive officer and those individuals serving in the positions of secretary and treasurer;
  2. If a partnership is applying for a dispensary registration certificate, all individuals who are general partners and the principal officers of any entity general partner;
  3. If a limited liability company is applying for a dispensary registration certificate, all managers of a manager-managed limited liability company, all members of a member-managed limited liability company, and the principal officers of an entity manager or member;
  4. If an association or cooperative is applying for a dispensary registration certificate, the chief executive officer, executive director, or other comparable leader of the association or cooperative; and

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5. If a business organization type other than those described in subsections (A)(1) through (4) is applying for a dispensary registration certificate, two individuals who occupy the top leadership positions of the business organization.
- B.** For purposes of this Chapter, in addition to the individual or individuals identified in the dispensary's by-laws or other organizational governing documents as board members of the dispensary, if applicable, the following individuals are considered board members:
  1. If a corporation is applying for a dispensary registration certificate, the members of the board of directors of the corporation;
  2. If a partnership is applying for a dispensary registration certificate, the partners who are not limited partners;
  3. If a limited liability company is applying for a dispensary registration certificate, the principal officers of the limited liability company;
  4. If an association or cooperative is applying for a dispensary registration certificate, the principal officers of the association or cooperative; and
  5. If a business organization type other than the types of business organizations in subsections (B)(1) through (4), the principal officers of the business organization.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4).

Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2).

**R9-17-302. Repealed****Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Repealed by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4).

**R9-17-303. Dispensary Registration Certificate Allocation Process**

- A.** Each calendar year, the Department may review current valid dispensary registration certificates to determine if the Department may issue additional dispensary registration certificates pursuant to A.R.S. § 36-2804(C).
  1. If the Department determines that the Department may issue additional dispensary registration certificates, the Department shall post, on the Department's website, the information that the Department is accepting dispensary registration certificate applications, including the deadline for accepting dispensary registration certificate applications.
    - a. The Department shall post the information in subsection (A)(1) at least 30 calendar days before the date the Department begins accepting applications.
    - b. The deadline for submission of dispensary registration certificate applications is 10 working days after the date the Department begins accepting applications.
    - c. Sixty working days after the date the Department begins accepting applications, the Department shall determine if the Department received more dispensary registration certificate applications that are

complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process than the Department is allowed to issue.

- i. If the Department received more dispensary registration certificate applications than the Department is allowed to issue, the Department shall allocate any available dispensary registration certificates according to the priorities established in subsection (B).
  - ii. If the Department is allowed to issue a dispensary registration certificate for each dispensary registration certificate application the Department received, the Department shall allocate the dispensary registration certificates to those applicants.
2. If the Department determines that the Department is not allowed to issue additional dispensary registration certificates, the Department shall, on the Department's website:
  - a. Post the information that the Department is not accepting dispensary registration certificate applications, and
  - b. Maintain the information until the next review.
- B.** If the Department determined, according to subsection (A)(1)(c), that more dispensary registration certificate applications were received that are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process than the number of dispensary registration certificates the Department is allowed to issue, the Department shall allocate the dispensary registration certificates according to the following criteria:
  1. For dispensary registration certificate applications received for a county in which no dispensary is located:
    - a. If only one dispensary registration certificate application is received for a proposed dispensary located in the county, the Department shall allocate the dispensary registration certificate to that applicant; or
    - b. If more than one dispensary registration certificate application is received for a proposed dispensary located in the county, the Department shall prioritize and allocate a dispensary registration certificate to an applicant according to subsection (B)(2);
  2. For dispensary registration certificate applications received according to subsection (B)(1)(b), the Department shall prioritize and allocate a dispensary registration certificate to an applicant according to the following:
    - a. If only one dispensary registration certificate application is received for a proposed dispensary in a geographic area in the county, at a location that is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall allocate the dispensary registration certificate to that applicant;
    - b. If more than one dispensary registration certificate application is received for a proposed dispensary in a geographic area in the county, at a location that is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall:
      - i. Prioritize and allocate a dispensary registration certificate to an applicant based on which proposed dispensary location will provide dispensary services to the most qualifying patients within five miles of the proposed dispensary

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- location, as determined from the number of registry identification cards issued to qualifying patients; and
- ii. If two or more dispensary registration certificate applications specify the same location from which another dispensary has moved, comply with subsection (C); and
  - c. If no dispensary registration certificate applications are received for a proposed dispensary in a geographic area in the county, at a location that is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall allocate a dispensary registration certificate in the county as follows:
    - i. If only one dispensary registration certificate application is received for a proposed dispensary in a geographic area in the county at a location that is at least 25 miles from another dispensary, the Department shall allocate the dispensary registration certificate to that applicant;
    - ii. If more than one dispensary registration certificate application is received for a proposed dispensary in a geographic area in the county at a location that is at least 25 miles from another dispensary, the Department shall allocate a dispensary registration certificate to an applicant at a location that is at least 25 miles from another dispensary based on random drawing; and
    - iii. If no dispensary registration certificate is allocated according to subsection (B)(2)(c)(i) or (ii), the Department shall allocate a dispensary registration certificate to an applicant for a proposed dispensary located in the county based on random drawing;
  3. If additional dispensary registration certificates are available after dispensary registration certificates are allocated, for each county in which no dispensary is located, according to subsection (B)(1) or (2), the Department shall allocate the additional dispensary registration certificates for a location in any geographic area as follows:
    - a. If the number of dispensary registration certificate applications received for a proposed dispensary at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection (B)(1) or (2), and from which another dispensary has moved is less than or equal to the number of available dispensary registration certificates, the Department shall allocate the dispensary registration certificates to those applicants; or
    - b. If the number of dispensary registration certificate applications received for a proposed dispensary at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection (B)(1) or (2), and from which another dispensary has moved is greater than the number of available dispensary registration certificates, the Department shall:
      - i. Prioritize and allocate dispensary registration certificates to applicants based on which proposed dispensary location will provide dispensary services to the most qualifying patients within five miles of the proposed dispensary location, as determined from the number of registry identification cards issued to qualifying patients; and
      - ii. If two or more dispensary registration certificate applications specify the same location from which another dispensary has moved, comply with subsection (C);
  4. If additional dispensary registration certificates are available after dispensary registration certificates are allocated according to subsections (B)(1), (2), and (3), the Department shall allocate the dispensary registration certificates for a location in any geographic area as follows:
    - a. If the number of dispensary registration certificate applications received for a proposed dispensary at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection (B)(1), (2), or (3), is less than or equal to the number of available dispensary registration certificates, the Department shall allocate a dispensary registration certificate to those applicants; or
    - b. If the number of dispensary registration certificate applications received for a proposed dispensary at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection (B)(1), (2), or (3), is greater than the number of available dispensary registration certificates, the Department shall allocate a dispensary registration certificate to an applicant:
      - i. Based on random drawing; and
      - ii. If two or more dispensary registration certificate applications specify the same location, comply with subsection (C); and
  5. If additional dispensary registration certificates are available after dispensary registration certificates are allocated according to subsections (B)(1) through (4), for all dispensary registration certificate applications not allocated a dispensary registration certificate, the Department shall allocate a dispensary registration certificate to an applicant:
    - a. Based on random drawing; and
    - b. If two or more dispensary registration certificate applications specify the same location, comply with subsection (C).
  - C. The Department shall randomly select one dispensary registration certificate application for allocation of a dispensary registration certificate if:
    1. There is a tie or a margin of 0.1% or less in the scores generated by applying the criteria in subsection (B), or
    2. Two or more dispensary registration certificate applications specify the same location.
  - D. For purposes of subsection (B):
    1. "Five miles" includes the area contained within a circle that extends for five miles in all directions from a specific location, not the distance travelled from the specific location by road; and
    2. "25 miles" includes the area contained within a circle that extends for 25 miles in all directions from the center of a proposed dispensary location, not the distance travelled from one location to another location by road.



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- E.** If the Department does not allocate a dispensary registration certificate to an applicant that had submitted a dispensary registration certificate application that the Department determined was complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process, the Department shall provide a written notice to the applicant that states that, although the applicant's dispensary registration certificate application was complete and complied with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department did not allocate the applicant a dispensary registration certificate under the processes in this Section.
- F.** If the Department receives a dispensary registration certificate application at a time other than the time stated in subsection (B), the Department shall return the dispensary registration certificate application, including the application fee, to the applicant.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-304. Applying for a Dispensary Registration Certificate**

- A.** An individual shall not be a principal officer or board member on more than five dispensary registration certificate applications.
- B.** If the Department determines that an individual is a principal officer or board member on more than five dispensary registration certificate applications, the Department shall review the applications and provide the applicant on each of the dispensary registration certificate applications with a written comprehensive request for more information that includes the specific requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter that the dispensary registration certificate application does not comply with.
1. If an applicant withdraws an application to comply with this Chapter and submits information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall process the applicant's remaining dispensary registration certificate applications according to this Chapter.
  2. If an applicant does not withdraw an application or submit information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue a denial to the applicant according to R9-17-322.
  3. An application fee submitted with a dispensary registration certificate application in subsection (B) that is withdrawn is not refunded.
- C.** To apply for a dispensary registration certificate, an applicant shall submit to the Department the following:
1. An application in a Department-provided format that includes:
    - a. The legal name of the proposed dispensary;
    - b. The physical address of the proposed dispensary;
    - c. The name of the geographic area;
    - d. The county in which the geographic area in subsection (C)(1)(c) is located;
    - e. If applicable, the name of the dispensary that previously held a dispensary registration certificate at the physical address of the proposed dispensary and the approximate date the dispensary left the location;
    - f. The following information for the applicant:
      - i. Name of the entity applying,
      - ii. Type of business organization,
      - iii. Arizona mailing address,
      - iv. Telephone number, and
      - v. Email address;
    - g. The name of the principal officer or board member designated to submit dispensary agent registry identification card applications on behalf of the proposed dispensary;
    - h. The name and professional license number of the proposed dispensary's medical director;
    - i. The name, residence address, and date of birth of each:
      - i. Principal officer, and
      - ii. Board member;
    - j. Whether the applicant agrees to allow the Department to submit supplemental requests for information;
    - k. A statement that, if the applicant is issued a dispensary registration certificate, the proposed dispensary will not operate until the proposed dispensary is inspected and obtains an approval to operate from the Department;
    - l. A statement that the applicant understands that, if the applicant is issued a dispensary registration certificate, the dispensary may relocate only as specified in A.R.S. § 36-2803.01(D);
    - m. An attestation that the information provided to the Department to apply for a dispensary registration certificate is true and correct; and
    - n. The signatures of each principal officer and each board member of the proposed dispensary according to R9-17-301 and the date signed;
  2. If the applicant is one of the business organizations in R9-17-301(A)(2) through (5), a copy of documentation that the applicant is in good standing with the Arizona Corporation Commission;
  3. For each principal officer and each board member:
    - a. An attestation signed and dated by the principal officer or board member that the principal officer or board member:
      - i. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
      - ii. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
    - b. Documentation that the principal officer or board member has a valid marijuana facility agent license;
  4. Policies and procedures that comply with the requirements in this Chapter for:
    - a. Inventory control,
    - b. Qualifying patient recordkeeping, and
    - c. Security;
  5. As required in A.R.S. § 36-2804(B)(1)(d), a sworn statement, signed and dated by each principal officer and each

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board member of the proposed dispensary according to R9-17-301, certifying that the proposed dispensary is in compliance with any local zoning restrictions;

6. A statement, in a Department-provided format, signed and dated within 60 calendar days before the date of the application by a representative of the local jurisdiction:
  - a. Certifying that the proposed dispensary is in compliance with any local zoning restrictions; and
  - b. Including:
    - i. Information identifying the local jurisdiction and the local jurisdiction's representative,
    - ii. The legal name of the proposed dispensary, and
    - iii. The physical address of the proposed dispensary as specified according to subsection (C)(1)(b);
7. Documentation, in a Department-provided format, of:
  - a. Ownership by the applicant of the physical address of the proposed dispensary, signed and dated within 60 calendar days before the date of the application; or
  - b. Permission from the owner of the physical address of the proposed dispensary for the applicant for a dispensary registration certificate to operate a dispensary at the physical address, signed, notarized, and dated within 60 calendar days before the date of the application; and
8. The applicable fee in R9-17-102 for applying for a dispensary registration certificate.

- D.** Before an entity with a dispensary registration certificate begins operating a dispensary, the entity shall apply for and obtain an approval to operate a dispensary from the Department.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-305. Applying for Approval to Operate a Dispensary**

- A.** To apply for approval to operate a dispensary, a person holding a dispensary registration certificate shall submit to the Department, and, if the dispensary registration certificate was issued on or after April 1, 2020, within 18 months after the dispensary registration certificate was issued, the following:
1. The following information in a Department-provided format:
    - a. The name and registry identification number of the dispensary;
    - b. The physical address of the dispensary;
    - c. The name, address, and date of birth of each dispensary agent;
    - d. Except as provided in R9-17-324, the name and professional license number of the dispensary's medical director;

- e. If applicable, the physical address of the dispensary's cultivation site;
  - f. The dispensary's Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
  - g. The dispensary's proposed hours of operation during which the dispensary plans to be available to dispense medical marijuana to qualifying patients and designated caregivers;
  - h. Whether the dispensary plans to:
    - i. Cultivate marijuana;
    - ii. Manufacture marijuana products;
    - iii. Prepare marijuana-infused edible food products; or
    - iv. Sell or dispense marijuana-infused edible food products that are either:
      - (1) A time/temperature control for safety food, or
      - (2) Not prepared in individually packaged containers;
  - i. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;
  - j. Whether the dispensary and, if applicable, the dispensary's cultivation site are ready for an inspection by the Department;
  - k. If the dispensary and, if applicable, the dispensary's cultivation site are not ready for an inspection by the Department, the date the dispensary and, if applicable, the dispensary's cultivation site will be ready for an inspection by the Department;
  - l. An attestation that the information provided to the Department to apply for approval to operate a dispensary is true and correct; and
  - m. The signatures of each principal officer and each board member of the dispensary according to R9-17-301 and the date signed;
2. A copy of the dispensary's license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, if the dispensary plans to:
    - a. Prepare marijuana-infused edible food products, as specified in subsection (A)(1)(h)(iii); or
    - b. Sell or dispense marijuana-infused edible food products, as specified in subsection (A)(1)(h)(iv);
  3. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the building as a dispensary and, if applicable, as the dispensary's cultivation site, such as a certificate of occupancy, a special use permit, or a conditional use permit;
  4. The distance to the closest private school or public school from:
    - a. The dispensary; and
    - b. If applicable, the dispensary's cultivation site;
  5. A site plan drawn to scale of the dispensary location showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains;
  6. A floor plan drawn to scale of the building where the dispensary is located showing the:
    - a. Layout and dimensions of each room,
    - b. Name and function of each room,
    - c. Location of each hand washing sink,
    - d. Location of each toilet room,
    - e. Means of egress,

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- f. Location of each video camera,
- g. Location of each panic button, and
- h. Location of natural and artificial lighting sources;
- 7. If applicable, a site plan drawn to scale of the dispensary's cultivation site showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
- 8. If applicable, a floor plan drawn to scale of each building at the dispensary's cultivation site showing the:
  - a. Layout and dimensions of each room,
  - b. Name and function of each room,
  - c. Location of each hand washing sink,
  - d. Location of each toilet room,
  - e. Means of egress,
  - f. Location of each video camera,
  - g. Location of each panic button, and
  - h. Location of natural and artificial lighting sources.

- B. A dispensary's cultivation site may be located anywhere in the state where a cultivation site is allowed by the local jurisdiction.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4).

Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-306. Changes to a Dispensary Registration Certificate**

- A. Except as provided in R9-17-324, a dispensary may not transfer or assign the dispensary registration certificate.
- B. A dispensary may change the location of the:
  - 1. Dispensary:
    - a. If the dispensary was allocated a dispensary registration certificate on or after April 1, 2020, according to A.R.S. § 36-2803.01(D); and
    - b. If the dispensary was allocated a dispensary registration certificate before April 1, 2020:
      - i. Within the first three years after the Department issued the dispensary's registration certificate, to another location in the geographic area where the dispensary is located; or
      - ii. After the first three years after the Department issued a dispensary registration certificate to the dispensary, to another location in the state; or
  - 2. Dispensary's cultivation site to another location in the state.
- C. A dispensary or the dispensary's cultivation site shall not cultivate, manufacture, distribute, dispense, or sell medical marijuana at a new location or make a change in the activities conducted at a current location until the dispensary:
  - 1. Submits an application for a change in R9-17-307; and
  - 2. Receives an amended dispensary registration certificate or an approval for:
    - a. The dispensary's new location, including the activities to be conducted at the new location;

- b. The dispensary's cultivation site's new location, including the activities to be conducted at the new location; or
- c. The requested change in the activities conducted at a current location.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4).

Amended by exempt rulemaking at 27 A.A.R. 1587, with an immediate effective date of September 7, 2021 (Supp. 21-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-307. Applying to Change a Dispensary Registration Certificate**

- A. A dispensary shall submit a separate application to the Department for each request for one of the possible changes in R9-17-306(C).
- B. To request any of the changes specified in R9-17-306(C), a dispensary shall submit to the Department:
  - 1. The following information in a Department-provided format:
    - a. The legal name of the dispensary;
    - b. The registry identification number for the dispensary;
    - c. Whether the request is for:
      - i. A change of location for the dispensary,
      - ii. A change of location for the dispensary's cultivation site,
      - iii. An addition of a cultivation site, or
      - iv. A change in the activities conducted at a current location;
    - d. The current physical address of the dispensary or the dispensary's cultivation site;
    - e. The physical address of the proposed location for the dispensary or the dispensary's cultivation site, if applicable;
    - f. For a change of location or an addition of a cultivation site, the distance to the closest public school or private school from:
      - i. The proposed location for the dispensary, or
      - ii. The proposed location for the dispensary's cultivation site;
    - g. For a request to change activities conducted at a current location or include any of the following activities at a new location, whether the dispensary plans to:
      - i. Cultivate marijuana;
      - ii. Manufacture marijuana products;
      - iii. Prepare marijuana-infused edible food products; or
      - iv. Sell or dispense marijuana-infused edible food products that are either:
        - (1) A time/temperature control for safety food, or
        - (2) Not prepared in individually packaged containers;
    - h. The name of the entity applying;
    - i. If applicable, the anticipated date of the change of location or activities;

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- j. Whether the proposed dispensary, the dispensary's proposed cultivation site, or the location of the change in activities is ready for an inspection by the Department;
  - k. If the proposed dispensary, the dispensary's proposed cultivation site, or the location of the change in activities is not ready for an inspection by the Department, the date the dispensary, the dispensary's proposed cultivation site, or the location of the change in activities will be ready for an inspection by the Department;
  - l. An attestation that the information provided to the Department to apply for a change in location is true and correct; and
  - m. The signature of each principal officer and each board member of the dispensary according to R9-17-301 and the date signed;
2. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the proposed building as a dispensary or location as the dispensary's cultivation site for the activities to be conducted at the location, such as a certificate of occupancy, a special use permit, or a conditional use permit;
  3. A copy of the dispensary's license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, if the dispensary plans to:
    - a. Prepare marijuana-infused edible food products, as specified in subsection (B)(1)(g)(iii); or
    - b. Sell or dispense marijuana-infused edible food products, as specified in subsection (B)(1)(g)(iv);
  4. A copy of documentation, in a Department-provided format, of:
    - a. Ownership of the physical address of the proposed dispensary, proposed cultivation site, or location for the change in activities, signed and dated within 60 calendar days before the date of the request; or
    - b. Permission from the owner of the physical address of the proposed dispensary, proposed cultivation site, or location for the change in activities, for the dispensary to operate a dispensary or conduct the specified activities at the physical address, signed, notarized, and dated within 60 calendar days before the date of the request;
  5. For a change in location of the dispensary, including when any of the activities specified according to subsection (B)(1)(g) is to be conducted at the new location:
    - a. A site plan drawn to scale of the proposed dispensary location showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
    - b. A floor plan drawn to scale of the building where the proposed dispensary is located showing the:
      - i. Layout and dimensions of each room;
      - ii. Name and function of each room;
      - iii. Location of each hand washing sink;
      - iv. If applicable, location of each piece of fixed equipment required to conduct the activity;
      - v. Location of each toilet room;
      - vi. Means of egress;
      - vii. Location of each video camera;
      - viii. Location of each panic button; and
  - ix. Location of natural and artificial lighting sources;
6. For a change in location of the dispensary's cultivation site or for adding a cultivation site, including when any of the activities specified according to subsection (B)(1)(g) is to be conducted at the new or added cultivation site:
    - a. A site plan drawn to scale of the dispensary's proposed cultivation site showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
    - b. If applicable, a floor plan drawn to scale of each building used by the dispensary's proposed cultivation site showing the:
      - i. Layout and dimensions of each room;
      - ii. Name and function of each room;
      - iii. Location of each hand washing sink;
      - iv. If applicable, location of each piece of fixed equipment required to conduct the activity;
      - v. Location of each toilet room;
      - vi. Means of egress;
      - vii. Location of each video camera;
      - viii. Location of each panic button; and
      - ix. Location of natural and artificial lighting sources;
  7. For changing an activity conducted at a current location, a floor plan drawn to scale of the building where the activity will occur showing the:
    - a. Layout and dimensions of each room,
    - b. Name and function of each room,
    - c. Location of each hand washing sink,
    - d. Location of each piece of fixed equipment required to conduct the activity,
    - e. Means of egress,
    - f. Location of each video camera,
    - g. Location of each panic button, and
    - h. Location of natural and artificial lighting sources; and
  8. The applicable fee in R9-17-102 for applying for a change in location or the addition of a cultivation site, or to change activities conducted at a current location or add activities at a new location.
- C. If the information and documents submitted by the dispensary comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue an amended dispensary registration certificate that includes the new address of the new location or the new activities and retains the expiration date of the previously issued dispensary registration certificate.
  - D. An application for a change in location of a dispensary or a dispensary's cultivation site or the addition of a cultivation site may not be combined with an application for renewing a dispensary registration certificate. The Department shall process each application separately according to the applicable timeframe established in R9-17-107.
  - E. A dispensary shall submit written notification to the Department when the dispensary no longer uses a previously approved cultivation site.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 111, with

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an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-308. Renewing a Dispensary Registration Certificate**

To renew a dispensary registration certificate, a dispensary that has an approval to operate a dispensary issued by the Department, shall submit to the Department, at least 30 calendar days before the expiration date of the dispensary's current dispensary registration certificate, the following:

1. An application in a Department-provided format that includes:
  - a. The legal name of the dispensary;
  - b. The registry identification number for the dispensary;
  - c. If the dispensary is a dual licensee, the marijuana establishment license number;
  - d. The physical address of the dispensary;
  - e. The name of the entity applying;
  - f. Except as provided in R9-17-324(C), the name and license number of the dispensary's medical director;
  - g. The dispensary's hours of operation during which the dispensary is available to dispense medical marijuana to qualifying patients and designated caregivers;
  - h. The name, address, date of birth, and registry identification number of each:
    - i. Principal officer,
    - ii. Board member, and
    - iii. Dispensary agent;
  - i. For each principal officer or board member, whether the principal officer or board member:
    - i. Has served as a principal officer or board member for a dispensary that had the dispensary registration certificate revoked,
    - ii. Has served as a principal officer or board member for a marijuana establishment that had the marijuana establishment license revoked, or
    - iii. Is a physician currently providing written certifications for qualifying patients;
  - j. The dispensary's Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
  - k. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;
  - l. An attestation that the information provided to the Department to renew the dispensary registration certificate is true and correct; and
  - m. The signature of each principal officer and each board member of the dispensary according to R9-17-301 and the date signed;
2. Either:
  - a. An attestation, in a Department-provided format, that the dispensary is operating on a not-for-profit basis; or
  - b. Both of the following:
    - i. A copy of an annual financial statement for the previous two years, or for the portion of the previous two years the dispensary was operational, prepared according to generally accepted accounting principles; and

- ii. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (2)(b)(i); and
3. The applicable fee in R9-17-102 for applying to renew a dispensary registration certificate.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by exempt rulemaking at 27 A.A.R. 1229, with an immediate effective date of July 23, 2021; amended by exempt rulemaking at 27 A.A.R. 1587, with an immediate effective date of September 7, 2021 (Supp. 21-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-309. Inspections**

- A. Submission of an application for a dispensary registration certificate constitutes permission for entry to and inspection of the dispensary and, if applicable, the dispensary's cultivation site.
- B. The Department shall not accept allegations of a dispensary's or a dispensary's cultivation site's noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter from an anonymous source.
- C. If the Department receives an allegation of a dispensary's or a dispensary's cultivation site's noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter, the Department may conduct an inspection of the dispensary or the dispensary's cultivation site.
- D. If the Department identifies a violation of A.R.S. Title 36, Chapter 28.1 or this Chapter during an inspection of a dispensary or the dispensary's cultivation site:
  1. The Department shall provide the dispensary with a written notice that includes the specific rule or statute that was violated; and
  2. The dispensary shall notify the Department in writing, with a postmark date within 20 working days after the date of the notice of violations, identifying the corrective actions taken and the date of the correction.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-310. Administration**

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- A. A dispensary shall:
1. Ensure that the dispensary is operating and available to dispense medical marijuana and marijuana products to qualifying patients and designated caregivers:
    - a. At least 30 hours weekly between the hours of 7:00 a.m. and 10:00 p.m.; and
    - b. For a dispensary with a dispensary registration certificate issued on or after April 1, 2020:
      - i. At the location specified according to R9-17-304(C)(1)(b), and
      - ii. Within 18 months after receiving the dispensary registration certificate;
  2. Develop, document, and implement policies and procedures regarding:
    - a. Job descriptions and employment contracts, including:
      - i. Personnel duties, authority, responsibilities, and qualifications;
      - ii. Personnel supervision;
      - iii. Training in and adherence to confidentiality requirements;
      - iv. Periodic performance evaluations; and
      - v. Disciplinary actions;
    - b. Business records, such as manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers;
    - c. Inventory control, including:
      - i. Tracking;
      - ii. Packaging;
      - iii. Accepting marijuana from qualifying patients and designated caregivers;
      - iv. Acquiring marijuana or marijuana products from a marijuana establishment or another dispensary;
      - v. Providing marijuana or marijuana products to a marijuana establishment or another dispensary; and
      - vi. Either:
        - (1) Providing samples of marijuana or marijuana products to a laboratory for testing, or
        - (2) Allowing a laboratory agent access to medical marijuana or marijuana product to collect samples;
    - d. Laboratory testing, including:
      - i. The analytes, including possible contaminants, to be tested for;
      - ii. The process for separating a batch of marijuana or of a marijuana product until laboratory testing has been completed and testing results received by the dispensary;
      - iii. The process for collecting samples of medical marijuana or a marijuana product for laboratory testing, including:
        - (1) The amount to be collected from each batch,
        - (2) The method for ensuring that a sample collected is representative of the batch,
        - (3) The packaging of the sample,
        - (4) The method for documenting chain of custody for the sample, and
        - (5) Methods to deter tampering with the sample and to determine whether tampering has occurred;
      - iv. The process for submitting a sample of medical marijuana or a marijuana product to a laboratory agent or laboratory for testing, including specifying the analytes to be tested for consistent with R9-17-317.01(A);
      - v. The process for requesting retesting of the remaining portion of a sample of medical marijuana or a marijuana product; and
      - vi. Actions to be taken on the basis of laboratory testing results;
    - e. Remediation, including:
      - i. Criteria for when a batch of medical marijuana or marijuana product can be remediated;
      - ii. The process by which each type of medical marijuana or marijuana product is remediated, including the methods for remediation and subsequent retesting; and
      - iii. Documentation of the remediation process;
    - f. Disposal of medical marijuana or a marijuana product, including:
      - i. Destroying a batch of marijuana or a marijuana product that does not meet the requirements in Table 3.1 and documenting the destruction;
      - ii. Submitting marijuana that is not usable marijuana to a local law enforcement agency and documenting the submission; or
      - iii. Otherwise disposing of marijuana or a marijuana product such that the marijuana or marijuana product is unrecognizable or cannot otherwise be used and documenting the method of disposal, the dispensary agent overseeing the disposal, and the date of disposal;
    - g. Qualifying patient records, including purchases, denials of sale, any delivery options, confidentiality, and retention; and
    - h. Patient education and support, including the development and distribution of materials on:
      - i. Availability of different strains of marijuana and the purported effects of the different strains;
      - ii. Information about the purported effectiveness of various methods, forms, and routes of medical marijuana administration;
      - iii. Information about laboratory testing, the analytes for which the dispensary receives testing results, the right to receive a copy of the final report of testing specified in R9-17-404.06 upon request, and how to read and understand the final report of testing;
      - iv. Methods of tracking the effects on a qualifying patient of different strains and forms of marijuana; and
      - v. Prohibition on the smoking of medical marijuana in public places;
  3. Maintain copies of the policies and procedures at the dispensary and provide copies to the Department for review upon request;
  4. Maintain at the dispensary current and valid documentation of any certificate or permit issued by a local jurisdiction related to the operation of the dispensary or the dispensary's cultivation site and provide copies to the Department for review upon request;

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5. Review dispensary policies and procedures at least once every 12 months from the issue date of the dispensary registration certificate and update as needed;
  6. Except as provided in R9-17-324(C), employ or contract with a medical director;
  7. Ensure that each dispensary agent or marijuana facility agent associated with the dispensary has the applicable registry identification card or marijuana facility agent license in the dispensary agent's or marijuana facility agent's immediate possession when the dispensary agent or marijuana facility agent is:
    - a. Working or providing volunteer services at the dispensary or the dispensary's cultivation site, or
    - b. Transporting marijuana for the dispensary;
  8. Ensure that a dispensary agent or marijuana facility agent associated with the dispensary accompanies any individual other than another dispensary agent or marijuana facility agent associated with the dispensary when the individual is present in the enclosed, locked facility where marijuana is cultivated by the dispensary;
  9. Not allow an individual who does not possess a dispensary agent registry identification card issued under the dispensary registration certificate or marijuana facility agent license associated with the dispensary to:
    - a. Serve as a principal officer or board member for the dispensary,
    - b. Serve as the medical director for the dispensary,
    - c. Be employed by the dispensary, or
    - d. Provide volunteer services at or on behalf of the dispensary;
  10. Provide written notice to the Department, including the date of the event, within 10 working days after the date, when a dispensary agent or marijuana facility agent associated with the dispensary no longer:
    - a. Serves as a principal officer or board member for the dispensary,
    - b. Serves as the medical director for the dispensary,
    - c. Is employed by the dispensary, or
    - d. Provides volunteer services at or on behalf of the dispensary;
  11. Document and report any loss or theft of marijuana from the dispensary or the dispensary's cultivation site to the appropriate law enforcement agency;
  12. Maintain copies of any documentation required in this Chapter for at least 12 months after the date on the documentation and provide copies of the documentation to the Department for review upon request;
  13. Post the following information in a place that can be viewed by individuals entering the dispensary:
    - a. If applicable, the dispensary's approval to operate;
    - b. The dispensary's registration certificate;
    - c. Except as provided in R9-17-324(C), the name of the dispensary's medical director and the medical director's professional license number on a sign at least 20 centimeters by 30 centimeters;
    - d. The hours of operation during which the dispensary will dispense medical marijuana to a qualifying patient or a designated caregiver;
    - e. A sign in a Department-provided format that contains the following language:
      - i. "WARNING: There may be potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breast-feeding," and
      - ii. "WARNING: Use of marijuana during pregnancy may result in a risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;" and
  - f. A sign stating that a qualifying patient has the right to receive the results of laboratory testing of medical marijuana or a marijuana product; and
14. Except as provided in R9-17-324(C):
- a. Not lend any part of the dispensary's income or property without receiving adequate security and a reasonable rate of interest,
  - b. Not purchase property for more than adequate consideration in money or cash equivalent,
  - c. Not pay compensation for salaries or other compensation for personal services that is in excess of a reasonable allowance,
  - d. Not sell any part of the dispensary's property or equipment for less than adequate consideration in money or cash equivalent, and
  - e. Not engage in any other transaction that results in a substantial diversion of the dispensary's income or property.
- B.** If a dispensary cultivates marijuana, the dispensary shall cultivate the marijuana in an enclosed, locked facility.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by final rulemaking at 23 A.A.R. 970, effective June 6, 2017 (Supp. 17-2). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-311. Submitting an Application for a Dispensary Agent Registry Identification Card**

Except as provided in R9-17-107(F) or R9-17-324(C), to obtain a dispensary agent registry identification card for an individual serving as a principal officer or board member for the dispensary, employed by the dispensary, or providing volunteer services at or on behalf of the dispensary, the dispensary shall submit to the Department the following for each individual:

1. An application in a Department-provided format that includes:
  - a. The individual's first name; middle initial, if applicable; last name; and suffix, if applicable;
  - b. The individual's residence address and Arizona mailing address;
  - c. The county where the individual resides;
  - d. The individual's date of birth;
  - e. The identifying number on the applicable card or document in subsection (4)(a) through (c);

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- f. The name and registry identification number of the dispensary; and
- g. The signature of the individual in R9-17-304(C)(1)(d) or of a principal officer or board member, as applicable, designated to submit dispensary agent applications on the dispensary's behalf and the date signed;
2. An attestation signed and dated by the individual that the individual:
  - a. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
  - b. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
3. A statement in a Department-provided format signed by the individual pledging not to divert marijuana to any other individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
4. A copy of the individual's:
  - a. Arizona driver's license issued on or after October 1, 1996;
  - b. Arizona identification card issued on or after October 1, 1996;
  - c. Arizona registry identification card;
  - d. Photograph page in the individual's U.S. passport or a U.S. passport card; or
  - e. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the individual:
    - i. Birth certificate verifying U.S. citizenship,
    - ii. U.S. Certificate of Naturalization, or
    - iii. U.S. Certificate of Citizenship;
5. A current photograph of the individual;
6. For the Department's criminal records check authorized in A.R.S. §§ 36-2804.01 and 36-2804.05:
  - a. The individual's fingerprints on a fingerprint card that includes:
    - i. The individual's first name; middle initial, if applicable; and last name;
    - ii. The individual's signature;
    - iii. If different from the individual, the signature of another individual physically rolling the individual's fingerprints;
    - iv. The individual's address;
    - v. If applicable, the individual's surname before marriage and any names previously used by the individual;
    - vi. The individual's date of birth;
    - vii. The individual's Social Security number;
    - viii. The individual's citizenship status;
    - ix. The individual's gender;
    - x. The individual's race;
    - xi. The individual's height;
    - xii. The individual's weight;
    - xiii. The individual's hair color;
    - xiv. The individual's eye color; and
    - xv. The individual's place of birth;
  - b. If the individual's fingerprints and information required in subsection (6)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card for another dispensary, or laboratory agent registry identification card

within the previous six months, the registry identification number on the registry identification card issued to the individual as a result of the application; or

- c. Documentation that the individual has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
7. The applicable fee in R9-17-102 for applying for a dispensary agent registry identification card.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-312. Submitting an Application to Renew a Dispensary Agent's Registry Identification Card**

To renew a dispensary agent's registry identification card, a dispensary shall submit to the Department, at least 30 calendar days before the expiration of the dispensary agent's registry identification card, the following:

1. An application in a Department-provided format that includes:
  - a. The dispensary agent's first name; middle initial, if applicable; last name; and suffix, if applicable;
  - b. The dispensary agent's residence address and Arizona mailing address;
  - c. The county where the dispensary agent resides;
  - d. The dispensary agent's date of birth;
  - e. The registry identification number on the dispensary agent's current registry identification card;
  - f. The name and registry identification number of the dispensary; and
  - g. The signature of the individual in R9-17-304(C)(1)(d) or of a principal officer or board member, as applicable, designated to submit dispensary agent applications on the dispensary's behalf and the date signed;
2. An attestation signed and dated by the dispensary agent that the dispensary agent:
  - a. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
  - b. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
3. If the dispensary agent's name in subsection (1)(a) is not the same name as on the dispensary agent's current registry identification card, one of the following with the dispensary agent's new name:
  - a. An Arizona driver's license,
  - b. An Arizona identification card, or
  - c. The photograph page in the dispensary agent's U.S. passport or a U.S. passport card;



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4. A statement in a Department-provided format signed by the dispensary agent pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  5. A current photograph of the dispensary agent;
  6. For the Department's criminal records check authorized in A.R.S. § 36-2804.05:
    - a. The dispensary agent's fingerprints on a fingerprint card that includes:
      - i. The dispensary agent's first name; middle initial, if applicable; and last name;
      - ii. The dispensary agent's signature;
      - iii. If different from the dispensary agent, the signature of the individual physically rolling the dispensary agent's fingerprints;
      - iv. The dispensary agent's address;
      - v. If applicable, the dispensary agent's surname before marriage and any names previously used by the dispensary agent;
      - vi. The dispensary agent's date of birth;
      - vii. The dispensary agent's Social Security number;
      - viii. The dispensary agent's citizenship status;
      - ix. The dispensary agent's gender;
      - x. The dispensary agent's race;
      - xi. The dispensary agent's height;
      - xii. The dispensary agent's weight;
      - xiii. The dispensary agent's hair color;
      - xiv. The dispensary agent's eye color; and
      - xv. The dispensary agent's place of birth;
    - b. If the dispensary agent's fingerprints and information required in subsection (6)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card for another dispensary, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the dispensary agent as a result of the application; or
    - c. Documentation that the dispensary agent has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
  7. The applicable fee in R9-17-102 for applying to renew a dispensary agent's registry identification card.
- B. During a dispensary's hours of operation, a medical director or an individual who is a physician and is designated by the medical director to serve as medical director in the medical director's absence is:
    1. Onsite; or
    2. Able to be contacted by any means possible, such as by telephone or pager.
  - C. A medical director shall:
    1. Develop and provide training to the dispensary's dispensary agents at least once every 12 months from the initial date of the dispensary's registration certificate on the following subjects:
      - a. Guidelines for providing information to qualifying patients related to risks, benefits, and side effects associated with medical marijuana;
      - b. Guidelines for providing support to qualifying patients related to the qualifying patient's self-assessment of the qualifying patient's symptoms, including a rating scale for pain, cachexia or wasting syndrome, nausea, seizures, muscle spasms, and agitation;
      - c. Recognizing signs and symptoms of substance abuse; and
      - d. Guidelines for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana; and
    2. Assist in the development and implementation of review and improvement processes for patient education and support provided by the dispensary.
  - D. A medical director shall provide oversight for the development and dissemination of:
    1. Educational materials for qualifying patients and designated caregivers that include:
      - a. Alternative medical options for the qualifying patient's debilitating medical condition;
      - b. Information about possible side effects of and contraindications for medical marijuana including possible impairment with use and operation of a motor vehicle or heavy machinery, when caring for children, or of job performance;
      - c. Guidelines for notifying the physician who provided the written certification for medical marijuana if side effects or contraindications occur;
      - d. A description of the potential for differing strengths of medical marijuana strains and products;
      - e. Information about potential drug-to-drug interactions, including interactions with alcohol, prescription drugs, non-prescription drugs, and supplements;
      - f. Techniques for the use of medical marijuana and marijuana paraphernalia;
      - g. Information about different methods, forms, and routes of medical marijuana administration;
      - h. Signs and symptoms of substance abuse, including tolerance, dependency, and withdrawal; and
      - i. A listing of substance abuse programs and referral information;
    2. A system for a qualifying patient or the qualifying patient's designated caregiver to document the qualifying patient's pain, cachexia or wasting syndrome, nausea, seizures, muscle spasms, or agitation that includes:
      - a. A log book, maintained by the qualifying patient and or the qualifying patient's designated caregiver, in which the qualifying patient or the qualifying patient's designated caregiver may track the use and

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-313. Medical Director**

- A. Except as provided in R9-17-324(C), a dispensary shall appoint an individual who is a physician to function as a medical director.

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effects of specific medical marijuana strains and products;

- b. A rating scale for pain, cachexia or wasting syndrome, nausea, seizures, muscles spasms, and agitation;
  - c. Guidelines for the qualifying patient's self-assessment or, if applicable, assessment of the qualifying patient by the qualifying patient's designated caregiver; and
  - d. Guidelines for reporting usage and symptoms to the physician providing the written certification for medical marijuana and any other treating physicians; and
3. Policies and procedures for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana.
- E. A medical director for a dispensary shall not provide a written certification for medical marijuana for any qualifying patient.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-314. Dispensing Medical Marijuana**

- A. Before a dispensary agent dispenses medical marijuana or a marijuana product to a qualifying patient or a designated caregiver, the dispensary agent shall:
1. Verify the qualifying patient's or the designated caregiver's identity,
  2. Offer any appropriate patient education or support materials,
  3. Make available the results of testing of the medical marijuana or marijuana product required in R9-17-317.01(A), if requested by the qualifying patient or designated caregiver,
  4. Enter the qualifying patient's or designated caregiver's registry identification number on the qualifying patient's or designated caregiver's registry identification card into the medical marijuana electronic verification system,
  5. Verify the validity of the qualifying patient's or designated caregiver's registry identification card,
  6. Verify that the amount of medical marijuana or marijuana product the qualifying patient or designated caregiver is requesting would not cause the qualifying patient to exceed the limit on obtaining no more than two and one-half ounces of medical marijuana during any 14-calendar-day period, and
  7. Enter the following information into the medical marijuana electronic verification system for the qualifying patient or designated caregiver:
    - a. The amount of medical marijuana dispensed,
    - b. Whether the medical marijuana was dispensed to the qualifying patient or to the qualifying patient's designated caregiver,
    - c. The date and time the medical marijuana was dispensed,
    - d. The dispensary agent's registry identification number, and
    - e. The dispensary's registry identification number.
- B. A dispensary shall ensure that medical marijuana or a marijuana product provided by the dispensary to a qualifying

patient or a designated caregiver is dispensed in a container made of material that will not react with or leach into the medical marijuana or marijuana product.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 26 A.A.R. 2991, with an effective date of November 1, 2020 (Supp. 20-4).

**R9-17-315. Qualifying Patient Records**

- A. A dispensary shall ensure that:
1. A qualifying patient record is established and maintained for each qualifying patient who obtains medical marijuana or a marijuana product from the dispensary;
  2. An entry in a qualifying patient record:
    - a. Is recorded only by a dispensary agent authorized by dispensary policies and procedures to make an entry,
    - b. Is dated and signed by the dispensary agent,
    - c. Includes the dispensary agent's registry identification number, and
    - d. Is not changed to make the initial entry illegible;
  3. If an electronic signature is used to sign an entry, the dispensary agent whose signature the electronic code represents is accountable for the use of the electronic signature;
  4. A qualifying patient record is only accessed by a dispensary agent authorized by dispensary policies and procedures to access the qualifying patient record;
  5. A qualifying patient record is provided to the Department for review upon request;
  6. A qualifying patient record is protected from loss, damage, or unauthorized use; and
  7. A qualifying patient record is maintained for five years after the date of the qualifying patient's or, if applicable, the qualifying patient's designated caregiver's last request for medical marijuana from the dispensary.
- B. If a dispensary maintains qualifying patient records electronically, the dispensary shall ensure that:
1. There are safeguards to prevent unauthorized access, and
  2. The date and time of an entry in a qualifying patient record is recorded electronically by an internal clock.
- C. A dispensary shall ensure that the qualifying patient record for a qualifying patient who requests or whose designated caregiver on behalf of the qualifying patient requests medical marijuana or a marijuana product from the dispensary contains:
1. Qualifying patient information that includes:
    - a. The qualifying patient's name;
    - b. The qualifying patient's date of birth; and
    - c. The name of the qualifying patient's designated caregiver, if applicable;
  2. Documentation of any patient education and support materials provided to the qualifying patient or the qualifying patient's designated caregiver, including a description of the materials and the date the materials were provided; and
  3. For each time the qualifying patient requests and does not obtain medical marijuana or a marijuana product or, if applicable, the designated caregiver requests on behalf of the qualifying patient and does not obtain medical marijuana or a marijuana product from the dispensary, the following:
    - a. The date,

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- b. The name and registry identification number of the individual who requested the medical marijuana or marijuana product, and
- c. The dispensary's reason for refusing to provide the medical marijuana or marijuana product.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3).

**R9-17-316. Inventory Control System**

- A.** A dispensary shall designate in writing a dispensary agent or marijuana facility agent associated with the dispensary who has oversight of the dispensary's medical marijuana inventory control system.
  - B.** A dispensary shall only acquire marijuana from:
    - 1. The dispensary's cultivation site,
    - 2. Another dispensary or another dispensary's cultivation site,
    - 3. A marijuana establishment licensed under 9 A.A.C. 18,
    - 4. A qualifying patient authorized by the Department to cultivate marijuana, or
    - 5. A designated caregiver authorized by the Department to cultivate marijuana.
  - C.** A dispensary shall establish and implement an inventory control system for the dispensary's medical marijuana and marijuana products that documents:
    - 1. The following amounts:
      - a. Each day's beginning inventory of medical marijuana and marijuana products,
      - b. Acquisitions according to subsection (B),
      - c. Medical marijuana harvested by the dispensary,
      - d. Medical marijuana and marijuana products provided to a marijuana establishment or another dispensary,
      - e. Medical marijuana and marijuana products dispensed to a qualifying patient or designated caregiver,
      - f. Medical marijuana and marijuana products submitted to a laboratory for testing according to R9-17-317.01,
      - g. Medical marijuana or marijuana products that were disposed of, and
      - h. The day's ending medical marijuana and marijuana products inventory;
    - 2. For acquiring medical marijuana from a qualifying patient or designated caregiver:
      - a. A description of the medical marijuana acquired including the amount and strain,
      - b. The name and registry identification number of the qualifying patient or designated caregiver who provided the medical marijuana,
      - c. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent receiving the medical marijuana on behalf of the dispensary, and
      - d. The date of acquisition;
    - 3. For acquiring medical marijuana or a marijuana product from another dispensary or a marijuana establishment:
      - a. A description of the medical marijuana or marijuana product acquired including:
        - i. The amount, batch number, and strain of the medical marijuana or marijuana product;
- ii. For a marijuana product, the ingredients in order of abundance; and
  - iii. For an edible food product infused with medical marijuana or a marijuana product:
    - (1) The date of manufacture,
    - (2) The total weight of the marijuana-infused edible food product, and
    - (3) The estimated amount and batch number of the medical marijuana or marijuana product infused in the edible food product;
  - b. As applicable, either:
    - i. The name and registry identification number of the dispensary providing the medical marijuana or marijuana product, or
    - ii. The name and license number of the marijuana establishment providing the medical marijuana or marijuana product;
  - c. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent providing the medical marijuana or marijuana product;
  - d. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent receiving the medical marijuana or marijuana product on behalf of the dispensary; and
  - e. The date of acquisition;
- 4. For each batch of marijuana cultivated:
    - a. The batch number;
    - b. Whether the batch originated from marijuana seeds or marijuana cuttings;
    - c. The origin and strain of the marijuana seeds or marijuana cuttings planted;
    - d. The number of marijuana seeds or marijuana cuttings planted;
    - e. The date the marijuana seeds or cuttings were planted;
    - f. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers used in the cultivation;
    - g. The number of plants grown to maturity; and
    - h. Harvest information including:
      - i. Date of harvest,
      - ii. Final usable marijuana yield weight, and
      - iii. Name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent responsible for the harvest;
  - 5. For providing medical marijuana or a marijuana product to another dispensary or a marijuana establishment:
    - a. A description of the medical marijuana or marijuana product provided including:
      - i. The amount, batch number, and strain of the medical marijuana or marijuana product;
      - ii. For a marijuana product, the ingredients in order of abundance; and
      - iii. For an edible food product infused with medical marijuana or a marijuana product:
        - (1) The date of manufacture,
        - (2) The total weight of the marijuana-infused edible food product, and
        - (3) The estimated amount and batch number of the medical marijuana or marijuana product infused in the edible food product;

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- b. The name and registry identification number or marijuana establishment license number, as applicable, of the other dispensary or the marijuana establishment;
- c. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent who received the medical marijuana or marijuana product on behalf of the other dispensary or the marijuana establishment; and
- d. The date the medical marijuana or marijuana product was provided;
- 6. For submitting marijuana or marijuana products to a laboratory agent or laboratory for testing:
  - a. The amount, strain, and batch number of the marijuana or marijuana product submitted;
  - b. The name and registry identification number of the laboratory;
  - c. The name and registry identification number of the laboratory agent who received the marijuana or marijuana product on behalf of the laboratory; and
  - d. The date the marijuana or marijuana product was submitted to the laboratory; and
- 7. For disposal of medical marijuana or a marijuana product that is not to be dispensed or used for making a marijuana product:
  - a. Description of and reason for the medical marijuana or marijuana product being disposed of including, if applicable:
    - i. The number of failed or other unusable plants, and
    - ii. The results of laboratory testing;
  - b. Date of disposal;
  - c. Method of disposal; and
  - d. Name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent responsible for the disposal.
- D. The individual designated in subsection (A) shall conduct and document an audit of the dispensary's inventory that is accounted for according to generally accepted accounting principles at least once every 30 calendar days.
  - 1. If the audit identifies a reduction in the amount of medical marijuana or a marijuana product in the dispensary's inventory not due to documented causes, the dispensary shall determine and document where the loss has occurred and take and document corrective action.
  - 2. If the reduction in the amount of medical marijuana or a marijuana product in the dispensary's inventory is due to suspected criminal activity by a dispensary agent or marijuana facility agent, the dispensary shall report the dispensary agent or marijuana facility agent to the Department and to the local law enforcement authorities.
- E. A dispensary shall:
  - 1. Maintain the documentation required in subsections (C) and (D) at the dispensary for at least five years after the date on the document, and
  - 2. Provide the documentation required in subsections (C) and (D) to the Department for review upon request.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of

August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-317. Product Labeling and Packaging**

- A. A dispensary shall ensure that medical marijuana or a marijuana product provided by the dispensary to a qualifying patient or a designated caregiver is labeled with:
  - 1. The dispensary's registry identification number;
  - 2. The amount, strain, and batch number of the medical marijuana or marijuana product;
  - 3. The form of the medical marijuana or marijuana product;
  - 4. As applicable, the weight of the medical marijuana or marijuana product;
  - 5. In compliance with Table 3.1, the potency of the medical marijuana or marijuana product, based on laboratory testing results, including the number of milligrams per designated unit or percentage of:
    - a. Total tetrahydrocannabinol, reported according to R9-17-404.03(S)(3)(a);
    - b. Total cannabidiol, reported according to R9-17-404.03(S)(3)(b); and
    - c. Any other cannabinoid for which the dispensary is making a claim related to the effect of the cannabinoid on the human body;
  - 6. The following statement: "ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Marijuana use can be addictive and can impair an individual's ability to drive a motor vehicle or operate heavy machinery. Marijuana smoke contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, and lung infection. Marijuana use may affect the health of a pregnant woman and the unborn child. KEEP OUT OF REACH OF CHILDREN";
  - 7. If not cultivated by the dispensary, whether the medical marijuana was obtained from a qualifying patient, a designated caregiver, a marijuana establishment, or another dispensary;
  - 8. If not infused or prepared for sale by the dispensary, whether the marijuana product was obtained from a marijuana establishment or another dispensary;
  - 9. For a marijuana product:
    - a. The ingredients in order of abundance; and
    - b. If the marijuana product contains ethanol, the percentage of ethanol in the marijuana product;
  - 10. The date of manufacture, harvest, or sale; and
  - 11. The registry identification number of the qualifying patient.
- B. If a dispensary provides medical marijuana cultivated, or a marijuana product infused or prepared for sale, by the dispensary to a marijuana establishment or another dispensary, the dispensary shall ensure that:
  - 1. The medical marijuana or marijuana product is labeled with:
    - a. The dispensary's registry identification number or marijuana establishment's license number, as applicable;
    - b. The amount, strain, and batch number of the medical marijuana or marijuana product; and
    - c. The date of harvest or sale; and

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2. A copy of laboratory testing results for the medical marijuana or marijuana product is provided to the receiving dispensary or marijuana establishment.
- C. A dispensary shall ensure that medical marijuana or a marijuana product provided by the dispensary to a qualifying patient or a designated caregiver is dispensed in a container made of material that will not react with or leach into the medical marijuana or marijuana product.
- D. A dispensary shall ensure that medical marijuana or a marijuana product being submitted to a laboratory for testing is labeled according to requirements in R9-17-317.01(B)(5).
3. If the results of testing of the dispensary's medical marijuana and marijuana products for heavy metals, according to R9-17-404.03, indicate that the medical marijuana and marijuana products are in compliance with Table 3.1 for a period of at least six consecutive months:
  - a. Each batch of medical marijuana or a marijuana product is tested according to requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 for all analytes except heavy metals; and
  - b. At least once every three months, each batch of medical marijuana or a marijuana product is tested according to requirements in R9-17-404.03 and Table 3.1 for heavy metals.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020; amended by exempt rulemaking at 26 A.A.R. 968, effective April 20, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 2991, with an effective date of November 1, 2020; amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3447 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-17-317.01. Analysis of Medical Marijuana or a Marijuana Product**

- A. Before offering a batch of medical marijuana or of a marijuana product for sale or dispensing to a qualifying patient or designated caregiver, a dispensary shall ensure that:
  1. Except as provided in subsection (A)(2) or (3), each batch of medical marijuana or marijuana product is tested in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1;
  2. Each batch of a marijuana product is tested according to requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 for, as applicable:
    - a. At least potency and microbial contaminants other than mycotoxins if the marijuana product was prepared from another marijuana product, such as a concentrate or tincture, that is in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, using none of the following:
      - i. A temperature above which any analyte could chemically decompose or react with a component of the marijuana product;
      - ii. A pressure above which any analyte could chemically decompose or react with a component of the marijuana product;
      - iii. A process by which any analyte in the marijuana product that is in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 may be further concentrated; or
      - iv. A solvent other than water; or
    - b. All analytes except:
      - i. Ethanol if the marijuana product is intended to contain ethanol; or
      - ii. For a marijuana product intended for topical application, isopropanol if the marijuana product is intended to contain isopropanol; and
- B. A dispensary shall ensure that:
  1. Until laboratory testing has been completed and testing results received by the dispensary that comply with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, a batch of marijuana or of a marijuana product is stored in a location away from medical marijuana and marijuana products offered for dispensing;
  2. Except as provided in subsection (D), only one sample of each batch of medical marijuana or marijuana product is collected according to ANSI/ASQ Standard Z1.4 (2018), General Inspection Level II, incorporated by reference, including no future editions, and available at <https://asq.org/quality-resources/z14-z19>, including:
    - a. Use, as applicable, of one of the following sampling methods:
      - i. Top, middle, and bottom sampling using a sample thief, a device consisting of two nested tubes with one or more aligned slots through which a sample may be collected and then sealed into the inner tube by rotating the outer tube;
      - ii. Star pattern sampling from the top, middle, and bottom of each storage container;
      - iii. Collecting discrete incremental units of a batch, such as every tenth unit or every twentieth drop; or
      - iv. Quartering until the sample reaches the size specified in subsection (B)(3); and
    - b. For sampling methods specified in subsections (B)(2)(a)(i) through (iii), quartering the volume of the aggregated portions collected to obtain the sample size specified in subsection (B)(3);
  3. The size of the sample provided to a laboratory is sufficient for testing and, if necessary, retesting;
  4. Each sample in subsection (B)(3) is packaged in a container made of:
    - a. The same material that would be used for dispensing, or
    - b. Another material that will not react with or leach into the sample;
  5. Each packaged sample is labeled with the:
    - a. The dispensary's registry identification number;
    - b. The amount, strain, and batch number of the medical marijuana or marijuana product;
    - c. The analytes for which testing is being requested;
    - d. The storage temperature for the marijuana or marijuana product; and
    - e. The date of sampling;
  6. A packaged sample in subsection (B)(4) is submitted to a laboratory that:

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- a. Has a laboratory registration certificate issued by the Department, and
    - b. Is approved for testing by the Department for an analyte for which testing is being requested;
  7. Except as specified in subsections (A)(2) and (3) and (C)(1), as applicable, the samples in subsection (B)(4) are tested for each analyte specified in Table 3.1 by a laboratory that is approved by the Department for testing the analyte;
  8. Only batches of marijuana or marijuana products for which laboratory testing results in subsection (B)(7) are in compliance with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 are offered for sale or dispensing; and
  9. Except as provided in subsection (C), any batch of marijuana or marijuana product that does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 is remediated, if applicable, or destroyed according to policies and procedures.
- C.** If a dispensary receives a final report of testing, specified in R9-17-404.06(B)(3), from a laboratory that indicates that a batch of medical marijuana or marijuana product does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, the dispensary:
1. Within seven days after receiving the final report of testing, may request retesting of the remaining portion of the sample in subsection (B)(4) for all analytes that do not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 by no more than two other laboratories that are independent of a laboratory conducting a test included in the final report of testing and that are approved by the Department for testing the analytes;
  2. If the final report of testing conducted according to subsection (C)(1) from another, independent laboratory indicates that any analyte tested for according to subsection (C)(1) does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, shall remediate, if applicable, or destroy the batch of medical marijuana or marijuana product according to policies and procedures; and
  3. If the final report of testing from each of the two other independent laboratories, allowed according to subsection (C)(1), indicates that all analytes tested for according to subsection (C)(1) comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, may offer the batch of medical marijuana or marijuana product for sale or dispensing.
- D.** A dispensary may request retesting of a batch of medical marijuana or marijuana product using a second sample if:
1. The batch of marijuana or marijuana product is still in the possession of the dispensary;
  2. The dispensary receives notification from the Department, a marijuana establishment, or another dispensary that indicates that the final report of testing from a laboratory, specified in R9-17-404.06(B)(3), for the batch of medical marijuana or marijuana product may be inaccurate;
3. The dispensary:
- a. If the notification in subsection (D)(2) is from a marijuana establishment or another dispensary, informs the Department that the final report of testing may be inaccurate, providing the name of the notifying dispensary or marijuana establishment;
  - b. Collects the second sample according to subsections (B)(2) and (3);
  - c. Packages and labels the sample according to subsections (B)(4) and (5); and
  - d. Submits the sample to a second, independent laboratory that is approved by the Department for testing the analytes; and
4. The dispensary follows the requirements in subsections (C)(1) through (3) in determining whether the batch of medical marijuana or marijuana product:
- a. May be offered for sale or dispensing, or
  - b. Is required to be remediated, if applicable, or destroyed.
- E.** A dispensary shall ensure that remediation of a batch of marijuana or of a marijuana product that has undergone laboratory testing and does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1:
1. Is performed according to policies and procedures,
  2. Uses a method that is appropriate to address an analyte not in compliance with Table 3.1, and
  3. Does not introduce or produce a substance in a concentration that is known to be harmful to humans.
- F.** If a batch of medical marijuana or a marijuana product is remediated, a dispensary shall submit samples from the remediated batch for laboratory testing according to subsection (B).
- G.** A dispensary shall provide to the Department upon request a sample of the dispensary's inventory of medical marijuana or a marijuana product of sufficient quantity to enable the Department to conduct an analysis of the medical marijuana or marijuana product.

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 26 A.A.R. 2991, with an effective date of November 1, 2020; amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**Table 3.1. Analytes**

Key:

CAS Number = Chemical Abstract Services Registry number

CFU = Colony-forming unit, a method to estimate the number of viable bacteria or fungal cells in a sample

\* = Required for marijuana products only

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A. Microbial Contaminants		
Analyte	Maximum Allowable Contaminants	Required Action
<i>Escherichia coli</i>	10 CFU/g for edible marijuana or a marijuana-infused edible food product 100 CFU/g for all other medical marijuana and marijuana products	Remediate and retest, or Destroy
<i>Salmonella</i> spp.	Detectable in 1 gram	Destroy
<i>Aspergillus flavus</i> <i>Aspergillus fumigatus</i> <i>Aspergillus niger</i> <i>Aspergillus terreus</i>	Inhalable: Detectable in 1 gram	Remediate and retest, Remediate and use for preparing an extract or a concentrate, or Destroy
*Mycotoxins: Aflatoxin B1, B2, G1, and G2 Ochratoxin A	Marijuana product, except a marijuana product intended for topical application, prepared from an extract or concentrate of medical marijuana: 20 µg/kg (ppb) of total aflatoxins 20 µg/kg (ppb) of ochratoxin	Destroy

B. Heavy Metals		
Analyte	Maximum Allowable Concentration	Required Action
Arsenic	0.4 ppm	Remediate and retest, or Destroy
Cadmium	0.4 ppm	
Lead	1.0 ppm	
Mercury	0.2 ppm for inhalable medical marijuana or an inhalable marijuana product 1.2 ppm for non-inhalable medical marijuana and all other marijuana products	

C. *Residual Solvents			
Analyte	CAS Number	Maximum Allowable Concentration	Required Action
Acetone	67-64-1	1,000 ppm	Remediate and retest, or Destroy
Acetonitrile	75-05-8	410 ppm	
Benzene	71-43-2	2 ppm	
Butanes (measured as the cumulative residue of n-butane and iso-butane)	106-97-8 and 75-28-5, respectively	5,000 ppm	
Chloroform	67-66-3	60 ppm	
Dichloromethane	75-09-2	600 ppm	
Ethanol	64-17-5	5,000 ppm	
Ethyl Acetate	141-78-6	5,000 ppm	
Ethyl Ether	60-29-7	5,000 ppm	
Heptane	142-82-5	5,000 ppm	
Hexanes (measured as the cumulative residue of n-hexane, 2-methylpentane, 3-methylpentane, 2,2-dimethylbutane, and 2,3-dimethylbutane)	110-54-3, 107-83-5, 96-14-0, 75-83-2, and 79-29-8, respectively	290 ppm	
Isopropyl Acetate	108-21-4	5,000 ppm	
Methanol	67-56-1	3,000 ppm	
Pentanes (measured as the cumulative residue of n-pentane, iso-pentane, and neo-pentane)	109-66-0, 78-78-4, and 463-82-1, respectively	5,000 ppm	
2-Propanol (IPA)	67-63-0	5,000 ppm	
Toluene	108-88-3	890 ppm	
Xylenes (measured as the cumulative residue of 1,2-dimethylbenzene, 1,3-dimethylbenzene, and 1,4-dimethylbenzene, and the non-xylene, ethyl benzene)	1330-20-7 (95-47-6, 108-38-3, and 106-42-3, respectively, and 100-41-4)	2,170 ppm	

D. Pesticides, Fungicides, Growth Regulators			
Analyte	CAS Number	Maximum Allowable Concentration	Required Action

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Abamectin (B1a)	71751-41-2	0.5 ppm	Remediate and retest, or Destroy
Acephate	30560-19-1	0.4 ppm	
Acetamiprid	135410-20-7	0.2 ppm	
Aldicarb	116-06-3	0.4 ppm	
Azoxystrobin	131860-33-8	0.2 ppm	
Bifenazate	149877-41-8	0.2 ppm	
Bifenthrin	82657-04-3	0.2 ppm	
Boscalid	188425-85-6	0.4 ppm	
Carbaryl	63-25-2	0.2 ppm	
Carbofuran	1563-66-2	0.2 ppm	
Chlorantraniliprole	500008-45-7	0.2 ppm	
Chlorfenapyr	122453-73-0	1.0 ppm	
Chlorpyrifos	2921-88-2	0.2 ppm	
Clofentezine	74115-24-5	0.2 ppm	
Cyfluthrin	68359-37-5	1.0 ppm	
Cypermethrin	52315-07-8	1.0 ppm	
Daminozide	1596-84-5	1.0 ppm	
DDVP (Dichlorvos)	62-73-7	0.1 ppm	
Diazinon	333-41-5	0.2 ppm	
Dimethoate	60-51-5	0.2 ppm	
Ethoprophos	13194-48-4	0.2 ppm	
Etofenprox	80844-07-1	0.4 ppm	
Etoxazole	153233-91-1	0.2 ppm	
Fenoxycarb	72490-01-8	0.2 ppm	
Fenpyroximate	134098-61-6	0.4 ppm	
Fipronil	120068-37-3	0.4 ppm	
Flonicamid	158062-67-0	1.0 ppm	
Fludioxonil	131341-86-1	0.4 ppm	
Hexythiazox	78587-05-0	1.0 ppm	
Imazalil	35554-44-0	0.2 ppm	
Imidacloprid	138261-41-3	0.4 ppm	
Kresoxim-methyl	143390-89-0	0.4 ppm	
Malathion	121-75-5	0.2 ppm	
Metalaxyl	57837-19-1	0.2 ppm	
Methiocarb	2032-65-7	0.2 ppm	
Methomyl	16752-77-5	0.4 ppm	
Myclobutanil	88671-89-0	0.2 ppm	
Naled	300-76-5	0.5 ppm	
Oxamyl	23135-22-0	1.0 ppm	
Pacllobutrazol	76738-62-0	0.4 ppm	
Permethrins (measured as the cumulative residue of cis- and trans- isomers)	52645-53-1 (54774-45-7 and 51877-74-8)	0.2 ppm	
Phosmet	732-11-6	0.2 ppm	
Piperonyl butoxide	51-03-6	2.0 ppm	
Prallethrin	23031-36-9	0.2 ppm	
Propiconazole	60207-90-1	0.4 ppm	
Propoxur	114-26-1	0.2 ppm	
Pyrethrins (measured as the cumulative residue of pyrethrin I and II)	8003-34-7 (121-21-1, 25402- 06-6, and 4466-14- 2)	1.0 ppm	
Pyridaben	96489-71-3	0.2 ppm	
Spinosad (measured as the cumulative residue of Spinosyn A and Spinosyn D)	168316-95-8	0.2 ppm	
Spiromesifen	283594-90-1	0.2 ppm	
Spirotetramat	203313-25-1	0.2 ppm	
Spiroxamine	118134-30-8	0.4 ppm	
Tebuconazole	107534-96-3	0.4 ppm	



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Thiacloprid	111988-49-9	0.2 ppm
Thiamethoxam	153719-23-4	0.2 ppm
Trifloxystrobin	141517-21-7	0.2 ppm

E. Potency		
Analyte	Labeling	Required Action
Tetrahydrocannabinolic acid (THC-A)	Label claim is not within +/- 20% of tested value	Revise label as necessary
Delta-9-tetrahydrocannabinol ( $\Delta$ 9-THC)		
Cannabidiolic acid (CBD-A)		
Cannabidiol (CBD)		

**Historical Note**

New Table 3.1 Analytes made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 26 A.A.R. 2848, with an immediate effective date of October 15, 2020; amended by exempt rulemaking at 26 A.A.R. 2991, with an effective date of November 1, 2020 (Supp. 20-4). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-318. Security**

- A.** A dispensary shall ensure that access into areas of the dispensary or the dispensary's cultivation site where marijuana is cultivated, processed, as defined in A.R.S. § 36-2850, manufactured, or stored is limited to the dispensary's principal officers, board members, and authorized individuals, unless the individual is supervised by an individual authorized according to subsection (G)(2)(a).
- B.** A dispensary agent may transport marijuana, marijuana plants, marijuana products, and marijuana paraphernalia between the dispensary and:
  1. The dispensary's cultivation site,
  2. A qualifying patient,
  3. Another dispensary,
  4. A marijuana establishment licensed according to 9 A.A.C. 18, and
  5. A laboratory that has a laboratory registration certificate issued by the Department.
- C.** Before transportation, a dispensary agent shall:
  1. Complete a trip plan that includes:
    - a. The name of the dispensary agent in charge of transporting the marijuana, marijuana plants, marijuana products, or marijuana paraphernalia;
    - b. The date and start time of the trip;
    - c. A description of the marijuana, marijuana plants, marijuana products, or marijuana paraphernalia being transported;
    - d. Any anticipated stops during the trip, including the locations of the stops and arrival time and departure time for each location; and
    - e. The anticipated route of transportation; and
  2. Provide a copy of the trip plan in subsection (C)(1) to the dispensary.
- D.** During transportation, a dispensary agent shall:
  1. Carry a copy of the trip plan in subsection (C)(1) with the dispensary agent for the duration of the trip;
  2. Use a vehicle that has a current registration with the Arizona Department of Motor Vehicles, issued according to A.R.S. Title 28, Chapter 7, Article 2:
    - a. Without any marijuana identification;
    - b. Equipped with a global positioning system or other means for the dispensary to track the current location of the vehicle at any point in time;
    - c. Capable of providing electronic information about where the vehicle has been during at least the previous 90 days;
  3. Have a means of communication with the dispensary;
  4. Note the arrival time and departure time for each stop; and
  5. Ensure that the marijuana, marijuana plants, or marijuana products are stored in the locked compartment specified in subsection (D)(2)(e) and are not visible.
- E.** After transportation, a dispensary agent shall:
  1. Enter the end time of the trip and any changes to the trip plan on the trip plan required in subsection (C)(1), and
  2. Ensure that the updated trip plan is provided to the dispensary.
- F.** A dispensary shall:
  1. Maintain the documents required in subsection (C)(2) and (E) for at least two years after the date of the documentation;
  2. If transporting a sample to a laboratory for testing, provide a copy of the trip plan to the laboratory; and
  3. Provide a copy of the documents required in subsection (C)(2) and (E) to the Department for review upon request.
- G.** To prevent unauthorized access to medical marijuana at the dispensary and, if applicable, the dispensary's cultivation site, the dispensary shall have the following:
  1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include:
    - a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio-frequency method, such as cellular, private radio signals, or other mechanical or electronic device;
  2. With an operational video surveillance system and recording equipment that:
    - i. Shows the interior of the vehicle, including the driver's seat and location of the marijuana, marijuana plants, or marijuana products being transported;
    - ii. Is turned on for the duration of a trip while medical marijuana or a marijuana product is in the vehicle; and
    - iii. Either stores the recording for at least 30 calendar days or transmits the recorded images at the time of recording to another location, where the recorded images are stored for at least 30 calendar days; and
  3. With a locked compartment in which any marijuana, marijuana plants, or marijuana products being transported may be stored during a trip;

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- b. Exterior lighting to facilitate surveillance;
  - c. Electronic monitoring including:
    - i. At least one 19-inch or greater call-up monitor;
    - ii. A printer capable of immediately producing a clear still photo from any video camera image;
    - iii. Video cameras:
      - (1) Providing coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and
      - (2) Having a recording resolution of at least 704 x 480 or the equivalent;
    - iv. A video camera at each point of sale location allowing for the identification of any qualifying patient or designated caregiver purchasing medical marijuana;
    - v. A video camera in each grow room capable of identifying any activity occurring within the grow room in low light conditions;
    - vi. Storage of video recordings from the video cameras for at least 30 calendar days;
    - vii. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; and
    - viii. Sufficient battery backup for video cameras and recording equipment to support at least five minutes of recording in the event of a power outage; and
  - d. Panic buttons in the interior of each building; and
2. Policies and procedures:
- a. That provide for the identification of authorized individuals;
  - b. That deter unauthorized removal of marijuana or marijuana products from the premises, including:
    - i. Restricting access to the areas of the dispensary that contain marijuana and, if applicable, the dispensary's cultivation site to authorized individuals only; and
    - ii. Ensuring that an individual other than an authorized individual is supervised by an authorized individual when in an area specified in subsection (G)(2)(b)(i);
  - c. That prevent loitering;
  - d. For conducting electronic monitoring; and
  - e. For the use of a panic button.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3447 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-17-319. Edible Food Products**

- A. A dispensary that prepares, sells, or dispenses marijuana-infused edible food products shall:

1. Before preparing marijuana-infused edible food products, obtain a license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, to prepare marijuana-infused edible food products;
  2. If the dispensary prepares the marijuana-infused edible food products, ensure that the marijuana-infused edible food products are prepared according to the applicable requirements in 9 A.A.C. 8, Article 1;
  3. If the marijuana-infused edible food products are not prepared at the dispensary, obtain and maintain at the dispensary a copy of the current license or permit as a food establishment, issued under 9 A.A.C. 8, Article 1, to prepare marijuana-infused edible food products from the dispensary or marijuana establishment that prepares the marijuana-infused edible products;
  4. Before selling or dispensing marijuana-infused edible food products, obtain a license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, to sell or dispense marijuana-infused edible food products that are either:
    - a. A time/temperature control for safety food, or
    - b. Not prepared in individually packaged containers; and
  5. If a dispensary sells or dispenses marijuana-infused edible food products, ensure that the marijuana-infused edible food products are sold or dispensed according to applicable requirements in 9 A.A.C. 8, Article 1.
- B. A dispensary is responsible for the content and quality of any edible food product sold or dispensed by the dispensary.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

**R9-17-320. Cleaning and Sanitation**

- A. A dispensary shall ensure that:
1. Any building or equipment used by a dispensary for the cultivation, harvest, preparation, packaging, storage, infusion, or sale of medical marijuana or marijuana products is maintained in a clean and sanitary condition;
  2. Medical marijuana or marijuana products, in the process of production, preparation, manufacture, packing, storage, sale, distribution, or transportation, are protected from flies, dust, dirt, and all other contamination;
  3. Refuse or waste products incident to the manufacture, preparation, packing, selling, distributing, or transportation of medical marijuana or marijuana products are removed from the building used as a dispensary and, if applicable, a building at the dispensary's cultivation site at least once every 24 hours or more often as necessary to maintain a clean condition;
  4. All trucks, trays, buckets, other receptacles, platforms, racks, tables, shelves, knives, saws, cleavers, other utensils, or the machinery used in moving, handling, cutting, chopping, mixing, canning, packaging, or other processes are cleaned daily;
  5. Any equipment used in the preparation of marijuana products is clean, in good repair, and, if applicable, calibrated according to the manufacturer's recommendations;
  6. Any supplies used in the preparation of marijuana products, including flammable or volatile chemicals, are

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stored in a manner to avoid a hazardous condition from occurring; and

7. All stored marijuana products are securely covered.
- B.** A dispensary shall ensure that a dispensary agent at the dispensary or the dispensary's cultivation site:
  1. Cleans the dispensary agent's hands and exposed portions of the dispensary agent's arms in a hand washing sink:
    - a. Before preparing medical marijuana or marijuana products including working with food, equipment, and utensils;
    - b. During preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks;
    - c. After handling soiled equipment or utensils;
    - d. After touching bare human body parts other than the dispensary agent's clean hands and exposed portions of arms; and
    - e. After using the toilet room;
  2. If working directly with the preparation of medical marijuana or the infusion of marijuana into non-edible products:
    - a. Keeps the dispensary agent's fingernails trimmed, filed, and maintained so that the edges and surfaces are cleanable;
    - b. Unless wearing intact gloves in good repair, does not have fingernail polish or artificial fingernails on the dispensary agent's fingernails; and
    - c. Wears protective apparel such as coats, aprons, gowns, or gloves to prevent contamination;
  3. Wears clean clothing appropriate to assigned tasks;
  4. Reports to the medical director any health condition experienced by the dispensary agent that may adversely affect the safety or quality of any medical marijuana or marijuana products with which the dispensary agent may come into contact; and
  5. If the medical director determines that a dispensary agent has a health condition that may adversely affect the safety or quality of the medical marijuana or marijuana products, is prohibited from direct contact with any medical marijuana, marijuana products, or equipment or materials for processing medical marijuana or marijuana products until the medical director determines that the dispensary agent's health condition will not adversely affect the medical marijuana or marijuana products.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4).

**R9-17-321. Physical Plant**

- A.** A dispensary or a dispensary's cultivation site shall be located at least 500 feet from a private school or a public school that existed, as applicable:
  1. Before the date the dispensary submitted the initial dispensary registration certificate application,
  2. Before the date of an application to change the location of the dispensary, or
  3. Before the date of an application to add a cultivation site.
- B.** A dispensary shall provide onsite parking or parking adjacent to the building used as the dispensary.

- C.** A building used as a dispensary or the location used as a dispensary's cultivation site shall have:
  1. At least one toilet room;
  2. Each toilet room shall contain:
    - a. A flushable toilet;
    - b. Mounted toilet tissue;
    - c. A sink with running water;
    - d. Soap contained in a dispenser; and
    - e. Disposable, single-use paper towels in a mounted dispenser or a mechanical air hand dryer;
  3. At least one hand washing sink not located in a toilet room, with running water, soap contained in a dispenser, and either disposable, single-use paper towels in a mounted dispenser or a mechanical air hand dryer;
  4. Designated storage areas for medical marijuana or materials used in direct contact with medical marijuana separate from storage areas for toxic or flammable materials; and
  5. If preparation or packaging of medical marijuana is done in the building, a designated area for the preparation or packaging that:
    - a. Includes work space that can be sanitized, and
    - b. Is only used for the preparation or packaging of medical marijuana.
- D.** For each commercial device used at a dispensary or the dispensary's cultivation site, the dispensary shall:
  1. Ensure that the commercial device is licensed or certified pursuant to A.R.S. § 3-3451,
  2. Maintain documentation of the commercial device's license or certification, and
  3. Provide a copy of the commercial device's license or certification to the Department for review upon request.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-322. Denial or Revocation of a Dispensary Registration Certificate**

- A.** The Department shall deny an application for a dispensary registration certificate or a renewal if:
  1. For an application for a dispensary registration certificate, the physical address of the building or, if applicable, the physical address of the dispensary's cultivation site is within 500 feet of a private school or a public school that existed before the date the dispensary submitted the initial dispensary registration certificate application, before the date of an application to change the location of the dispensary, or before the date of an application to add a cultivation site;
  2. A principal officer or board member:
    - a. Has been convicted of an excluded felony offense;
    - b. Has served as a principal officer or board member for a dispensary or marijuana establishment that had the dispensary registration certificate or marijuana establishment license revoked;
    - c. Is under 21 years of age; or
    - d. Is a physician currently providing written certifications for medical marijuana for qualifying patients; or

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3. The application or the dispensary does not comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter.
- B. The Department may deny an application for a dispensary registration certificate if a principal officer or board member of the dispensary:
  1. Did not obtain an approval to operate the dispensary or marijuana establishment, as applicable, within 18 months after the dispensary registration certificate or marijuana establishment license was issued; or
  2. Provides false or misleading information to the Department.
- C. The Department shall revoke a dispensary's registration certificate if:
  1. The dispensary:
    - a. Operates before obtaining approval to operate a dispensary from the Department;
    - b. Diverts marijuana to a person other than:
      - i. Another dispensary with a valid dispensary registration certificate issued by the Department,
      - ii. A marijuana establishment with a valid marijuana establishment license issued under 9 A.A.C. 18;
      - iii. A laboratory with a valid laboratory registration certificate issued by the Department,
      - iv. A qualifying patient with a valid registry identification card issued by the Department,
      - v. A designated caregiver with a valid registry identification card issued by the Department,
      - vi. A dispensary agent with a valid registry identification card or marijuana facility agent with a valid marijuana facility agent license issued by the Department accepting the marijuana on behalf of a dispensary or marijuana establishment, or
      - vii. A laboratory agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a laboratory;
    - c. Acquires usable marijuana or mature marijuana plants from any entity other than another dispensary with a valid dispensary registration certificate issued by the Department, a marijuana establishment with a marijuana establishment license issued under 9 A.A.C. 18, a qualifying patient with a valid registry identification card, or a designated caregiver with a valid registry identification card; or
    - d. Acquires a marijuana product from any person other than another dispensary with a valid dispensary registration certificate issued by the Department or a marijuana establishment with a marijuana establishment license issued under 9 A.A.C. 18; or
  2. A principal officer or board member has been convicted of an excluded felony offense.
- D. The Department may revoke a dispensary registration certificate if the dispensary does not:
  1. Comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter; or
  2. Implement the policies and procedures or comply with the statements provided to the Department with the dispensary's application.
- E. If the Department denies a dispensary registration certificate application, the Department shall provide notice to the applicant that includes:
  1. The specific reason or reasons for the denial, and
2. All other information required by A.R.S. § 41-1076.
- F. If the Department revokes a dispensary registration certificate, the Department shall provide notice to the dispensary that includes:
  1. The specific reason or reasons for the revocation; and
  2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by emergency rulemaking at 18 A.A.R. 1010, effective April 11, 2012 for 180 days (Supp. 12-2). Emergency expired (Supp. 12-4). Amended by final rulemaking at 18 A.A.R. 3354, with an immediate effective date of December 5, 2012 (Supp. 12-4). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-323. Denial or Revocation of a Dispensary Agent's Registry Identification Card**

- A. The Department shall deny a dispensary agent's application for or renewal of the dispensary agent's registry identification card if the dispensary agent does not meet the definition "non-profit medical marijuana dispensary agent" in A.R.S. § 36-2801.
- B. The Department may deny a dispensary agent's application for or renewal of the dispensary agent's registry identification card if the dispensary agent:
  1. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or this Chapter;
  2. Previously had a marijuana facility agent license revoked for not complying with A.R.S. Title 36, Chapter 28.2 or 9 A.A.C. 18; or
  3. Provides false or misleading information to the Department.
- C. The Department shall revoke a dispensary agent's registry identification card if the dispensary agent:
  1. Diverts medical marijuana to a person other than:
    - a. Another dispensary with a valid dispensary registration certificate issued by the Department,
    - b. A marijuana establishment with a valid marijuana establishment license issued under 9 A.A.C. 18;
    - c. A laboratory with a valid laboratory registration certificate issued by the Department,
    - d. A qualifying patient with a valid registry identification card issued by the Department,
    - e. A designated caregiver with a valid registry identification card issued by the Department,
    - f. A dispensary agent with a valid registry identification card or marijuana facility agent with a valid marijuana facility agent license issued by the Department accepting the marijuana on behalf of a dispensary or marijuana establishment, or
    - g. A laboratory agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a laboratory; or

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2. Except as provided in A.R.S. § 36-2804.01(D), has been convicted of an excluded felony offense.
- D. The Department may revoke a dispensary agent's registry identification card if the dispensary agent knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.
- E. If the Department denies or revokes a dispensary agent's registry identification card, the Department shall provide notice to the dispensary agent and the dispensary agent's dispensary that includes:
  1. The specific reason or reasons for the denial or revocation; and
  2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 734, effective April 14, 2011 (Supp. 11-2). Amended by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-324. Dual Licensees**

- A. If a dispensary is a dual licensee, the dispensary shall:
  1. Provide marijuana and marijuana products, according to A.A.C. R9-18-309, to consumers, as defined in A.R.S. § 36-2850, at the same location as the dispensary dispenses medical marijuana and marijuana products to qualifying patients and designated caregivers;
  2. Notify the Department within five calendar days after beginning to operate on a for-profit basis, as allowed by A.R.S. § 36-2858(D)(2), and, if applicable, provide to the Department the documents required in R9-17-304(C)(2) for the new organizational or corporate structure;
  3. Comply with the requirements in A.R.S. § 36-2858(D)(3); and
  4. Comply with the requirements in A.R.S. § 36-2854(D) and A.A.C. R9-18-312.01.
- B. If a dispensary is a dual licensee, the entity holding the valid dispensary registration certificate may:
  1. Request that the dispensary's cultivation site, specified according to R9-17-305(A)(1)(e) or R9-17-307(A)(1), be transferred under the entity's marijuana establishment license according to A.A.C. R9-18-303(E)(3);
  2. Request approval of a change in the location in subsection (A)(1) by complying with the requirements in both:
    - a. R9-17-307(A), and
    - b. A.A.C. R9-18-306; or
  3. Transfer or assign both the dispensary registration certificate and the marijuana establishment license to the same entity.
- C. A dispensary that is a dual licensee is exempt from the requirements in:
  1. R9-17-310(A)(6), (13), and (14);
  2. R9-17-313; and
  3. R9-17-320(B)(4) and (5), but shall ensure that a dispensary agent or marijuana facility agent at the dispensary or the dispensary's cultivation site:

- a. Reports to a principal officer or board member of the dispensary any health condition experienced by the dispensary agent or marijuana facility agent that may adversely affect the safety or quality of any medical marijuana or marijuana products with which the dispensary agent or marijuana facility agent may come into contact; and
- b. If the principal officer or board member determines that a dispensary agent or marijuana facility agent has a health condition that may adversely affect the safety or quality of the medical marijuana or marijuana products, is prohibited from direct contact with any medical marijuana, marijuana products, or equipment or materials for processing medical marijuana, as defined in A.R.S. § 36-2850, or preparing marijuana products until the principal officer or board member determines that the dispensary agent's or marijuana facility agent's health condition will not adversely affect the medical marijuana or marijuana products.

- D. If the Department identifies an instance of noncompliance with a requirement of both this Chapter and 9 A.A.C. 18 during an inspection of a dual licensee, the Department shall note the instance of noncompliance on a notice of deficiencies associated with the dual licensee's marijuana establishment license under 9 A.A.C. 18, rather than on both the notice of deficiencies for the dispensary registration certificate and the notice of deficiencies for the marijuana establishment license.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 747, effective May 3, 2021 (Supp. 21-2). Amended by exempt rulemaking at 27 A.A.R. 1587, with an immediate effective date of September 7, 2021 (Supp. 21-3). Amended by final expedited rulemaking at 28 A.A.R. 2562 (September 30, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3447 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**ARTICLE 4. LABORATORIES AND LABORATORY AGENTS****R9-17-401. Owner**

- A. For the purposes of this Article the following individuals are considered owners:
  1. If an individual is applying for a laboratory registration certificate, the individual;
  2. If a corporation is applying for a laboratory registration certificate, two individuals who are officers of the corporation;
  3. If a partnership is applying for a laboratory registration certificate, two of the individuals who are partners;
  4. If a limited liability company is applying for a laboratory registration certificate, a manager or, if the limited liability company does not have a manager, an individual who is a member of the limited liability company;
  5. If an association or cooperative is applying for a laboratory registration certificate, two individuals who are members of the governing board of the association or cooperative;

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6. If a joint venture is applying for a laboratory registration certificate, two of the individuals who signed the joint venture agreement; and
7. If a business organization type other than those described in subsections (A)(2) through (6) is applying for a laboratory registration certificate, two individuals who are members of the business organization.

**B.** When a laboratory is required by this Chapter to provide information, sign documents, or ensure actions are taken, the individual or individuals in subsection (A) shall comply with the requirement on behalf of the laboratory.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4).

**R9-17-402. Applying for a Laboratory Registration Certificate**

**A.** To apply for a laboratory registration certificate, an applicant shall submit to the Department the following:

1. An application in a Department-provided format that includes:
  - a. The physical address of the laboratory;
  - b. The distance to the closest private school or public school from the laboratory;
  - c. The following information for the laboratory applying:
    - i. The legal name of the laboratory,
    - ii. Type of business organization,
    - iii. Mailing address,
    - iv. Telephone number, and
    - v. Email address;
  - d. The name of the owner designated to submit laboratory agent registry identification card applications on behalf of the laboratory;
  - e. The name, residence address, and date of birth of each owner;
  - f. The identifying number on the applicable card or document in subsection (A)(4)(d)(i) through (v);
  - g. The name, residence address, and date of birth of the technical laboratory director designated according to R9-17-404(3);
  - h. The name, residence address, and date of birth of each laboratory agent other than an owner or the technical laboratory director, if applicable;
  - i. Whether the laboratory agrees to allow the Department to submit supplemental requests for information;
  - j. A statement that, if the applicant is issued a laboratory registration certificate, the laboratory will not begin testing marijuana pursuant to R9-17-317.01 until the laboratory has been inspected and issued an approval for testing by the Department;
  - k. An attestation that the information provided to the Department to apply for a laboratory registration certificate is true and correct; and
  - l. The signatures of the owner of the laboratory, according to R9-17-401(A), and the technical laboratory director and the date each signed;
2. Policies and procedures that comply with the requirements in this Chapter that contain:
  - a. Inventory control;
  - b. A chain of custody and sample requirement process;

- c. A records retention process;
  - d. A secure method to transfer the portion of a sample remaining after testing to another laboratory with an approval for testing issued by the Department:
    - i. For testing of parameters or analytes that the laboratory receiving the sample from a dispensary is not approved by the Department to conduct, or
    - ii. For retesting at the request of a dispensary according to R9-17-317.01(C);
  - e. Security; and
  - f. A process for disposal of marijuana or marijuana products that are submitted to the laboratory for testing;
3. If the applicant is one of the business organizations in R9-17-401(A)(2) through (7), a copy of the business organization's articles of incorporation, articles of organization, or partnership or joint venture documents that include:
    - a. The name of the business organization,
    - b. The type of business organization, and
    - c. The names and titles of the individuals in R9-17-401(A);
  4. For each owner:
    - a. An attestation signed and dated by the owner that the owner has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;
    - b. An attestation signed and dated by the owner that the owner does not have a direct or indirect familial or financial relationship with or interest in a dispensary, marijuana establishment, or related medical marijuana business entity or management company;
    - c. An attestation signed and dated by the owner that the laboratory will not test marijuana or marijuana products for a designated caregiver who the owner has a direct or indirect familial or financial relationship with;
    - d. An attestation signed and dated by the owner pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
    - e. A copy the owner's:
      - i. Arizona driver's license issued on or after October 1, 1996;
      - ii. Arizona identification card issued on or after October 1, 1996;
      - iii. Arizona registry identification card;
      - iv. Photograph page in the owner's U.S. passport or a U.S. passport card; or
      - v. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the owner:
        - (1) Birth certificate verifying U.S. citizenship,
        - (2) U. S. Certificate of Naturalization, or
        - (3) U. S. Certificate of Citizenship; and
    - f. For the Department's criminal records check authorized in A.R.S. §§ 36-2804.01 and 36-2804.07:
      - i. The owner's fingerprints on a fingerprint card that includes:
        - (1) The owner's first name; middle initial, if applicable; and last name;
        - (2) The owner's signature;
        - (3) If different from the owner, the signature of the individual physically rolling the owner's fingerprints;

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- (4) The owner's residence address;
  - (5) If applicable, the owner's surname before marriage and any names previously used by the owner;
  - (6) The owner's date of birth;
  - (7) The owner's Social Security number;
  - (8) The owner's citizenship status;
  - (9) The owner's gender;
  - (10) The owner's race;
  - (11) The owner's height;
  - (12) The owner's weight;
  - (13) The owner's hair color;
  - (14) The owner's eye color; and
  - (15) The owner's place of birth; or
  - ii. If the fingerprints and information required in subsection (A)(4)(f)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the owner as a result of the application;
5. If zoning restrictions have been enacted, a statement, in a Department-provided format, signed and dated within 60 calendar days before the date of the application by a representative of the local jurisdiction:
- a. Certifying that the laboratory is in compliance with any local zoning restrictions; and
  - b. Including:
    - i. Information identifying the local jurisdiction and the local jurisdiction's representative,
    - ii. The legal name of the laboratory, and
    - iii. The physical address of the laboratory as specified according to subsection (A)(1)(a);
6. A copy of documentation issued by the local jurisdiction to the laboratory authorizing occupancy of the building as a laboratory, such as a certificate of occupancy, a special use permit, or a conditional use permit;
7. A site plan drawn to scale of the laboratory location showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains;
8. A building plan drawn to scale of the building where the laboratory is located showing the:
- a. Layout and dimensions of each room;
  - b. Name and function of each room;
  - c. Fire ratings of the materials used for ceilings, walls, doors, and floors of rooms used to store flammable substances;
  - d. Location of each fire protection device;
  - e. Layout of heating, air conditioning, exhaust, and ventilation systems;
  - f. Location and layout of refrigerated rooms or freezer rooms;
  - g. Location of each sink, safety shower, other water supply, or plumbing fixture;
  - h. Location of fixed or movable equipment and instruments that require dedicated electrical, water, vacuum, gas, or other building systems;
  - i. Location of security measures or equipment to protect from diversion of marijuana or marijuana products; and
  - j. Means of egress;
9. Documentation of accreditation of the location specified according to subsection (A)(1)(a) for which the applicant is applying for a laboratory registration certificate;
10. The laboratory's Transaction Privilege Tax Number issued by the Arizona Department of Revenue, if applicable; and
11. The applicable fee in R9-17-102 for applying for a laboratory registration certificate.
- B.** Within 72 hours after an owner receives a laboratory registration certificate pursuant to an application submitted according to subsection (A), the owner shall apply for a laboratory agent registry identification card, according to R9-17-405, for each laboratory agent, including a technical laboratory director.
- C.** A change in location of the laboratory's physical address or ownership requires a new application to be submitted according to subsection (A).
- D.** A separate laboratory registration certificate is required for each noncontiguous portion of a laboratory.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020; amended by exempt rulemaking at 26 A.A.R. 968, effective April 20, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-402.01. Applying for Approval for Testing**

To apply for approval for testing, an applicant shall submit to the Department, at least 60 calendar days before the expiration of the initial laboratory registration certificate for the laboratory, the following:

- 1. An application in a Department-provided format that includes:
  - a. The name and registry identification number of the laboratory;
  - b. The physical address of the laboratory;
  - c. The name of the applicant;
  - d. The name of the technical laboratory director designated according to R9-17-404(3);
  - e. For each parameter for which approval for testing is being requested:
    - i. The analyte to be tested for,
    - ii. The instruments and equipment to be used for testing, and
    - iii. The software to be used at the laboratory for instrument control and data reduction interpretation;
  - f. The laboratory's proposed hours of operation;
  - g. Whether the laboratory agrees to allow the Department to submit supplemental requests for information;
  - h. Whether the laboratory is ready for an inspection by the Department;
  - i. If the laboratory is not ready for an inspection by the Department, the date the laboratory will be ready for an inspection by the Department;

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- j. An attestation that the information provided to the Department to apply for approval for testing is true and correct; and
- k. The signatures of the owner of the laboratory, according to R9-17-401(A), and the technical laboratory director and the date each signed;
- 2. For each parameter and analyte listed according to subsection (1)(e):
  - a. A copy of current accreditation;
  - b. The limit of quantitation for each matrix, according to R9-17-404.03(I);
  - c. A copy of a proficiency testing report;
  - d. A copy of the standard operating procedure; and
  - e. Documentation of the initial demonstration of capabilities for each matrix, according to R9-17-404.03(D);
- 3. Policies and procedures that comply with the requirements in this Chapter that include:
  - a. A quality assurance program and standards,
  - b. A process to ensure marijuana or marijuana products testing results are accurate, precise, and scientifically valid before reporting the results; and
  - c. A process to compile testing results into a single laboratory report to be provided to a dispensary; and
- 4. If different from the building plan submitted according to R9-17-402(A)(8), a building plan drawn to scale of the building where the laboratory is located showing the:
  - a. Layout and dimensions of each room;
  - b. Name and function of each room;
  - c. Fire ratings of the materials used for ceilings, walls, doors, and floors of rooms used to store flammable substances;
  - d. Location of each fire protection device;
  - e. Layout of heating, air conditioning, exhaust, and ventilation systems;
  - f. Location and layout of refrigerated rooms or freezer rooms;
  - g. Location of each sink, safety shower, other water supply, or plumbing fixture;
  - h. Location of fixed or movable equipment and instruments that require dedicated electrical, water, vacuum, gas, or other building systems;
  - i. Location of security equipment to protect from diversion of marijuana or marijuana products; and
  - j. Means of egress.
- a. The physical address of the laboratory;
- b. The following information for the laboratory:
  - i. The legal name of the laboratory,
  - ii. The registry identification number for the laboratory,
  - iii. Type of business organization,
  - iv. Mailing address,
  - v. Telephone number, and
  - vi. Email address;
- c. The name of the owner designated to submit laboratory agent registry identification card applications on behalf of the laboratory;
- d. The name, residence address, and date of birth of each owner;
- e. The name, residence address, and date of birth of the technical laboratory director designated according to R9-17-404(3);
- f. The name, residence address, and date of birth of each laboratory agent, if applicable;
- g. Whether the laboratory agrees to allow the Department to submit supplemental requests for information;
- h. An attestation that the information provided to the Department to renew the laboratory registration certificate is true and correct; and
- i. The signatures of the owner of the laboratory, according to R9-17-401(A), and the technical laboratory director and the date each signed;
- 2. For each owner:
  - a. An attestation signed and dated by the owner that the owner has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801; and
  - b. An attestation signed and dated by the owner that the laboratory will not test medical marijuana and medical marijuana products for:
    - i. A dispensary, related medical marijuana business entity, or management company that the owner has a direct or indirect familial or financial relationship with or interest in; or
    - ii. A designated caregiver who the owner has a direct or indirect familial or financial relationship with;
- 3. For each current parameter and analyte, documentation of current accreditation;
- 4. If a change has been made to the standard operating procedure for a current parameter, a copy of the revised standard operating procedure;
- 5. If a change has been made in the quality assurance plan for a current parameter required in R9-17-404.03 or R9-17-404.04, a copy of the revised quality assurance plan; and
- 6. The applicable fee in R9-17-102 for applying to renew a laboratory registration certificate.

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020; amended by exempt rulemaking at 26 A.A.R. 968, effective April 20, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-403. Renewing a Laboratory Registration Certificate**

To renew a laboratory registration certificate, an applicant shall submit to the Department, at least 30 calendar days before the expiration date of the current laboratory registration certificate, but no more than 90 days before the expiration date of the current laboratory registration certificate, the following:

- 1. An application in a Department-provided format that includes:

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020; amended by exempt rulemaking at 26 A.A.R. 968, effective April 20, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3).

**R9-17-404. Administration**



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An owner of a laboratory with a laboratory registration certificate shall:

1. Comply with the:
  - a. Quality assurance requirements in R9-17-404.05,
  - b. Operation requirements in R9-17-404.06, and
  - c. Laboratory records and reports requirements in R9-17-404;
2. Maintain accreditation for each approved parameter and analyte;
3. Designate in writing a technical laboratory director who:
  - a. Has knowledge and experience in overseeing a laboratory as documented by:
    - i. A doctoral degree in chemistry, biochemistry, microbiology, or a similar laboratory science;
    - ii. A master's degree in chemistry, biochemistry, microbiology, or a similar laboratory science and at least two years of experience working in a laboratory and providing laboratory testing; or
    - iii. A bachelor's degree in chemistry, biochemistry, microbiology, or a similar laboratory science and at least four years of experience working in a laboratory and providing laboratory testing; and
  - b. Is responsible for:
    - i. Ensuring that all services and tests provided by the laboratory are performed in compliance with the requirements in this Article;
    - ii. Directing and supervising services and tests provided by the laboratory;
    - iii. Overseeing the work of all personnel in the laboratory;
    - iv. Providing ongoing training to laboratory agents, as applicable to the functions performed by a laboratory agent; and
    - v. Ensuring safety and hazardous substance control in the laboratory;
4. Notify the Department in writing within 20 business working days after any change in the technical laboratory director, providing the name and contact information for the new technical laboratory director;
5. Develop, document, and implement policies and procedures regarding:
  - a. Job descriptions and employment contracts, including:
    - i. Personnel duties, authority, responsibilities, and qualifications;
    - ii. Personnel supervision;
    - iii. Ongoing training, applicable to the functions performed by a laboratory agent;
    - iv. Training in and adherence to confidentiality requirements;
    - v. Periodic performance evaluations, including proficiency testing on a rotating basis among all laboratory agents performing similar functions; and
    - vi. Disciplinary actions;
  - b. Business records, such as manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers;
  - c. Inventory control, including:
    - i. Tracking;
    - ii. Accepting medical marijuana or marijuana products for testing;
    - iii. Transferring a portion of a sample prepared or selected according to subsection (5)(e)(v) to another laboratory for testing of parameters or analytes that the laboratory is not approved by the Department to conduct;
    - iv. Testing medical marijuana and marijuana products;
    - v. Providing a representative portion of the sample of tested medical marijuana or a marijuana product, which had been prepared or selected according to subsection (5)(e)(v), to up to two other laboratories, with an approval for testing issued by the Department, at the request of a dispensary according to R9-17-317.01(C);
    - vi. Retaining the residual portion of a sample accepted for testing from a dispensary for at least 14 days after sending the final report of testing required in R9-17-404.06(B)(3) to the dispensary; and
    - vii. Disposing of medical marijuana or a marijuana product such that the marijuana or marijuana product is unrecognizable or cannot otherwise be used and documenting:
      - (1) The method of disposal;
      - (2) Whether the medical marijuana or marijuana product was tested;
      - (3) If not tested, the reason for not testing;
      - (4) The laboratory agent overseeing the disposal; and
      - (5) The date of disposal;
  - d. Standard operating procedures, including:
    - i. The review and updating of standard operating procedures;
    - ii. Requirements for a laboratory agent to review current, new, or updated standard operating procedures applicable to the functions performed by the laboratory agent; and
    - iii. Documenting the review of standard operating procedures by applicable laboratory agents;
  - e. Laboratory records, including:
    - i. Maintenance and monitoring of instruments and equipment;
    - ii. Acceptance of medical marijuana and marijuana products for testing, including the specification of the analytes to be tested for;
    - iii. The chain of custody and applicable trip plan, according to R9-17-408, for a sample accepted by the laboratory for testing;
    - iv. The storage of a submitted sample prior to testing to maintain the integrity of the sample and analyte;
    - v. The process for ensuring that a homogeneous portion of a submitted sample is prepared or selected for testing, including:
      - (1) The aseptic removal of a homogeneous portion of the sample for testing according to R9-17-404.04; and
      - (2) Further preparation of a homogeneous portion of the sample, if necessary, for testing according to R9-17-404.03;

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- vi. Ensuring testing results are accurate, precise, and scientifically valid before reporting the results;
  - vii. Reporting of testing results, including:
    - (1) Testing results obtained from another laboratory for testing of parameters or analytes that the laboratory is not approved by the Department to conduct, or
    - (2) Testing results provided to another laboratory from which the laboratory had received a portion of a sample for testing of parameters or analytes that the other laboratory is not approved by the Department to conduct;
  - viii. If applicable, transfer of a portion of a sample, according to subsection (5)(c)(v), to another laboratory with an approval for testing issued by the Department for testing of parameters or analytes that the laboratory is not approved by the Department to conduct, including:
    - (1) The name and registry identification number of the dispensary from which the sample was obtained,
    - (2) The name and registry identification number of the laboratory to which the portion of the sample is being transferred,
    - (3) The date of the transfer,
    - (4) The amount of sample being transferred,
    - (5) The name and registry identification number of the laboratory agent receiving the marijuana or marijuana products on behalf of the other laboratory;
    - (6) The parameters or analytes being tested by the other laboratory, and
    - (7) The testing results obtained from the other laboratory;
  - ix. If applicable, transfer of the portion of a sample remaining after testing, according to subsection (5)(c)(v), to no more than two other laboratories with an approval for testing issued by the Department at the request of a dispensary according to R9-17-317.01(C), including:
    - (1) The name and registry identification number of the dispensary,
    - (2) The name and registry identification number of the dispensary agent requesting the transfer on behalf of the dispensary,
    - (3) The date of the request,
    - (4) The amount of sample being transferred,
    - (5) The name and registry identification number of each other laboratory, and
    - (6) The name and registry identification number of the laboratory agent receiving the marijuana or marijuana products on behalf of each other laboratory;
  - x. Confidentiality; and
  - xi. Sample retention;
  - f. A quality assurance program and standards;
  - g. A records retention process; and
  - h. Security;
6. Review and document the review of laboratory policies and procedures at least once every 12 months after the issue date of the laboratory registration certificate and update as needed;
- 7. Ensure that each laboratory agent has the laboratory agent's registry identification card in the laboratory agent's immediate possession when the laboratory agent is working or providing volunteer services related to marijuana or marijuana products testing at the laboratory;
  - 8. Ensure that a laboratory agent accompanies any individual other than another laboratory agent associated with the laboratory when the individual is present in the area of the laboratory where marijuana or marijuana products are being tested or stored for testing;
  - 9. Not allow an individual who does not possess a laboratory agent registry identification card issued under the laboratory registration certificate to:
    - a. Serve as an owner for the laboratory,
    - b. Be employed by the laboratory, or
    - c. Provide volunteer services at or on behalf of the laboratory;
  - 10. Provide written notice to the Department, including the date of the event, within 10 working days after the date, when a laboratory agent no longer:
    - a. Serves as an owner for the laboratory,
    - b. Is employed by the laboratory, or
    - c. Provides volunteer services at or on behalf of the laboratory;
  - 11. Unless otherwise specified, maintain copies of any documentation required in this Chapter for at least two years after the date on the documentation and provide copies of the documentation to the Department for review upon request.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-404.01. Compliance Monitoring**

- A. Submission of an application for a laboratory registration certificate constitutes permission for:
  - 1. The Department's entry to and inspection of the laboratory, and
  - 2. The Department to conduct proficiency testing according to R9-17-404.02.
- B. The Department shall conduct:
  - 1. An initial laboratory inspection; and
  - 2. A follow-up laboratory inspection, at least annually.
- C. The Department shall comply with A.R.S. § 41-1009 in conducting a laboratory inspection or investigation.
- D. The Department shall not accept allegations of a laboratory's noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter from an anonymous source.
- E. If the Department receives an allegation of a laboratory's noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter, the Department may conduct an unannounced inspection of the laboratory.
- F. If the Department determines that a laboratory is not in compliance with the requirements of A.R.S. Title 36, Chapter 28.1, or this Chapter, the Department:

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1. Shall provide the owner, according to R9-17-401(A), and technical laboratory director with a written notice that includes the specific rule or statute that was violated; and
  2. May:
    - a. Take an enforcement action as described in R9-17-410; or
    - b. Require that the technical laboratory director submit to the Department, within 30 calendar days after written notice from the Department, a corrective action plan to address issues of compliance that do not directly affect the health or safety of a qualifying patient or laboratory agent that:
      - i. Describes how each identified instance of non-compliance will be corrected and reoccurrence prevented, and
      - ii. Includes a date for correcting each instance of noncompliance that is appropriate to the actions necessary to correct the instance of noncompliance.
- G.** Under A.R.S. § 41-1009(G) and (I), the Department's decision regarding whether a technical laboratory director may submit a corrective action plan on behalf of a laboratory or whether a deficiency has been corrected or has been corrected within a reasonable period of time is not an appealable agency action as defined by A.R.S. § 41-1092.
5. If proficiency testing is not provided by the Department, the laboratory selects a proficiency testing service and contracts with and pays the proficiency testing service directly for proficiency testing; and
  6. For any analyte not within the acceptance limit established by the Department or the proficiency testing service in subsection (C)(5), as applicable:
    - a. A corrective action plan:
      - i. Is submitted to the Department within 10 calendar days after failing to demonstrate competency in proficiency testing,
      - ii. Describes how each identified instance of failing to demonstrate competency will be corrected, and
      - iii. Includes a date for correcting the failure to demonstrate competency that is appropriate to the actions necessary to correct the instance of noncompliance; and
    - b. If the laboratory fails to demonstrate competency in proficiency testing for any analyte twice in a row, the laboratory does not test for the analyte until the laboratory has demonstrated competency in testing for the analyte by repeat proficiency testing.
- D.** The Department may submit proficiency testing samples to a laboratory at any time during the certification period.

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2).

**R9-17-404.02. Proficiency Testing**

- A.** At least once in each 12-month period, and more often if requested by the Department, a technical laboratory director shall have at least one laboratory agent, selected according to policies and procedures, participate in proficiency testing provided by the Department or a proficiency testing service that:
1. Includes at least one proficiency testing sample, in a matrix similar to the medical marijuana or marijuana products accepted for testing, for each parameter and analyte for which the laboratory has been approved or is requesting approval;
  2. Demonstrates the laboratory agent's competence in testing for the parameter; and
  3. If the laboratory has been approved or has requested approval to test an analyte by different methods, may use the same proficiency testing sample for each method.
- B.** To demonstrate competence in testing for a parameter, testing results reported for the parameter shall be within acceptance limits established by the Department, according to R9-17-404.03 or R9-17-404.04, or the proficiency testing service, as applicable.
- C.** A technical laboratory director shall ensure that:
1. Each sample for proficiency testing accepted at the laboratory is analyzed at the laboratory;
  2. Each sample for proficiency testing is tested according to R9-17-404.03 or R9-17-404.04, using the same procedures and techniques employed for routine sample testing;
  3. A proficiency testing service provides the results for each proficiency testing sample directly to the laboratory and the Department;
  4. If proficiency testing is provided by the Department, the laboratory submits to the Department payment for the actual costs of the materials for proficiency testing;

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-404.03. Method Criteria and References for Chemical Analyses**

- A.** In addition to the definitions in A.R.S. § 36-2801 and R9-17-101, the following definitions apply in this Section unless otherwise stated:
1. "Limit of quantitation" means the lowest concentration of an analyte that may be detected and the concentration of the analyte reliably and accurately determined.
  2. "Mid-level standard" means a standard that is between the highest concentration and lowest concentration of standards containing the same substances that are used as a reference when testing for the concentration of an analyte.
  3. "Response factor" means the ratio between a signal produced by an analyte relative to a signal produced by an internal standard at a specific concentration.
  4. "Retention time" means the length of time taken by an analyte to pass through a chromatography column.
  5. "Standard" means a sample of known concentration and containing specific substances that is used as a reference when testing for the concentration of an analyte.
- B.** To perform laboratory testing using chemical analytical methods for any of the analytes in Table 3.1, a laboratory may use:
1. An established national or international chemical method; or
  2. A laboratory-developed method that was validated according to:
    - a. AOAC - Appendix K: Guidelines for Dietary Supplements and Botanicals, 2013, which is incorporated by reference, includes no future editions or

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- amendments, and is available at [http://www.coma.aoac.org/app\\_k.pdf](http://www.coma.aoac.org/app_k.pdf);
- b. USDA - Guidelines for the Validation of Chemical Methods for the FDA FVM Program, 2nd Edition, April 2015, which is incorporated by reference, includes no future editions or amendments, and is available at <https://www.fda.gov/media/81810/download>; or
  - c. ICH - Validation of Analytical Procedures: Text and Methodology Q2(R1) 2005, which is incorporated by reference, includes no future editions or amendments, and is available at [https://database.ich.org/sites/default/files/Q2\\_R1\\_Guideline.pdf](https://database.ich.org/sites/default/files/Q2_R1_Guideline.pdf) or <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/q2-r1-validation-analytical-procedures-text-and-methodology>.
- C. A technical laboratory director shall ensure that all instruments and equipment used for testing medical marijuana or a marijuana product by chemical analytical methods are:
1. Set up, tuned, and calibrated according to:
    - a. Manufacturer's acceptance criteria, or
    - b. Criteria validated according to subsection (B), as applicable;
  2. Monitored and maintained according to AOAC - Guidelines for Laboratories Performing Microbiological and Chemical Analyses of Food, Dietary Supplements, and Pharmaceuticals, Appendix A: Equipment, August 2018, which is incorporated by reference, includes no future editions or amendments, and is available at <https://www.aoac.org/aoac-accreditation-guidelines-for-laboratories-alacc>; and
  3. Applicable for the analytes to be tested.
- D. A technical laboratory director shall ensure that for an initial demonstration of capability:
1. Before implementing a method or using a new instrument, at least four replicate reference samples including each analyte that are to be tested using the method or the instrument are:
    - a. Spiked into a clean matrix that is similar to the medical marijuana or marijuana product to be tested with a mid-level standard;
    - b. Taken through the entire sample preparation and analysis process;
    - c. Have a relative standard deviation of no more than 20%; and
    - d. Have an accuracy that meets the acceptance criteria in subsection (K)(2)(d);
  2. Whenever a significant change to instrumentation or to a standard operating procedure occurs, the laboratory demonstrates, as specified in subsection (D)(1), that acceptable precision and bias can still be obtained by the changed conditions; and
  3. Whenever a new laboratory agent who will be performing testing on medical marijuana or marijuana products is being trained, the laboratory agent demonstrates, as specified in subsection (D)(1), acceptable precision and bias.
- E. For potency testing or testing for pesticides, fungicides, growth regulators, mycotoxins, or residual solvents, a technical laboratory director shall ensure that the retention time window for each analyte is established by using the absolute retention time for each analyte and internal standard from the calibration verification standard, prepared according to subsection (H) or (J) as applicable, at the beginning of the analytical sequence.
- F. A technical laboratory director shall ensure that:
1. The laboratory complies with the following requirements related to calibration and standards:
    - a. Except as specified in subsection (F)(1)(c), a minimum of:
      - i. Five standards are used for an average response factor or for a linear model,
      - ii. Six standards are used for a quadratic model, and
      - iii. Seven standards are used for a cubic model;
    - b. An X-value of zero is not included as a calibration point;
    - c. A calibration curve for heavy metal testing includes a minimum of three standards and a calibration blank;
    - d. One standard is less than or equal to the limit of quantitation;
    - e. The maximum allowable concentration in Table 3.1 for an analyte, with or without dilution, is less than the concentration of the highest calibration standard for the analyte; and
    - f. As applicable, a standard is created containing a concentration of specific analytes that is a dilution factor from the maximum allowable concentration in Table 3.1 for the analyte and is used when performing multiple runs on a sample, with or without dilution, to cover the range of maximum allowable concentrations in Table 3.1;
  2. The acceptance criteria for testing is one of the following, as applicable:
    - a. The maximum relative standard deviation for the average calibration factor, for an external calibration model, or the response factor, for an internal calibration model, is no more than 20%; and
    - b. For linear and non-linear calibration models, the coefficient of determination ( $r^2$ ) is greater than or equal to 0.990 with no rounding;
  3. For chromatographic testing methods using internal standards for calibration:
    - a. The relative retention time of each analyte to the internal calibration standard is within 0.06 units;
    - b. The areas of the peaks for the internal standards in any sample are between 50 and 200% of the area of the peak of a mid-level standard used for calibration; and
    - c. The internal standards:
      - i. Have retention times similar to the analytes being tested for,
      - ii. Do not interfere with any of the analytes, and
      - iii. Have similar chemical properties as the analytes being tested for;
  4. For methods testing for heavy metals using internal standards, the internal standards:
    - a. Are appropriate for the analyte, and
    - b. Do not interfere with any of the analytes;
  5. When using a selective ion monitoring technique for data gathering, the integration window includes the entire analyte peak; and
  6. All standards included for calibration that are below the limit of quantitation have a signal-to-noise ratio of at least 3:1 according to ASTM E685-93, Standard Practice for Testing Fixed-Wavelength Photometric Detectors Used in Liquid Chromatography (2013), which is incorporated by reference, includes no future editions or amendments, and

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is available at <https://webstore.ansi.org/Standards/ASTM/astme685932013>.

**G.** To obtain an acceptable calibration, a technical laboratory director, for each calibration event:

1. May use any of the following options:
  - a. Perform instrument maintenance to optimize analyte responses, as long as all resulting calibration models meet the acceptance criteria appropriate for the analyte;
  - b. If the problem appears to be associated with a single standard:
    - i. Reanalyze that one standard, at the time of calibration and before any samples are analyzed, to rule out problems due to random error; and
    - ii. Recalculate and reevaluate the standard against the acceptance criteria;
  - c. Narrow the calibration range by replacing one or more of the calibration standards at the upper or lower ends of the curve;
  - d. Narrow the calibration range by removing data points from either extreme end of the range and recalculating the calibration function; or
  - e. Perform a new initial calibration according to subsection (F); and
2. May not:
  - a. Remove data points from within a calibration range while still retaining the extreme ends of the calibration range,
  - b. Use non-linear calibrations to compensate for detector saturation or to avoid proper instrument maintenance;
  - c. Use multiple points at the same calibration level if not also being done for all quality control samples, such as a sample required in subsection (K), and samples accepted for testing; or
  - d. Include calibration data from another calibration that was run at a different time.

**H.** A technical laboratory director shall ensure that, during each calibration event for initial calibration verification:

1. Standards are prepared either from a different source or from a different lot of standards from the same source than the source from which the initial calibration standards specified in subsection (F)(1) were obtained and must:
  - a. Be a mid-level standard; and
  - b. Contain all analytes being reported to comply with R9-17-317(A)(5); and
2. The following acceptance criteria are used:
  - a. For potency testing, 80 to 120% recovery of true value;
  - b. For testing for pesticides, fungicides, growth regulators, mycotoxins, or residual solvents other than butanes, 70 to 130% recovery of the true value;
  - c. For butanes, 60 to 140% recovery of the true value; and
  - d. For heavy metal testing, 90 to 110% recovery of the true value.

**I.** A technical laboratory director shall ensure that for the limit of quantitation:

1. The limit of quantitation is initially verified by the analysis of at least seven replicate samples, spiked with all analytes at the limit of quantitation, and processed through all preparation and analysis steps for each method;

2. The signal-to-noise ratio of the replicate samples in subsection (I)(1) is at least 5:1 according to ASTM E685-93, Standard Practice for Testing Fixed-Wavelength Photometric Detectors Used in Liquid Chromatography (2013), which is incorporated by reference, includes no future editions or amendments, and is available at <https://webstore.ansi.org/Standards/ASTM/astme685932013>;
3. The mean recovery of the replicate samples in subsection (I)(1) is:
  - a. For potency testing,  $\pm 20\%$  of the true value;
  - b. For testing for pesticides, fungicides, growth regulators, mycotoxins, or residual solvents,  $\pm 50\%$  of the true value; and
  - c. For heavy metal testing,  $\pm 35\%$  of the true value;
4. The relative standard deviation of the replicate samples in subsection (I)(1) is less than 20%;
5. The limit of quantitation is, as applicable, no greater than:
  - a. Half the maximum allowable concentrations for an analyte in Table 3.1;
  - b. For chlorfenapyr, cyfluthrin, or cypermethrin, the maximum allowable concentrations for the analyte in Table 3.1; or
  - c. 1.0 mg/g for each analyte for potency testing;
6. Any changes to specific sample amounts, dilutions, or volumes employed are reflected in the limit of quantitation stated on a sample report;
7. The signal-to-noise ratio in subsection (I)(2) is reverified each time the instrument used for testing is calibrated; and
8. Documentation of the current limit of quantitation is maintained for each analyte, matrix, and instrument.

**J.** Except as provided in subsection (P), a technical laboratory director shall ensure that for batch analysis:

1. Continuing calibration verification standards:
  - a. Are prepared and spiked with a mid-level concentration of all analytes from the same calibration standard source used to prepare the standards specified in subsection (F)(1); and
  - b. Have the following acceptance criteria:
    - i. For potency testing, 80 - 120% recovery of true value;
    - ii. For testing for pesticides, fungicides, growth regulators, or mycotoxins, or residual solvents other than butanes, 70 - 130% recovery of the true value;
    - iii. For butanes, 60 - 140% recovery of the true value; and
    - iv. For heavy metal testing, 90 - 110% recovery of the true value;
2. If internal standards are used in continuing calibration verification, the acceptability criteria of the internal standards is determined as follows:
  - a. For testing for pesticides, fungicides, growth regulators, mycotoxins, or residual solvents by mass spectrometry, if the area of the peak for an internal standard is different by a factor of two from the area of the respective standard in subsection (F)(1)(e), for the most recent initial calibration sequence, according to subsection (F):
    - i. The mass spectrometer is inspected for malfunctions and corrected, and
    - ii. Reanalysis of the continuing calibration verification meets acceptance criteria in subsection (J)(1)(b)(ii) before any samples are tested; and

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- b. For heavy metal testing:
      - i. The intensity of an internal standard is monitored for each analysis to ensure that the intensity does not vary by more than  $\pm 30\%$ , with respect to the intensity during the initial calibration in subsection (F); and
      - ii. If the intensity of an internal standard is outside the range also observed in the calibration blank required in subsection (F)(1)(c):
        - (1) Testing is stopped until the problem is corrected, the instrument is recalibrated, and the new calibration is verified;
        - (2) Reanalysis of the continuing calibration verification meets acceptance criteria in subsection (J)(1)(b)(iii) before any samples are tested; and
        - (3) The affected samples are retested; and
  - 3. The frequency of continuing calibration verification is as follows:
    - a. For testing by a method other than mass spectrometry:
      - i. At the beginning of the test;
      - ii. After every 20 samples, not counting a quality control sample, such as a sample required in subsection (K); and
      - iii. At the end of the test; and
    - b. For testing by mass spectrometry:
      - i. At the beginning of the testing,
      - ii. After every 12 hours of running, and
      - iii. At the end of the run.
- K. Except as provided in subsection (P), a technical laboratory director shall ensure that for batch analysis, which may contain no more than 20 samples accepted for testing:
  - 1. A method blank, with a matrix similar to each type of sample matrix to be tested within the batch:
    - a. Contains the same internal standards as the samples in the batch,
    - b. Is prepared and tested with each batch, and
    - c. Produces results below the limit of quantitation;
  - 2. Except as provided in subsection (R), a laboratory control sample and duplicate, with a matrix similar to each type of sample matrix to be tested within the batch:
    - a. Are prepared with a mid-level standard;
    - b. Are spiked before extraction;
    - c. Are carried through all stages of sample preparation and included with each analytical batch; and
    - d. Have either the following acceptance criteria:
      - i. For potency testing, 80 - 120% recovery of true value;
      - ii. For pesticides, fungicides, growth regulators, mycotoxins, or residual solvents other than butanes, 70 - 130% recovery of the true value or according to control limits derived according to R9-17-404.05(B)(10);
      - iii. For butanes, 60 - 140% recovery of the true value or acceptance criteria within statistically derived limits developed by the laboratory; and
      - iv. For heavy metal testing, 80 - 120% recovery of the true value or acceptance criteria within statistically derived limits developed by the laboratory;
  - 3. The relative percent difference for the laboratory control sample and duplicate for each analyte, calculated on the basis of concentration or amount, is no more than 20%; and
- 4. For all new matrix types to be tested, a matrix spike derived from a dispensary submitted sample:
  - a. Is prepared for each analyte in Table 3.1 with a mid-level standard;
  - b. Is carried through all stages of sample preparation and included with each analytical batch of up to 20 samples for each matrix type; and
  - c. Has either the following acceptance criteria or acceptance criteria within statistically derived limits developed by the laboratory:
    - i. For potency testing, 80 - 120% recovery of true value or according to control limits derived according to R9-17-404.05(B)(10);
    - ii. For testing for pesticides, fungicides, growth regulators, mycotoxins, or residual solvents, 70 - 130% recovery of the true value or according to control limits derived according to R9-17-404.05(B)(10); and
    - iii. For heavy metal testing, 75 - 125% recovery of the true value.
- L. A technical laboratory director shall ensure that:
  - 1. Except as provided in subsection (P), for potency testing or testing for pesticides, fungicides, growth regulators, mycotoxins, or residual solvents by mass spectrometry, the relative intensities of the characteristic ions agrees within 30% of the relative intensities of these ions in the reference spectrum; and
  - 2. For heavy metal testing, the intensity of each internal standard is monitored for each analysis to ensure that the intensity does not vary more than  $\pm 30\%$ , with respect to the intensity of the internal standard during the initial calibration specified in subsection (F).
- M. A technical laboratory director shall ensure that:
  - 1. In testing, by a method other than mass spectrometry, the resolution of chromatographic peaks is maintained so that the height of the valley between two chromatographic peaks is less than 50% of the lower peak height; and
  - 2. For testing by mass spectrometry methods, the resolution of chromatographic peaks is maintained so that the height of the valley between two chromatographic peaks is less than 50% of the average of the two peak heights.
- N. A technical laboratory director shall ensure that confirmation for testing for pesticides, fungicides, growth regulators, or residual solvents by a method other than mass spectrometry:
  - 1. Is performed using:
    - a. A second column:
      - i. That has a stationary phase dissimilar to the stationary phase in the primary column, and
      - ii. From which the analyte is eluted in a different order than from the primary column;
    - b. A different instrument type, such as gas chromatography followed by mass spectrometry;
    - c. Gas chromatography with two different types of detectors; or
    - d. Other recognized confirmation techniques;
  - 2. Meets the applicable criteria in subsections (D) through (M); and
  - 3. Includes as part of the confirmation of the analyte:
    - a. An evaluation of the agreement of the quantitative values of the results from both methods of testing; and

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- b. Determination of the relative percent difference between the values.
- O. If the relative percent difference between the values obtained according to subsection (N) is more than 40%, a technical laboratory director shall ensure that:
1. The chromatograms are checked to see if an obviously overlapping peak is causing an erroneously high result, and the chromatographic conditions are reviewed; and
  2. Either:
    - a. If a problem is found with one of the tests, the result from the other test is reported; and
    - b. If there is no evidence of a chromatographic problem, the higher result is reported.
- P. A technical laboratory director may release testing results that are scientifically valid and defensible, according to R9-17-404.06(B)(3), with the following data qualifier notations if:
1. The target analyte detected in the calibration blank required in subsection (F)(1)(c) or the method blank specified in subsection (K)(1) is at or above the limit of quantitation, but the sample result:
    - a. For potency testing, is below the limit of quantitation - B1; or
    - b. When testing for pesticides, fungicides, growth regulators, mycotoxins, heavy metals, or residual solvents, is below the maximum allowable concentration in Table 3.1 for the analyte - B2;
  2. The limit of quantitation and the sample results were adjusted to reflect sample dilution - D1;
  3. The relative intensity of a characteristic ion in a sample analyte exceeded the acceptance criteria in subsection (L)(1) with respect to the reference spectra, indicating interference - I1;
  4. When testing for pesticides, fungicides, growth regulators, mycotoxins, heavy metals, or residual solvents, the percent recovery of a laboratory control sample is greater than the acceptance limits in subsection (K)(2)(c), but the sample's target analytes were not detected above the maximum allowable concentrations in Table 3.1 for the analytes in the sample - L1;
  5. The recovery from the matrix spike in subsection (K)(4) was:
    - a. High, but the recovery from the laboratory control sample in subsection (K)(2) was within acceptance criteria - M1,
    - b. Low, but the recovery from the laboratory control sample in subsection (K)(2) was within acceptance criteria - M2, or
    - c. Unusable because the analyte concentration was disproportionate to the spike level, but the recovery from the laboratory control sample in subsection (K)(2) was within acceptance criteria - M3;
  6. The analysis of a spiked sample required a dilution such that the spike recovery calculation does not provide useful information, but the recovery from the associated laboratory control sample in subsection (K)(2) was within acceptance criteria - M4;
  7. The analyte concentration was determined by the method of standard addition, in which the standard is added directly to the aliquots of the analyzed sample - M5;
  8. A description of the variance is described in the final report of testing according to R9-17-404.06(B)(3)(d)(ii) - N1;
  9. The relative percent difference for the laboratory control sample and duplicate exceeded the limit in subsection (K)(3), but the recovery in subsection (K)(2) was within acceptance criteria - R1;
  10. The relative percent difference for a sample and duplicate exceeded the limit in subsection (O) - R2; or
  11. The recovery from initial or continuing calibration verification standards is greater than the acceptance limits in subsection (H)(2) or (J)(1)(b) as applicable, but the sample's target analytes were not detected above the maximum allowable concentrations in Table 3.1 for the analytes in the sample - V1.
- Q. A technical laboratory director shall include in the final report of testing, according to R9-17-404.06(B)(3)(d)(iii), the following data qualifier notations if:
1. Sample integrity was not maintained - Q1;
  2. The sample is heterogeneous, and sample homogeneity could not be readily achieved using routine laboratory practices - Q2; or
  3. Testing result is for informational purposes only and cannot be used to satisfy dispensary testing requirements in R9-17-317.01(A) or labeling requirements in R9-17-317 - Q3.
- R. For batch analysis of samples to determine potency, a technical laboratory director may check precision by using either a duplicate laboratory control sample or a duplicate sample prepared from the medical marijuana or marijuana product being tested, according to requirements in subsections (K)(2) and (3).
- S. A technical laboratory director shall ensure that the reporting units for:
1. Pesticides, fungicides, growth regulators, heavy metals, or residual solvents are in parts per million (ppm);
  2. Mycotoxins are according to R9-17-404.04(I)(4); and
  3. Potency are:
    - a. In either:
      - i. Percent (w/w) relative to the bulk plant material or marijuana product, as applicable; or
      - ii. Number of milligrams per designated unit; and
    - b. For:
      - i. Total tetrahydrocannabinol, the sum of tetrahydrocannabinolic acid (THC-A), multiplied by 0.877, and delta-9-tetrahydrocannabinol ( $\Delta$ 9-THC); and
      - ii. Total cannabidiol, the sum of cannabidiolic acid (CBD-A), multiplied by 0.877, and cannabidiol (CBD).

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 26 A.A.R. 2848, with an immediate effective date of October 15, 2020; amended by exempt rulemaking at 26 A.A.R. 2991, effective November 1, 2020; amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-404.04. Method Criteria and References for Analyses for Microbial Contaminants**

- A. To perform laboratory testing for the microbial contaminants in Table 3.1, a laboratory shall use an applicable method:
1. Described in:

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- a. The Bacteriological Analytical Manual (BAM), 2019, which is incorporated by reference, includes no future editions or amendments, and is available at <https://www.fda.gov/food/laboratory-methods-food/bacteriological-analytical-manual-bam>; or
  - b. AOAC Official Methods of Analysis, 21st Edition, 2019, which is incorporated by reference, includes no future editions or amendments, and is available at <https://www.aoac.org/official-methods-of-analysis-21st-edition-2019>;
  2. Validated according to, as applicable:
    - a. AOAC - Appendix J: Guidelines for Validation of Microbiological Methods for Food and Environmental Surfaces, 2012, which is incorporated by reference, includes no future editions or amendments, and is available at [http://www.eoma.aoac.org/app\\_j.pdf](http://www.eoma.aoac.org/app_j.pdf);
    - b. AOAC - Appendix K: Guidelines for Dietary Supplements and Botanicals, 2013, which is incorporated by reference, includes no future editions or amendments, and is available at [http://www.eoma.aoac.org/app\\_k.pdf](http://www.eoma.aoac.org/app_k.pdf);
    - c. ICH - Validation of Analytical Procedures: Text and Methodology Q2(R1) 2005, which is incorporated by reference, includes no future editions or amendments, and is available at [https://database.ich.org/sites/default/files/Q2\\_R1\\_Guideline.pdf](https://database.ich.org/sites/default/files/Q2_R1_Guideline.pdf) or <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/q2-r1-validation-analytical-procedures-text-and-methodology>;
    - d. AOAC SMPR® 2019.001 - Standard Method Performance Requirements (SMPRs®) for Detection of *Aspergillus* in Cannabis and Cannabis Products, which is incorporated by reference, includes no future editions or amendments, and is available at [https://www.aoac.org/wp-content/uploads/2020/11/SMPR202019\\_001.pdf](https://www.aoac.org/wp-content/uploads/2020/11/SMPR202019_001.pdf); or
    - e. AOAC SMPR® 2020.002 - Standard Method Performance Requirements (SMPRs®) for Detection of *Salmonella* species in Cannabis and Cannabis Products, which is incorporated by reference, includes no future editions or amendments, and is available at [https://www.aoac.org/wp-content/uploads/2020/07/SMPR-2020\\_002.pdf](https://www.aoac.org/wp-content/uploads/2020/07/SMPR-2020_002.pdf);
  3. For *Escherichia coli* testing, having a limit of quantitation of at least 10 colony forming units per gram; and
  4. If applicable, meeting the requirements in subsection (I)(2) or (3).
- B.** A technical laboratory director shall ensure that all instruments and equipment used for testing medical marijuana or a marijuana product for microbial contaminants are:
1. Set up, calibrated, and verified according to:
    - a. Manufacturer's acceptance criteria; and
    - b. Requirements for the specific method, as specified in subsection (A)(1)(a) or (b), as applicable;
  2. Monitored and maintained according to AOAC - Guidelines for Laboratories Performing Microbiological and Chemical Analyses of Food, Dietary Supplements, and Pharmaceuticals, 6.3: Facilities and Environmental Conditions, 6.4: Equipment, 7.7: Ensuring the Validity of Results, and Appendix A: Equipment, August 2018, which is incorporated by reference, includes no future editions or amendments, and is available at [www.aoac.org/aoac-accreditation-guidelines-for-laboratories-alacc](https://www.aoac.org/aoac-accreditation-guidelines-for-laboratories-alacc); and
  3. Applicable for the analytes to be tested.
- C.** A technical laboratory director shall ensure that:
1. The organisms required as controls are checked, as appropriate for their application:
    - a. To ensure there is no contamination with other organisms,
    - b. For verification of biochemical or other biological characteristics, and
    - c. To ascertain the number of organisms; and
  2. Documentation is maintained of the:
    - a. Checking required in subsection (C)(1), and
    - b. Traceability of the organisms in subsection (C)(1) from date of possession.
- D.** A technical laboratory director shall ensure that for an initial demonstration of capability:
1. Before implementing a method, at least four replicate reference samples for each analyte are:
    - a. Spiked with control organisms at an amount allowing for quantitation, and
    - b. Taken through the entire sample preparation and analysis process;
  2. Whenever a significant change to instrumentation or to a standard operating procedure occurs, the laboratory demonstrates, as specified in subsection (D)(1), that acceptable precision and bias can still be obtained by the changed conditions; and
  3. Whenever a new laboratory agent who will be performing testing on medical marijuana or marijuana products is being trained, the laboratory agent demonstrates, as specified in subsection (D)(1), acceptable precision and bias.
- E.** A technical laboratory director shall ensure that each batch of media or reagent:
1. Is examined to ensure it is suitable for use;
  2. If externally prepared, has a certificate of meeting quality control standards, issued by the manufacturer, before the batch of media or reagent is used;
  3. If internally prepared, has documentation of:
    - a. Instructions for preparation;
    - b. Traceability to dehydrated media or reagent concentrate;
    - c. Sterility, including, as applicable:
      - i. Autoclave records showing the date, run number, autoclave identifier, nature of the material being autoclaved, time at desired temperature, and name of the laboratory agent starting the autoclave; and
      - ii. For another sterilization method, records showing the date, type of sterilization method, nature of the material being sterilized, confirmation of the sterilization as applicable to the method, and name of the laboratory agent initiating the sterilization method;
  - d. Checking for the following, as applicable, including the name of the laboratory agent who performed the check and date of the check:
    - i. pH,
    - ii. Appearance,
    - iii. Fill volumes,
    - iv. Batch size, and
    - v. Quantity; and



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4. Undergoes quality control verification, as applicable, including the name of the laboratory agent who performed the verification and date of verification, for:
  - a. The ability of media to sustain growth of the organism for which the media will be used;
  - b. If applicable, the ability of media to select for specific organisms or characteristics of an organism;
  - c. The ability of a reagent to function as intended; and
  - d. Sterility of the media or reagent before use.
- F. If test kits or other identification systems are used for laboratory testing, a technical laboratory director shall ensure that:
  1. Each lot of test kits or other identification systems undergoes quality control verification before use, including the name of the laboratory agent who performed the verification and date of verification, for:
    - a. Having a certificate of meeting quality control standards, issued by the manufacturer; and
    - b. Passing a visual inspection of physical characteristics;
  2. If an identification system is intended to speciate organisms, the identification system is tested with at least one control organism appropriate for the identification system to confirm acceptability; and
  3. For testing using ELISA:
    - a. The ELISA testing calibration curve has at least four standards;
    - b. The standards in subsection (F)(3)(a) bracket the maximum allowable contaminants in Table 3.1 for the analyte; and
    - c. For linear and non-linear calibration models, the coefficient of determination ( $r^2$ ) is greater than or equal to 0.990 with no rounding.
- G. A technical laboratory director shall ensure that:
  1. For testing for *Aspergillus* with a plating method:
    - a. One of the following plating media is used:
      - i. Malt extract agar, BAM Media M182;
      - ii. Dichloran rose bengal chloramphenicol agar, BAM Media M183; or
      - iii. Potato dextrose agar with rose bengal and chloramphenicol; and
    - b. Petrifilm™, Simplate™, or another pre-made plate that is unsuitable for growing spreading molds is not used;
  2. For testing for mycotoxins by any method, at least a 0.5 g sample is tested;
  3. For testing for *Aspergillus* or *Salmonella*, the samples are enriched using a validated AOAC method; and
  4. For samples that test “Detected” for *Aspergillus* or *Salmonella*:
    - a. A log is maintained identifying the samples, and
    - b. A sample is only retested when quality control standards have failed or when recommended by the instrument manufacturer.
- H. A technical laboratory director shall include in the final report of testing, according to R9-17-404.06(B)(3)(d)(iii), the following data qualifier notations if:
  1. The limit of quantitation and the sample results were adjusted to reflect sample dilution - D1;
  2. A description of the variance is described in the final report of testing according to R9-17-404.06(B)(3)(d)(ii) - N1;
  3. Sample integrity was not maintained - Q1;
  4. The sample is heterogeneous, and sample homogeneity could not be readily achieved using routine laboratory practices - Q2; or
  5. Testing result is for informational purposes only and cannot be used to satisfy dispensary testing requirements in R9-17-317.01(A) or labeling requirements in R9-17-317 - Q3.
- I. A technical laboratory director shall ensure that:
  1. The reporting units for *Escherichia coli* are colony forming units per gram (CFU/g);
  2. Reporting for *Salmonella* is “Detected” or “Not detected” in one gram;
  3. Reporting for *Aspergillus* is “Detected” or “Not detected” in one gram; and
  4. Reporting for mycotoxins includes:
    - a. Total aflatoxins in units of micrograms per kilogram ( $\mu\text{g/kg}$ ), and
    - b. Ochratoxin A in units of micrograms per kilogram ( $\mu\text{g/kg}$ ).

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-404.05. Quality Assurance**

- A. An owner holding a laboratory registration certificate or applicant shall ensure that the analytical data produced at the owner's or applicant's laboratory are of known and acceptable precision and accuracy, as prescribed by the method criteria for each analyte in R9-17-404.03 or R9-17-404.04, and are scientifically valid and defensible.
- B. An owner holding a laboratory registration certificate or applicant shall establish, implement, and comply with a written quality assurance plan that contains the following and is available at the laboratory for Department review:
  1. A title page identifying the laboratory and date of review and including the technical laboratory director's signature of approval;
  2. A table of contents;
  3. An organization chart or list of the laboratory personnel, including names, lines of authority, and identification of principal quality assurance personnel;
  4. A copy of the current laboratory registration certificate and a list of approved parameters;
  5. A statement of quality assurance objectives, including data quality objectives with precision and accuracy goals and the criteria for determining the acceptability of each testing;
  6. Specifications for preservation of samples;
  7. A procedure for documenting laboratory receipt of samples and tracking of samples during laboratory testing;
  8. A procedure for analytical instrument calibration, including frequency of calibration and complying with the requirements for calibration in subsection (D);
  9. A procedure for testing data reduction and validation and reporting of final results, including the identification and treatment of data outliers, the determination of the accuracy of data transcription, and all calculations;

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10. If using control limits derived by the laboratory as a basis for determining acceptance of a testing result, a procedure to ensure that the control limits are:
    - a. Statistically significant, valid, and defensible; and
    - b. Updated at least every 12 months;
  11. A statement of the frequency of all quality control checks;
  12. A statement of the acceptance criteria for all quality control checks;
  13. Preventive maintenance procedures and schedules;
  14. Assessment procedures for data acceptability, including appropriate procedures for manual integration of chromatograms and when manual integration is inappropriate;
  15. Corrective action procedures to be taken when results from analytical quality control checks are unacceptable, including steps to demonstrate the presence of any interference if the precision, accuracy, or limit of quantitation of the reported testing result is affected by the interference; and
  16. Procedures for chain-of-custody documentation, including procedures for the documentation and reporting of any deviation from the sample handling or preservation requirements.
- C. An owner holding a laboratory registration certificate or applicant shall ensure that a laboratory's written quality assurance plan is a separate document available at the laboratory and includes all of the components required in subsection (B), but an owner or applicant may satisfy the components required in subsections (B)(3) through (16) through incorporating by reference provisions in separate documents, such as standard operating procedures.
- D. An owner holding a laboratory registration certificate or applicant shall:
1. Have available at the laboratory all methods, equipment, reagents, and supplies necessary for the testing for which the owner or applicant is approved or is requesting approval;
  2. Use only reagents of a grade equal to or greater than that required by the method criteria in R9-17-404.03 or R9-17-404.04, and document the use of the reagents;
  3. Maintain and require each laboratory agent performing testing on medical marijuana or a marijuana product to comply with a complete and current standard operating procedure that meets the requirements for each method, as specified in R9-17-404.03 or R9-17-404.04, which shall include at least:
    - a. A description of all procedures to be followed, including the recording of the information required according to R9-17-404.06(B)(1)(g) and (k), when the method is performed;
    - b. A list of the concentrations for calibration standards, check standards, and spikes;
    - c. Requirements for instrumental conditions and set up;
    - d. A requirement for frequency of calibration;
    - e. The quantitative methods to be used to calculate the final concentration of an analyte in samples, including any factors used in the calculations and the calibration algorithm used; and
    - f. Requirements for preventative maintenance;
  4. Calibrate each instrument as required by the standard operating procedure, as specified in R9-17-404.03 or R9-17-404.04, for which the equipment is used;
  5. Maintain calibration documentation, including documentation that demonstrates the calculations performed using each calibration model;
  6. Develop, document, and maintain a current limit of quantitation, as specified in R9-17-404.03, for each compliance parameter for each instrument;
  7. For each parameter and analyte tested at the laboratory use the quality control acceptance criteria specified according to R9-17-404.03, R9-17-404.04, and Table 3.1;
  8. Discard or segregate all expired standards or reagents;
  9. Maintain a record showing the traceability of reagents; and
  10. Ensure that a calibration model is not used or changed to avoid necessary instrument maintenance.
- E. Except as provided in subsection (F), an owner holding a laboratory registration certificate or applicant shall ensure that each laboratory standard operating procedure is a separate document available at the laboratory and includes all of the components required in subsection (D)(3).
- F. An owner holding a laboratory registration certificate or applicant may satisfy the components required in subsections (D)(3)(e) and (f) through incorporating by reference provisions in separate documents, such as other standard operating procedures.

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-404.06. Operations**

- A. A technical laboratory director shall ensure that:
1. A sample of medical marijuana or a marijuana product accepted at the technical laboratory director's laboratory is analyzed:
    - a. Either:
      - i. At the laboratory with methods approved by the Department; or
      - ii. For testing of parameters or analytes that the laboratory is not approved by the Department to conduct, at another laboratory with an approval for testing issued by the Department;
    - b. As received; and
    - c. Within 10 calendar days after receipt;
  2. If an instrument or equipment used for testing medical marijuana or a marijuana product has a mechanism to track any changes made to testing results, the tracking mechanism is installed and activated;
  3. The facility and utilities required to operate equipment and perform testing of medical marijuana or marijuana products are maintained;
  4. Environmental controls are maintained within the laboratory to ensure that laboratory environmental conditions do not affect analytical results beyond quality control limits established for the methods performed at the laboratory;
  5. Storage, handling, and disposal of hazardous materials at the laboratory are in accordance with all state and federal regulations;

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6. The laboratory complies with all applicable federal, state, and local occupational safety and health regulations; and
7. The following information is maintained for all laboratory agents providing supervisory, quality assurance, or analytical functions related to testing of medical marijuana or a marijuana product:
  - a. A summary of each laboratory agent's education and professional experience;
  - b. Documentation of each laboratory agent's applicable certifications and specialized training;
  - c. Information related to the laboratory agent's registry identification card;
  - d. Documentation of each laboratory agent's review of the quality assurance plan required under R9-17-404.05(B) and the methods and laboratory standard operating procedures for all testing of marijuana or marijuana products performed by the laboratory agent or for which the laboratory agent has supervisory or quality assurance responsibility;
  - e. Documentation of each laboratory agent's completion of training on the use of equipment and of proper laboratory technique, including the name of the laboratory agent, the name of the instructor, the duration of the training, and the date of completion of the training;
  - f. Documentation of each laboratory agent's completion of training classes, continuing education courses, seminars, and conferences that relate to the testing procedures used by the laboratory agent for testing of marijuana or marijuana products;
  - g. Documentation of each laboratory agent's completion of initial demonstration of capability, as required in R9-17-404.03(D)(3) or R9-17-404.04(D)(3), for each approved method performed by the laboratory agent;
  - h. Documentation of each laboratory agent's performance of proficiency testing; and
  - i. Documentation of each laboratory agent's completion of training related to instrument calibration that includes:
    - i. Instruction on each calibration model that the laboratory agent will use or for which the laboratory agent will review data;
    - ii. For each calibration model in subsection (A)(7)(i)(i), description of the specific aspects of the calibration model that might compromise the data quality, such as detector saturation, lack of detector sensitivity, the calibration model's not accurately reflecting the calibration points, inappropriate extension of the calibration range, weighting factors, and dropping of mid-level calibration points without justification; and
    - iii. Instruction that a calibration model shall not be used or changed to avoid necessary instrument maintenance.
- B. A technical laboratory director shall ensure that:
  1. A testing record for marijuana or marijuana products contains:
    - a. Sample information, including the following:
      - i. A unique sample identification assigned at the laboratory;
      - ii. A description of the marijuana or marijuana product from which the submitted sample was taken, including the amount, strain, and batch number;
    - iii. The sample collection date and time;
    - iv. The type of testing to be performed, including whether the testing is to satisfy the requirement in R9-17-317.01(A) or for a dispensary's information only; and
    - v. The analytes to be tested for, as specified by the dispensary, laboratory, qualifying patient, or designated caregiver, identified according to subsection (B)(1)(c), submitting the sample to the laboratory;
  - b. A color picture of the sample as submitted;
  - c. The name and registry identification number of the dispensary, qualifying patient, or designated caregiver submitting the sample to the laboratory;
  - d. If applicable, name and the registry identification number of the dispensary agent submitting the sample to the laboratory on behalf of a dispensary;
  - e. The date and time of receipt of the sample at the laboratory;
  - f. The name and registry identification number of the laboratory agent who received the sample at the laboratory;
  - g. The dates and times of testing, including the date and time of each critical step;
  - h. Whether testing results related to a sample were changed;
  - i. If testing results related to a sample were changed, what was changed, the name of the laboratory agent who changed the testing results, the time and date the data were changed, and why the testing results were changed;
  - j. If testing results were changed due to retesting:
    - i. What was used or done to the sample, and
    - ii. The original and changed testing results;
  - k. The actual results of testing, including all raw data, work sheets, and calculations performed;
  - l. The actual results of quality control data validating the testing results, including the calibration and calculations performed;
  - m. The name of each laboratory agent who performed the testing; and
  - n. A copy of the final report;
2. A testing result for medical marijuana or a marijuana product that is known to be inaccurate is not reported; and
3. Except as specified in subsection (C) or (D) as applicable, a final report of testing of marijuana or marijuana products contains:
  - a. The name, address, and telephone number of the laboratory;
  - b. The registry identification number assigned to the laboratory by the Department;
  - c. Actual scientifically valid and defensible results of testing of a sample of medical marijuana or a marijuana product in appropriate units of measure, obtained in accordance with R9-17-404.03, R9-17-404.04, and the quality assurance plan;
  - d. As applicable:
    - i. A statement that testing results were obtained according to requirements in the quality assurance plan in R9-17-404.05, in the applicable standard operating procedure, and in R9-17-404.03 or R9-17-404.04;

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- ii. A description of any variances from the requirements in the quality assurance plan in R9-17-404.05, the applicable standard operating procedure, R9-17-404.03, or R9-17-404.04 made to ensure scientifically valid and defensible testing results, and the reason for the variance; or
    - iii. A qualifier, according to R9-17-404.03(P) or (Q) or R9-17-404.04(H), as applicable, located adjacent to the name of the analyte or testing result to which the qualifier pertains;
  - e. A list of each method used to obtain the reported results;
  - f. Sample information, including the following:
    - i. The unique sample identification assigned at the laboratory;
    - ii. A color picture of the sample as submitted;
    - iii. A description of the marijuana or marijuana product from which the submitted sample was taken, including the strain and batch number;
    - iv. The sample collection date and time;
    - v. The name and registry identification number of the dispensary, laboratory, qualifying patient, or designated caregiver submitting the sample to the laboratory; and
    - vi. Any changes made to the information recorded according to subsection (B)(1)(a) since sample submission;
  - g. The date of testing for each parameter reported;
  - h. The date of the final report; and
  - i. The technical laboratory director's or designee's signature.
- C. If a sample of medical marijuana or a marijuana product accepted at a laboratory is analyzed at another laboratory, as allowed according to R9-17-404.06(A)(1)(a)(ii), a technical laboratory director shall ensure that the final report of testing required in subsection (B)(3) includes a copy of the final report of testing from each laboratory to which the laboratory accepting the sample from a dispensary sent a portion of the sample for testing of parameters or analytes that the laboratory is not approved by the Department to conduct.
- D. If a final report of testing issued according to subsection (B)(3) needs to be changed, amended, or reissued, a technical laboratory director shall ensure that a changed, amended, or reissued report of testing is generated by the laboratory and includes:
- 1. The date of the changed, amended, or reissued report of testing;
  - 2. A statement that the changed, amended, or reissued report is an amendment to the original final report of testing, including any unique number or other designator given by the laboratory to the original final report of testing;
  - 3. If it is necessary to issue a completely new final report of testing, the information required in subsection (B)(3); and
  - 4. The change to the information provided in the original final report of testing and, where appropriate, the reason for the change, located either:
    - a. Adjacent to the testing result to which the change pertains, or
    - b. On the same page of the final report of testing with an indicator located adjacent to the testing result to which the change pertains.
- E. For a sample of marijuana or a marijuana product accepted at the technical laboratory director's laboratory, a technical labo-

ratory director shall ensure that the final report of testing in subsection (B)(3):

- 1. For a sample received from a dispensary, is sent to the dispensary within 10 calendar days after receipt of the sample;
- 2. For a sample received from another laboratory according to subsection (A)(1)(a)(ii), is sent to the other laboratory from which the sample was sent within seven calendar days after receipt of the sample;
- 3. For a sample received from another laboratory according to R9-17-317.01(C), is sent to the dispensary requesting retesting within seven calendar days after receipt of the sample; and
- 4. For a sample received from a qualifying patient or designated caregiver as recorded according to subsection (B)(1)(c), is sent to the qualifying patient or designated caregiver within 10 calendar days after receipt of the sample.

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-404.07. Adding or Removing Parameters for Testing**

- A. During the term of a laboratory registration certificate, an owner may request to have one or more parameters:
- 1. Added to the laboratory registration certificate, or
  - 2. Removed from the laboratory registration certificate.
- B. To request a change to one or more parameters, an applicant shall submit to the Department:
- 1. The following information in a Department-provided format:
    - a. The name, address, and telephone number of the applicant;
    - b. The name, address, and telephone number of the laboratory for which the change is requested;
    - c. If requesting the removal of a parameter, identification of the parameter to be removed;
    - d. If requesting the addition of a parameter:
      - i. The analyte to be tested for;
      - ii. The instruments and equipment to be used for testing;
      - iii. The software to be used at the laboratory for instrument control and data reduction interpretation; and
      - iv. The limit of quantitation, if applicable;
    - e. Whether the laboratory is ready for an inspection by the Department;
    - f. If the laboratory is not ready for an inspection by the Department, the date the laboratory will be ready for an inspection by the Department;
    - g. An attestation that the information provided to the Department to apply for the addition of a parameter is true and correct; and
    - h. The signatures of the owner of the laboratory, according to R9-17-401(A), and the technical laboratory director and the date each signed;
  - 2. The following for each parameter requested to be added:

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- a. A copy of current accreditation;
- b. A copy of a proficiency testing report;
- c. A copy of the standard operating procedure; and
- d. Documentation of the initial demonstration of capabilities, according to R9-17-404.03(D); and
- 3. If applicable, any changes to the quality assurance plan in R9-17-404.05(B) made due to the addition or removal of the parameter.
- C. The Department may conduct a laboratory inspection during the substantive review period for a request to have one or more parameters added to a laboratory registration certificate.
- D. The Department shall process a request to have one or more parameters added to a laboratory registration certificate as provided in R9-17-107.
- 3. A statement in a Department-provided format, signed by the laboratory agent, pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
- 4. A copy of the laboratory agent's:
  - a. Arizona driver's license issued on or after October 1, 1996;
  - b. Arizona identification card issued on or after October 1, 1996;
  - c. Arizona registry identification card;
  - d. Photograph page in the laboratory agent's U.S. passport or a U.S. passport card; or
  - e. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the laboratory agent:
    - i. Birth certificate verifying U.S. citizenship,
    - ii. U.S. Certificate of Naturalization, or
    - iii. U.S. Certificate of Citizenship;
- 5. A current photograph of the laboratory agent;
- 6. For the Department's criminal records check authorized in A.R.S. §§ 36-2804.01 and 36-2804.07:
  - a. The laboratory agent's fingerprints on a fingerprint card that includes:
    - i. The laboratory agent's first name; middle initial, if applicable; and last name;
    - ii. The laboratory agent's signature;
    - iii. If different from the laboratory agent, the signature of the individual physically rolling the laboratory agent's fingerprints;
    - iv. The laboratory agent's address;
    - v. If applicable, the laboratory agent's surname before marriage and any names previously used by the laboratory agent;
    - vi. The laboratory agent's date of birth;
    - vii. The laboratory agent's Social Security number;
    - viii. The laboratory agent's citizenship status;
    - ix. The laboratory agent's gender;
    - x. The laboratory agent's race;
    - xi. The laboratory agent's height;
    - xii. The laboratory agent's weight;
    - xiii. The laboratory agent's hair color;
    - xiv. The laboratory agent's eye color; and
    - xv. The laboratory agent's place of birth;
  - b. If the laboratory agent's fingerprints and information required in subsection (6)(a) were submitted to the Department within the previous six months as part of an application for a designated caregiver registry identification card, a dispensary agent registry identification card, or a laboratory agent registry identification card, the registry identification number on the registry identification card issued to the laboratory agent as a result of the application; or
  - c. Documentation that the laboratory agent has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
- 7. The applicable fee in R9-17-102 for applying for a laboratory agent registry identification card.

**Historical Note**

New Section made by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-405. Submitting an Application for a Laboratory Agent Registry Identification Card**

To obtain a laboratory agent registry identification card for an individual serving as an owner for the laboratory, employed by the laboratory, or providing volunteer services at or on behalf of the laboratory, the owner shall submit to the Department the following for each laboratory agent:

- 1. An application in a Department-provided format that includes:
  - a. The laboratory agent's first name; middle initial, if applicable; last name; and suffix, if applicable;
  - b. The laboratory agent's residence address and Arizona mailing address;
  - c. The county where the laboratory agent resides;
  - d. The laboratory agent's date of birth;
  - e. The identifying number on the applicable card or document in subsection (4)(a) through (e);
  - f. The name and registry identification number of the laboratory; and
  - g. The signature of the individual in R9-17-402(A)(1)(c) designated to submit laboratory agent applications on the laboratory's behalf and the date the individual signed;
- 2. An attestation signed and dated by the laboratory agent that the laboratory agent:
  - a. Either:
    - i. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
    - ii. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
  - b. Will not test medical marijuana and medical marijuana products for:
    - i. A dispensary, related medical marijuana business entity, or management company that the laboratory agent has a direct or indirect familial or financial relationship with or interest in; or
    - ii. A designated caregiver who the laboratory has a direct or indirect familial or financial relationship with;

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-406. Submitting an Application to Renew a Labora-**

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**tory Agent's Registry Identification Card**

To renew a laboratory agent's registry identification card for an individual serving as an owner for the laboratory, employed by the laboratory, or providing volunteer services at or on behalf of the laboratory, the laboratory shall submit to the Department, at least 30 calendar days before the expiration of the laboratory agent's registry identification card, but no more than 90 days before the expiration date of the laboratory's agent's registry identification card, the following:

1. An application in a Department-provided format that includes:
  - a. The laboratory agent's first name; middle initial, if applicable; last name; and suffix, if applicable;
  - b. The laboratory agent's residence address and Arizona mailing address;
  - c. The county where the laboratory agent resides;
  - d. The laboratory agent's date of birth;
  - e. The registry identification number on the laboratory agent's current registry identification card;
  - f. The name and registry identification number of the laboratory; and
  - g. The signature of the individual in R9-17-402(A)(1)(c) designated to submit laboratory agent applications on the laboratory's behalf and the date the individual signed;
2. If the laboratory agent's name in subsection (1)(a) is not the same name as on the laboratory agent's current registry identification card, one of the following with the laboratory agent's new name:
  - a. An Arizona driver's license,
  - b. An Arizona identification card, or
  - c. The photograph page in the laboratory agent's U.S. passport or a U.S. passport card;
3. An attestation signed and dated by the laboratory agent that the laboratory agent:
  - a. Either:
    - i. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
    - ii. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
  - b. Will not test medical marijuana and medical marijuana products for:
    - i. A dispensary, related medical marijuana business entity or management company the laboratory agent has a direct or indirect familial or financial relationship with or interest in; or
    - ii. A designated caregiver the laboratory has a direct or indirect familial or financial relationship with;
4. A statement in a Department-provided format signed by the laboratory agent pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
5. A current photograph of the laboratory agent;
6. For the Department's criminal records check authorized in A.R.S. §§ 36-2804.01 and 36-2804.07:
  - a. The laboratory agent's fingerprints on a fingerprint card that includes:
    - i. The laboratory agent's first name; middle initial, if applicable; and last name;
    - ii. The laboratory agent's signature;

- iii. If different from the laboratory agent, the signature of the individual physically rolling the laboratory agent's fingerprints;
  - iv. The laboratory agent's address;
  - v. If applicable, the laboratory agent's surname before marriage and any names previously used by the laboratory agent;
  - vi. The laboratory agent's date of birth;
  - vii. The laboratory agent's Social Security number;
  - viii. The laboratory agent's citizenship status;
  - ix. The laboratory agent's gender;
  - x. The laboratory agent's race;
  - xi. The laboratory agent's height;
  - xii. The laboratory agent's weight;
  - xiii. The laboratory agent's hair color;
  - xiv. The laboratory agent's eye color; and
  - xv. The laboratory agent's place of birth;
  - b. If the laboratory agent's fingerprints and information required in subsection (6)(a) were submitted to the Department within the previous six months as part of an application for a designated caregiver registry identification card, a dispensary agent registry identification card, or a laboratory agent registry identification card, the registry identification number on the registry identification card issued to the laboratory agent as a result of the application; or
  - c. Documentation that the laboratory agent has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
7. The applicable fee in R9-17-102 for applying to renew a laboratory agent's registry identification card.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-407. Inventory Control System**

- A. A laboratory shall not accept submissions of marijuana or marijuana products for testing from an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1.
- B. A technical laboratory director shall designate in writing a laboratory agent who has oversight of the laboratory's marijuana inventory control system.
- C. A technical laboratory director shall establish and implement an inventory control system for the laboratory's medical marijuana and marijuana products that documents:
  1. The following amounts in appropriate units:
    - a. Each day's beginning inventory of medical marijuana and marijuana products;
    - b. Medical marijuana and marijuana products accepted for testing, including verifying the amount of each sample of medical marijuana or marijuana product accepted for testing;
    - c. The portions of a sample of medical marijuana or a marijuana product removed for testing with the name of the laboratory agent removing each portion;
    - d. Medical marijuana and marijuana products transferred to or from another laboratory for testing of parameters or analytes that the laboratory receiving a sample from a dispensary is not approved by the Department to conduct;

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- e. Medical marijuana and marijuana products transferred to another laboratory at the request of a dispensary according to R9-17-317.01(C);
- f. Medical marijuana or marijuana products that were disposed of, including verifying that the amount of medical marijuana or marijuana product being disposed of is consistent with the original amount accepted for testing minus the amounts used for testing or transferred to another laboratory; and
- g. The day's ending medical marijuana and marijuana products inventory;
- 2. The chain of custody for each sample of medical marijuana or a marijuana product submitted to the laboratory for testing;
- 3. Any damage to a sample's container or possible tampering;
- 4. As applicable, for submissions of marijuana and marijuana products for testing:
  - a. A description of the submitted marijuana or marijuana products including the amount, strain and batch number;
  - b. The name and registry identification number of the dispensary that submitted the marijuana or marijuana products;
  - c. The name and registry identification number of the dispensary agent that submitted the marijuana or marijuana products;
  - d. The name and registry identification number of the qualifying patient that submitted the marijuana or marijuana products;
  - e. The name and registry identification number of the designated caregiver that submitted the marijuana or marijuana products;
  - f. The name and registry identification number of the laboratory agent receiving the marijuana or marijuana products on behalf of the laboratory; and
  - g. The date of acquisition; and
- 5. For disposal of the remaining sample of medical marijuana or a marijuana product after testing:
  - a. The unique sample identification assigned to the sample of medical marijuana or a marijuana product, according to R9-17-404.06(B)(1)(a);
  - b. The amount of the medical marijuana or marijuana product being disposed of;
  - c. Date of disposal;
  - d. Method of disposal; and
  - e. Name and registry identification number of the laboratory agent responsible for the disposal.
- D. The individual designated in subsection (B) shall conduct and document an audit of the laboratory's inventory that is accounted for according to generally accepted accounting principles at least once every 30 calendar days.
  - 1. If the audit identifies a reduction in the amount of marijuana or marijuana products in the laboratory's inventory not due to documented causes, the technical laboratory director shall determine where the loss has occurred and take and document corrective action.
  - 2. If the reduction in the amount of marijuana or marijuana products in the laboratory's inventory is due to suspected criminal activity by a laboratory agent, the technical laboratory director shall report the laboratory agent to the Department and to the local law enforcement authorities and document the report.
- E. A laboratory shall:
  - 1. Maintain the documentation required in subsections (C) and (D) at the laboratory for at least five years after the date on the document, and
  - 2. Provide the documentation required in subsections (C) and (D) to the Department for review upon request.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020; amended by exempt rulemaking at 26 A.A.R. 968, effective April 20, 2020 (Supp. 20-2). Amended by exempt rulemaking at 26 A.A.R. 1905, with an immediate effective date of August 28, 2020 (Supp. 20-3). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-408. Security**

- A. Except as provided in R9-17-404(8), a laboratory shall ensure that access to the area of the laboratory where marijuana or marijuana products are being tested or stored for testing is limited to a laboratory's owners and authorized laboratory agents.
- B. A laboratory agent may only transport marijuana or marijuana products submitted for testing to a laboratory having a registry identification number issued under this Chapter.
- C. Before transportation to a laboratory, a laboratory agent shall:
  - 1. Complete a trip plan that includes:
    - a. The name of the laboratory agent in charge of transporting the marijuana or marijuana products;
    - b. The date and start time of the trip;
    - c. A description of the marijuana or marijuana products being transported;
    - d. Any anticipated stops during the trip, including the locations of the stops and arrival time and departure time for each location; and
    - e. The anticipated route of transportation; and
  - 2. Provide a copy of the trip plan in subsection (C)(1) to the laboratory.
- D. During transportation to the laboratory, a laboratory agent shall:
  - 1. Carry a copy of the trip plan in subsection (C)(1) with the laboratory agent for the duration of the trip;
  - 2. Use a vehicle:
    - a. Without any marijuana identification;
    - b. Equipped with a global positioning system or other means of tracking the location of the vehicle;
    - c. With an operational video surveillance system and recording equipment that:
      - i. Shows the interior of the vehicle, including the driver's seat and location of the marijuana, marijuana plants, or marijuana products being transported;
      - ii. Is turned on for the duration of a trip while medical marijuana or a marijuana product is in the vehicle; and
      - iii. Either stores the recording for at least 30 calendar days or transmits the recorded images at the time of recording to another location, where the recorded images are stored for at least 30 calendar days; and

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- d. With a locked compartment in which any marijuana or marijuana products being transported may be stored during a trip;
  - 3. Have a means of communication with the laboratory; and
  - 4. Notate the arrival time and departure time for each stop; and
  - 5. Ensure that the marijuana or marijuana products are stored in the locked compartment specified in subsection (D)(2)(d) and are not visible.
  - E. After transportation, a laboratory agent shall enter the end time of the trip and any changes to the trip plan on the trip plan required in subsection (C)(1).
  - F. If a dispensary agent transports medical marijuana or a marijuana product to a laboratory for testing, the laboratory shall require that a copy of the trip plan be provided by the dispensary before accepting the medical marijuana or marijuana product for testing.
  - G. A laboratory shall:
    - 1. Maintain the documents required in subsections (C)(2), (E), and (F); and
    - 2. Provide a copy of the documents required in subsections (C)(2), (E), and (F) to the Department for review upon request.
  - H. To prevent unauthorized access to marijuana or marijuana products at the laboratory for testing, the laboratory shall have the following:
    - 1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include:
      - a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio frequency method, such as cellular, private radio signals, or other mechanical or electronic device;
      - b. Exterior lighting to facilitate surveillance;
      - c. Electronic monitoring including:
        - i. At least one 19-inch or greater call-up monitor;
        - ii. A video printer capable of immediately producing a clear still photo from any video camera image;
        - iii. Video cameras:
          - (1) Providing coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and
          - (2) Having a recording resolution of at least 704 x 480 or the equivalent;
        - iv. A video camera in each area of the laboratory where marijuana or marijuana products are being tested or stored for testing capable of identifying any activity occurring within the area in low light conditions;
        - v. Storage of video recordings from the video cameras for at least 30 calendar days;
        - vi. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; and
        - vii. Sufficient battery backup for video cameras and recording equipment to support at least five minutes of recording in the event of a power outage; and
      - d. Panic buttons in the interior of each building; and
    - 2. Policies and procedures that:
      - a. Restrict access to the areas of the laboratory that contain marijuana or marijuana products and, if applicable, to authorized individuals only;
      - b. Provide for the identification of authorized individuals; and
      - c. Prevent loitering.
- Historical Note**
- New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).
- R9-17-409. Physical Plant**
- A. A laboratory shall ensure that designated storage areas for marijuana or marijuana products or materials used in direct contact with marijuana or marijuana products are:
    - 1. Separate from storage areas for toxic or flammable materials; and
    - 2. Maintained in a manner to prevent:
      - a. Microbial contamination and proliferation, and
      - b. Contamination or infestation by insects or rodents.
  - B. A laboratory shall ensure that:
    - 1. Storage areas are designated for:
      - a. Medical marijuana and marijuana products awaiting testing;
      - b. Reagents, standards, and other testing related chemicals or materials; and
      - c. The remaining portions of tested medical marijuana and marijuana products retained according to R9-17-404(5)(c)(vi);
    - 2. Designated storage areas are monitored to ensure that a:
      - a. Room temperature storage area is maintained between 20°C and 28°C,
      - b. Refrigerated storage area is maintained between 2°C and 8°C, and
      - c. Freezer storage area is maintained at or less than -20°C;
    - 3. A storage area for the storage of medical marijuana or marijuana product awaiting testing is labeled to indicate the temperature range and types of medical marijuana or marijuana products to be stored in the storage area;
    - 4. Medical marijuana or a marijuana product awaiting testing is stored at an appropriate temperature, as specified on the packaged sample;
    - 5. Reagents, standards, and other testing related chemicals or materials are stored according to manufacturer's directions; and
    - 6. The remaining portions of tested medical marijuana and marijuana products are stored in a refrigerated storage area or a freezer storage area to reduce microbial proliferation.
  - C. A laboratory shall ensure that a designated area for testing medical marijuana or a marijuana product for microbial contaminants is maintained in a manner to prevent exposure of the medical marijuana or marijuana product to external microbial contaminants.
  - D. A laboratory shall ensure that a designated area for testing medical marijuana or a marijuana product for pesticides, fungicides, growth regulators, heavy metals, or residual solvents is maintained in a manner to prevent exposure of the medical marijuana or marijuana product to external contamination.



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**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by exempt rulemaking at 27 A.A.R. 111, with an immediate effective date of January 15, 2021 (Supp. 20-4). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-410. Denial or Revocation of a Laboratory Registration Certificate**

- A.** The Department shall deny an application for a laboratory registration certificate if:
1. The physical address of the laboratory is within 500 feet of a private school or a public school that existed before the date the laboratory submitted the initial laboratory registration certificate application;
  2. An owner:
    - a. Has been convicted of an excluded felony offense, or
    - b. Is under 21 years of age;
  3. The application or the laboratory does not comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter;
  4. The laboratory acquires marijuana or marijuana products from an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  5. The laboratory diverts marijuana or marijuana products to an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  6. An owner has any direct or indirect familial or financial relationship with or interest in a dispensary or related medical marijuana business entity or management company, or any direct or indirect familial or financial relationship with a designated caregiver for whom the laboratory is testing marijuana and marijuana products for medical use in this state; or
  7. The laboratory fails to maintain accreditation.
- B.** The Department may deny an application for a laboratory registration certificate if an owner of the laboratory provides false or misleading information to the Department.
- C.** The Department may deny an application for approval of a parameter for testing, submitted according to R9-17-402.01 or R9-17-404.07, if the applicant does not demonstrate compliance with the requirements of this Article related to the parameter or testing of an analyte.
- D.** The Department shall revoke a laboratory's registration certificate if:
1. The laboratory acquires marijuana or marijuana products from an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  2. The laboratory diverts marijuana or marijuana products to an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
  3. An owner has been convicted of an excluded felony offense;
  4. An owner has any direct or indirect familial or financial relationship with or interest in a dispensary or related medical marijuana business entity or management company, or any direct or indirect familial or financial relationship with a designated caregiver for whom the

laboratory is testing marijuana and marijuana products for medical use in this state; or

5. The laboratory fails to maintain accreditation.
- E.** The Department may deny an application for a laboratory registration certificate or revoke a laboratory registration certificate if the laboratory does not:
1. Comply with:
    - a. The requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter; or
    - b. The provisions in a corrective action plan submitted according to R9-17-404.01(F)(2)(b) or R9-17-404.02(C)(6)(a), as applicable; or
  2. Implement the policies and procedures or comply with the statements provided to the Department with the laboratory's application.
- F.** The Department may revoke a laboratory's approval of a parameter for testing if the laboratory does not continue to demonstrate compliance with the requirements of this Article related to the parameter or testing of an analyte.
- G.** If the Department denies a laboratory registration certificate application, the Department shall provide notice to the applicant that includes:
1. The specific reason or reasons for the denial, and
  2. All other information required by A.R.S. § 41-1076.
- H.** If the Department revokes a laboratory registration certificate, the Department shall provide notice to the laboratory that includes:
1. The specific reason or reasons for the revocation; and
  2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by exempt rulemaking at 26 A.A.R. 734, with an immediate effective date of April 2, 2020 (Supp. 20-2). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-17-411. Denial or Revocation of a Laboratory Agent's Registry Identification Card**

- A.** The Department shall deny an application for or renewal of a laboratory agent's registry identification card if the laboratory agent does not meet the requirements in A.R.S. § 36-2801.
- B.** The Department may deny an application for or renewal of a laboratory agent's registry identification card if the laboratory agent provides false or misleading information to the Department.
- C.** The Department shall revoke a laboratory agent's registry identification card if the laboratory agent:
1. Diverts medical marijuana or marijuana products to an individual who or entity that is not allowed to possess medical marijuana pursuant to A.R.S. Title 36, Chapter 28.1; or
  2. Except as provided in A.R.S. § 36-2804.01(D), has been convicted of an excluded felony offense.
- D.** The Department may revoke a laboratory agent's registry identification card if the laboratory agent knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.
- E.** If the Department denies or revokes a laboratory agent's registry identification card, the Department shall provide notice to the laboratory agent and the laboratory agent's laboratory that includes:

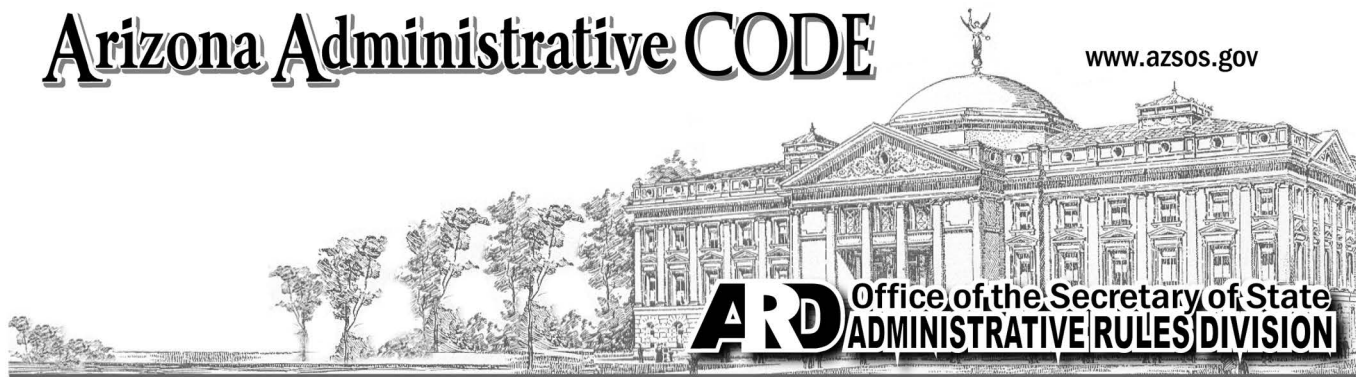
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1. The specific reason or reasons for the denial or revocation; and
2. The process for requesting a judicial review of the Department's decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 2421, effective August 27, 2019 (Supp. 19-3). Amended by final rulemaking at 29 A.A.R. 2396 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).



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The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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<a href="#">R9-18-202.</a>	<a href="#">Application to Renew a Marijuana Facility Agent License .....</a>	<a href="#">6</a>	<a href="#">R9-18-312.</a>	<a href="#">Security .....</a>	<a href="#">19</a>
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#### Questions about these rules? Contact:

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**The release of this Chapter in Supp. 24-4 replaces Supp. 23-3, 1-35 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 9. HEALTH SERVICES

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Authorizing statutes: A.R.S. §§ 36-136(G) and 36-2854

Implementing statutes: A.R.S. §§ 36-2854, 36-2855, 36-2858, 36-2859, 36-2860, 36-2864 and 36-2865

## Supp. 24-4

*Editor's Note: The rules under the Chapter named Department of Health Services - Local Health Department Services, Article 1, Sections R9-18-101 through R9-18-107 were recodified to 9 A.A.C. 1, Article 6, Sections R9-1-601 through R9-1-607, at 26 A.A.R. 3319, with an immediate effective date of December 7, 2020. A new Chapter named Department of Health Services - Adult-Use Marijuana Program was adopted by exempt rulemaking at 27 A.A.R. 140 with rules made effective January 15, 2021. Although exempt from the regular rulemaking process under Proposition 207 § 8, the Department was required to accept public comments on the exempt rulemaking. To assist with compliance of these rules, the Administrative Rules Division has expedited the publication of this Chapter and released it in Supp. 20-4.*

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## ARTICLE 1. GENERAL

**R9-18-101. Definitions**

In addition to the definitions in A.R.S. § 36-2850, the following definitions apply in this Chapter unless otherwise stated:

1. "Accreditation" means being deemed as technically competent under ISO 17025 by the:
  - a. American Association of Laboratory Accreditation,
  - b. Perry Johnson Laboratory Accreditation,
  - c. ANSI National Accreditation Board,
  - d. International Accreditation Services, or
  - e. Commission on Office Laboratory Accreditation.
2. "Acquire" means to obtain through any type of transaction and from any source.
3. "Analyte" means a specific substance for which testing is performed by a marijuana testing facility.
4. "Applicant" means:
  - a. An individual submitting an application for a marijuana facility agent license;
  - b. An entity submitting an application for a marijuana establishment license, to change a marijuana establishment license, or for an approval to operate a marijuana establishment; or
  - c. An individual or entity submitting an application for a marijuana testing facility license, for an approval to test, or for an approval to change parameters.
5. "Batch" means:
  - a. When referring to cultivated marijuana, a specific lot of marijuana that is uniform in strain, grown from one or more seeds or cuttings that are planted and harvested at the same time, and cultivated under the same conditions;
  - b. When referring to marijuana products, a specific amount of a marijuana product infused, manufactured, or prepared for sale from the same set of ingredients at the same time; and
  - c. When referring to a laboratory testing marijuana or a marijuana product according to R9-18-408, a specific set of no more than 20 samples prepared and tested during the same run using the same equipment.
6. "Batch number" means a unique numeric or alphanumeric identifier assigned to a batch by a marijuana establishment when:
  - a. The batch of marijuana is planted; or
  - b. The batch of a marijuana product is infused, manufactured, or prepared for sale.
7. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
8. "Change" means:
  - a. When used in relation to a marijuana facility agent license, adding or deleting information about a marijuana facility agent;
  - b. When used in relation to a place, moving to a different location;
  - c. When used in relation to a marijuana establishment license, adding or removing the activities that a licensee is approved to do at the marijuana establishment's retail site, cultivation site, or manufacturing site;
  - d. When used in relation to parameters, revising a marijuana testing facility's standard operating procedures or quality assurance plan, required in R9-18-409(B), due to:
    - i. Adding or removing a parameter,
    - ii. Altering a testing method, or
    - iii. Using a different instrument for performing a test; and
  - e. When used in relation to testing results, altering the testing results in any way and for any reason.
9. "Commercial device" means a "commercial device," as defined in A.R.S. § 3-3401, that is licensed or certified according to A.R.S. § 3-3451.
10. "Contaminant" means matter, pollutant, hazardous substance, or other substance that is not intended to be part of marijuana or a marijuana product.
11. "Cultivation site" means the single off-site location where marijuana may be cultivated and processed and where marijuana products may be manufactured for a marijuana establishment.
12. "Current photograph" means an image of an individual, taken no more than 60 calendar days before the submission of the individual's application, in a Department-approved electronic format capable of producing an image that:
  - a. Has a resolution of at least 600 x 600 pixels but not more than 1200 x 1200 pixels;
  - b. Is 2 inches by 2 inches in size;
  - c. Is in natural color;
  - d. Is a front view of the individual's full face, without a hat or headgear that obscures the hair or hairline;
  - e. Has a plain white or off-white background; and
  - f. Has between 1 and 1 3/8 inches from the bottom of the chin to the top of the head.
13. "Dispensary" means the same as "nonprofit medical marijuana dispensary" in A.R.S. § 36-2801.
14. "Dispensary agent" means the same as "nonprofit medical marijuana dispensary agent" as defined in A.R.S. § 36-2801.
15. "Edible food product" means a substance, beverage, or ingredient used or intended for use or for sale in whole or in part for human oral consumption.
16. "Entity" means the same as in A.R.S. § 29-2102.
17. "Inhalable" means intended for use through intake into the lungs of an individual.
18. "Laboratory" means a facility in which testing of a substance is performed through chemical analyses or microbial analyses to determine the level of contaminants in the substance.
19. "License" means the same as in A.R.S. § 41-1001.
20. "Manufacturing site" means the single off-site location where marijuana products may be manufactured and packaged and marijuana and marijuana products stored for a marijuana establishment.
21. "Parameter" means the combination of a particular type of sample with a specific instrument or equipment by which the sample will be tested for a specific analyte or characteristic.
22. "Proficiency testing" means a mechanism to determine the ability of a marijuana facility agent to analyze samples within specific acceptance criteria in which the characteristics of the samples are known by the source of the samples but are unknown to a marijuana testing facility receiving the samples from the source.

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23. "Proficiency testing service" means an independent company or other person with ISO/IEC 17043:2010 certification, that:
  - a. Is the source for samples with known characteristics for proficiency testing, and
  - b. Assesses the acceptability of the testing results generated by a marijuana facility agent of a marijuana testing facility from the samples with known characteristics during proficiency testing.
24. "Retail site" means the single location at which a marijuana establishment may sell marijuana and marijuana products to consumers, cultivate marijuana, and manufacture marijuana products.
25. "Sample" means:
  - a. A representative portion of a larger quantity marijuana or a marijuana product,
  - b. A specific quantity of a substance or set of substances to be used for testing purposes, or
  - c. To collect the representative portion in subsection (25)(a).
26. "Time/temperature control for safety food" means the same as in the Food Code: 2017 Recommendations of the United States Public Health Service, Food and Drug Administration, § 1-201.10.
27. "Topical" means intended for use through application to the surface of the skin of an individual.
28. "Working day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a state-wide furlough day.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 28 A.A.R. 2481 (September 23, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-102. Fees**

- A. An applicant submitting an application to the Department shall submit the following nonrefundable fees:
  1. Except as specified in subsection (B), for a marijuana facility agent license:
    - a. For an initial license for an applicant submitting the applicant's fingerprints on a fingerprint card, \$300;
    - b. For renewal of a license for an applicant submitting the applicant's fingerprints on a fingerprint card, \$300;
    - c. For an initial license for an applicant submitting a copy of the applicant's current level 1 fingerprint clearance card issued pursuant to A.R.S. § 41-1758.07, \$150; and
    - d. For renewal of a license for an applicant submitting a copy of the applicant's current level 1 fingerprint clearance card issued pursuant to A.R.S. § 41-1758.07, \$150;
  2. For changing information on a marijuana facility agent's license, \$10;
  3. For requesting a replacement marijuana facility agent license, \$10;
  4. For a marijuana establishment license:

- a. An application fee for an initial license, \$25,000; and
  - b. A license fee for license renewal, \$5,000;
5. For applying for an approval to operate a marijuana establishment, \$2,500;
  6. To change the location of a marijuana establishment's retail site, cultivation site, or manufacturing site, \$2,500;
  7. To add a cultivation site or manufacturing site for a marijuana establishment, \$2,500;
  8. To change or add to the approved activities for a marijuana establishment's retail site, cultivation site, or manufacturing site, \$2,500; and
  9. For a marijuana testing facility license:
    - a. For an initial license, \$25,000; and
    - b. For license renewal, \$5,000.

- B. An applicant for an initial marijuana facility agent license is not required to submit the applicable fee in subsection (A)(1) if the applicant, as part of the application packet in R9-18-201, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 897, effective June 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 27 A.A.R. 2604, with an immediate effective date of October 13, 2021 (Supp. 21-4). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-103. Time-frames**

- A. Within the administrative completeness review time-frame for each type of approval in Table 1.1, the Department shall:
  1. Issue:
    - a. A marijuana facility agent license;
    - b. An initial marijuana establishment license;
    - c. Renewal of a marijuana establishment license;
    - d. An approval to operate a marijuana establishment;
    - e. An approval to change the location of a marijuana establishment's retail site;
    - f. An approval to add or change the location of a marijuana establishment's cultivation site or manufacturing site;
    - g. An approval to change the activities that a licensee may do at the marijuana establishment's retail site, cultivation site, or manufacturing site;
    - h. An initial marijuana testing facility license;
    - i. Renewal of a marijuana testing facility license;
    - j. An approval for testing; or
    - k. An approval to add a parameter;
  2. Provide a notice of administrative completeness to an applicant; or
  3. Provide a notice of deficiencies to an applicant, including a list of the information or documents needed to complete the application.
- B. An application for approval to operate a marijuana establishment is not complete until the date the applicant states on a written notice provided to the Department according to R9-18-304 that the marijuana establishment is ready for an inspection by the Department.

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- C. An application for approval to make a change to a marijuana establishment license is not complete until the date the applicant states on a written notice provided to the Department according to R9-18-306 that the marijuana establishment is ready for an inspection by the Department.
- D. A marijuana testing facility's application for approval for testing or to add a parameter is not complete until the date the applicant states on a written notice provided to the Department according to R9-18-403 or R9-18-411, as applicable, that the marijuana testing facility is ready for an inspection by the Department.
- E. If the Department provides a notice of deficiencies to an applicant:
  - 1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant, and
  - 2. The Department shall consider the application withdrawn if the applicant does not submit the missing information or documents to the Department within the time-frame in Table 1.1.
- F. Within the substantive review time-frame for each type of approval in Table 1.1, the Department:
  - 1. According to subsection (H), shall issue or deny:
    - a. A marijuana facility agent license, marijuana establishment license renewal, or marijuana testing facility license; or
    - b. Approval to operate a marijuana establishment, approval to make a change to the marijuana establishment license, approval for testing, or approval to add a parameter;
  - 2. Shall notify an applicant for an initial marijuana establishment license according to subsection (H)(3)(b)(i) or (4), as applicable;
  - 3. May complete an inspection that may require more than one visit to a marijuana establishment;
  - 4. May complete an inspection that may require more than one visit to a marijuana testing facility; and
  - 5. May make one written comprehensive request for more information, unless the Department and the applicant agree in writing to allow the Department to submit supplemental requests for information.
- G. If the Department issues a written comprehensive request or a supplemental request for information:
  - 1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives all of the information requested, and
  - 2. The applicant shall submit to the Department all of the information and documents listed in the written comprehensive request or supplemental request for information within the time-frame in Table 1.1.
- H. The Department shall issue:
  - 1. The following, as applicable, if the Department determines that the applicant complies with A.R.S. Title 36, Chapter 28.2, and this Chapter:
    - a. A marijuana facility agent license;
    - b. Renewal of a marijuana establishment license;
    - c. An approval to operate a marijuana establishment;
    - d. An approval to change the location of a marijuana establishment's retail site;
  - e. An approval to add or change the location of a marijuana establishment's cultivation site or manufacturing site;
  - f. An approval to change an activity that a licensee may do at the marijuana establishment's retail site, cultivation site, or manufacturing site;
  - g. An initial marijuana testing facility license;
  - h. Renewal of a marijuana testing facility license;
  - i. An approval for testing; or
  - j. An approval to add a parameter;
- 2. For an applicant for a marijuana facility agent license, a denial that includes the reason for the denial and the process for requesting review if:
  - a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.2, or this Chapter; or
  - b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within the time-frame in Table 1.1 after the date of the comprehensive written request or supplemental request for information;
- 3. For an applicant for an initial marijuana establishment license, if the Department determines that the marijuana establishment license application complies with A.R.S. Title 36, Chapter 28.2, and this Chapter:
  - a. A marijuana establishment license, if not all available marijuana establishment licenses have been allocated according to the criteria and processes in R9-18-302; or
  - b. Written notice that:
    - i. The marijuana establishment license application complies with A.R.S. Title 36, Chapter 28.2, and this Chapter;
    - ii. The applicant was not allocated a marijuana establishment license according to the criteria and processes in R9-18-302 because all available marijuana establishment licenses have been allocated according to the criteria and processes in R9-18-302; and
    - iii. The written notice is not a denial and is not considered a final decision of the Department subject to administrative review; or
- 4. For an applicant for a marijuana establishment license, an approval to operate, an approval to change the location of a marijuana establishment's retail site, an approval to add or change the location of a marijuana establishment's cultivation site or manufacturing site, an approval to change an activity, a marijuana testing facility license, an approval for testing, or an approval to add a parameter, a denial that includes the reason for the denial and the process for administrative review if:
  - a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.2, or this Chapter; or
  - b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within the time-frame in Table 1.1 after the date of the comprehensive written request or supplemental request for information.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended



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by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 28 A.A.R. 2481 (September 23, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

Table 1.1. Time-frames

Type of approval	Authority (A.R.S. § or A.A.C.)	Overall Time-frame (in working days)	Time-frame for applicant to complete application (in working days)	Administrative Completeness Time-frame (in working days)	Substantive Review Time-frame (in working days)	Response Time for Request in R9-18-103(G)(2) (in working days)
Applying for a marijuana facility agent license	§ 36-2855 R9-18-201	15	30	5	10	10
Renewing a marijuana facility agent license	§ 36-2855 R9-18-202	15	30	5	10	10
Applying for a marijuana establishment license	§ 36-2854 R9-18-303	90	10	30	60	10
Applying for approval to operate a marijuana establishment	§ 36-2854 R9-18-304	45	90	15	30	60
Changing the location of a marijuana establishment's retail site or adding or changing a marijuana establishment's cultivation site or manufacturing site location	§ 36-2854 R9-18-306	90	90	30	60	60
Requesting approval to change an activity	§ 36-2854 R9-18-306	90	90	30	60	60
Renewing a marijuana establishment license	§ 36-2854 R9-18-307	15	30	5	10	10
Applying for a marijuana testing facility license	§ 36-2854	90	90	30	60	60
Applying for approval for testing	§ 36-2854	90	90	30	60	120
Renewing a marijuana testing facility license	§ 36-2854	15	30	5	10	60
Applying to add a parameter	§ 36-2854	90	90	30	60	120

## Historical Note

Table 1. Time-frames made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 2604, with an immediate effective date of October 13, 2021 (Supp. 21-4). Amended by exempt rulemaking at 28 A.A.R. 2481 (September 23, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3).

Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

## ARTICLE 2. MARIJUANA FACILITY AGENTS

**R9-18-201. Initial Application for a Marijuana Facility Agent License**

To apply for a marijuana facility agent license, an applicant who is at least 21 years of age shall submit to the Department in a Department-provided format:

1. The following:
  - a. The applicant's first name, middle initial if applicable, last name, and suffix if applicable;
  - b. The applicant's date of birth;
  - c. The applicant's residence address and Arizona mailing address;
  - d. The county where the applicant resides;
  - e. The identifying number on the applicable card or document in subsection (2); and
- f. The signature of the individual and the date the individual signed;
2. A copy of the applicant's:
  - a. Arizona driver's license issued on or after October 1, 1996;
  - b. Arizona identification card issued on or after October 1, 1996;
  - c. Arizona registry identification card issued according to 9 A.A.C. 17;
  - d. Marijuana facility agent license;
  - e. Photograph page in the applicant's U.S. passport or a U.S. passport card; or
  - f. Arizona driver's license or identification card issued before October 1, 1996 and one of the following for the applicant:
    - i. Birth certificate verifying U.S. citizenship,

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- ii. U.S. Certificate of Naturalization, or
- iii. U.S. Certificate of Citizenship;
- 3. A current photograph of the applicant;
- 4. For the Department's criminal records check authorized in A.R.S. § 36-2855(B)(2):
  - a. The applicant's fingerprints on a fingerprint card that includes:
    - i. The applicant's first name; middle initial, if applicable; and last name;
    - ii. The applicant's signature;
    - iii. If different from the applicant, the signature of another individual physically rolling the applicant's fingerprints;
    - iv. The applicant's address;
    - v. If applicable, the applicant's surname before marriage and any names previously used by the applicant;
    - vi. The applicant's date of birth;
    - vii. The applicant's Social Security number;
    - viii. The applicant's citizenship status;
    - ix. The applicant's gender;
    - x. The applicant's race;
    - xi. The applicant's height;
    - xii. The applicant's weight;
    - xiii. The applicant's hair color;
    - xiv. The applicant's eye color; and
    - xv. The applicant's place of birth;
  - b. If the applicant's fingerprints and information required in subsection (4)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card, within the previous six months, the registry identification number on the registry identification card issued to the applicant as a result of the application; or
  - c. Documentation that the applicant has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
- 5. An attestation that the applicant has not been convicted of an excluded felony offense;
- 6. An attestation that the information provided in the application is true and correct; and
- 7. The applicable fee in R9-18-102 for applying for an initial license as a marijuana facility agent.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-202. Application to Renew a Marijuana Facility Agent License**

To renew a license as a marijuana facility agent, an applicant shall submit to the Department, at least 30 calendar days before the expiration of the license as a marijuana facility agent and in a Department-provided format:

- 1. The applicant's license number on the marijuana facility agent license;
- 2. A current photograph of the applicant;
- 3. For the Department's criminal records check authorized in A.R.S. § 36-2855(B)(2):
  - a. The applicant's fingerprints on a fingerprint card that includes:

- i. The applicant's first name; middle initial, if applicable; and last name;
- ii. The applicant's signature;
- iii. If different from the applicant, the signature of another individual physically rolling the applicant's fingerprints;
- iv. The applicant's address;
- v. If applicable, the applicant's surname before marriage and any names previously used by the applicant;
- vi. The applicant's date of birth;
- vii. The applicant's Social Security number;
- viii. The applicant's citizenship status;
- ix. The applicant's gender;
- x. The applicant's race;
- xi. The applicant's height;
- xii. The applicant's weight;
- xiii. The applicant's hair color;
- xiv. The applicant's eye color; and
- xv. The applicant's place of birth;
- b. If the applicant's fingerprints and information required in subsection (3)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card, within the previous six months, the registry identification number on the registry identification card issued to the applicant as a result of the application; or
- c. Documentation that the applicant has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;
- 4. An attestation that the applicant has not been convicted of an excluded felony offense;
- 5. An attestation that the information provided in the application is true and correct; and
- 6. The applicable fee in R9-18-102 for renewal of a license as a marijuana facility agent.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-203. Updating Information for a Marijuana Facility Agent****A. A marijuana facility agent shall:**

- 1. Notify the Department, in a Department-provided format and within 10 working days, if any of the following information submitted to the Department changes:
  - a. The marijuana facility agent's name,
  - b. The marijuana facility agent's residential address or mailing address, or
  - c. The marijuana facility agent's e-mail address; and
- 2. Submit to the Department, in a Department-provided format:
  - a. For a change in the marijuana facility agent's name, one of the following with the marijuana facility agent's new name:
    - i. An Arizona driver's license,
    - ii. An Arizona identification card, or

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- iii. The photograph page in the marijuana facility agent's U.S. passport or a U.S. passport card;
  - b. For a change in address, the new address and the county where the new address is located;
  - c. For a change in e-mail address, the new e-mail address;
  - d. The effective date of the marijuana facility agent's new name or address; and
  - e. The fee in R9-18-102 for changing marijuana facility agent information.
- B. A marijuana facility agent shall notify the Department within 48 hours after the following:
  - 1. Beginning employment or other association with a marijuana establishment or marijuana testing facility, or
  - 2. Ending employment or other association with a marijuana establishment or marijuana testing facility.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-204. Requesting a Replacement Marijuana Facility Agent License**

To request a replacement marijuana facility agent license for a license that has been lost, stolen, or destroyed, a marijuana facility agent shall submit to the Department, in a Department-provided format and within 10 working days after the marijuana facility agent license was lost, stolen, or destroyed, a request for a replacement marijuana facility agent license that includes:

- 1. The marijuana facility agent's name and date of birth;
- 2. If known, the license number on the lost, stolen, or destroyed marijuana facility agent license;
- 3. If the marijuana facility agent cannot provide the license number on the lost, stolen, or destroyed marijuana facility agent license, a copy of one of the following documents that the marijuana facility agent submitted with an application for the license or to renew the license:
  - a. Arizona driver's license,
  - b. Arizona identification card, or
  - c. Photograph page in the marijuana facility agent's U.S. passport or a U.S. passport card; and
- 4. The fee in R9-18-102 for requesting a replacement marijuana facility agent license.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-205. Denial, Suspension, or Revocation of a Marijuana Facility Agent License**

- A. The Department shall deny an application for or renewal of a marijuana facility agent license if a marijuana facility agent does not meet the definition "marijuana facility agent" in A.R.S. § 36-2850.
- B. The Department may deny an application for or renewal of a license of a marijuana facility agent if the marijuana facility agent:
  - 1. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or 9 A.A.C. 17;

- 2. Previously had a marijuana facility agent license revoked for not complying with A.R.S. Title 36, Chapter 28.2 or this Chapter; or
  - 3. Provides false or misleading information to the Department.
- C. The Department may suspend or revoke the license of a marijuana facility agent and may assess a civil penalty if the marijuana facility agent:
  - 1. Diverts marijuana to an individual who or entity that is not allowed to possess marijuana, pursuant to A.R.S. Title 36, Chapter 28.1 or 28.2;
  - 2. Has been convicted of an excluded felony offense;
  - 3. Provides false or misleading information to the Department; or
  - 4. Knowingly violates:
    - a. A.R.S. Title 36, Chapter 28.2, or this Chapter; or
    - b. A.R.S. Title 36, Chapter 28.1, or 9 A.A.C. 17, if the marijuana facility agent is also acting as a dispensary agent for a dual licensee under A.R.S. § 36-2855(E).
- D. If the Department denies, suspends, or revokes the license of a marijuana facility agent, the Department shall provide notice to a marijuana facility agent that includes:
  - 1. The specific reason or reasons for the denial, suspension, or revocation; and
  - 2. The process for requesting a review of the Department's decision pursuant to A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**ARTICLE 3. MARIJUANA ESTABLISHMENTS****R9-18-301. Principal Officers and Board Members**

- A. For the purposes of this Chapter, in addition to the individual or individuals identified in the marijuana establishment's by-laws or other organizational governing documents as principal officers of the marijuana establishment, if applicable, the following individuals are considered principal officers:
  - 1. If a corporation is applying for a marijuana establishment license, two individuals who are officers of the corporation, including, but not limited to, the president or chief executive officer and those individuals serving in the positions of secretary and treasurer;
  - 2. If a partnership is applying for a marijuana establishment license, all individuals who are general partners and the principal officers of any entity general partner;
  - 3. If a limited liability company is applying for a marijuana establishment license, all managers of a manager-managed limited liability company, all members of a member-managed limited liability company, and the principal officers of an entity manager or member;
  - 4. If an association or cooperative is applying for a marijuana establishment license, the chief executive officer, executive director, or other comparable leader of the association or cooperative; and
  - 5. If a business organization type other than those described in subsections (A)(1) through (4) is applying for a mari-

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juana establishment license, two individuals who occupy the top leadership positions of the business organization.

- B.** For purposes of this Chapter, in addition to the individual or individuals identified in the marijuana establishment's by-laws or other organizational governing documents as board members of the marijuana establishment, if applicable, the following individuals are considered board members:
1. If a corporation is applying for a marijuana establishment license, the members of the board of directors of the corporation;
  2. If a partnership is applying for a marijuana establishment license, the partners who are not limited partners;
  3. If a limited liability company is applying for a marijuana establishment license, the principal officers of the limited liability company;
  4. If an association or cooperative is applying for a marijuana establishment license, the principal officers of the association or cooperative; and
  5. If a business organization type other than the types of business organizations in subsections (B)(1) through (4), the principal officers of the business organization.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4).

**R9-18-302. Marijuana Establishment License Allocation Process**

- A.** The Department may periodically review current valid marijuana establishment licenses to determine if the Department may issue additional marijuana establishment licenses pursuant to A.R.S. § 36-2854(A)(1)(b).
1. If the Department determines that the Department may issue additional marijuana establishment licenses, the Department shall post, on the Department's website, the information that the Department is accepting marijuana establishment license applications, including the deadline for accepting marijuana establishment license applications.
    - a. The Department shall post the information in subsection (A)(1) at least 30 calendar days before the date the Department begins accepting applications.
    - b. The deadline for submission of marijuana establishment license applications is 10 working days after the date the Department begins accepting applications.
    - c. Ninety working days after the date the Department begins accepting applications, the Department shall determine if the Department received more marijuana establishment license applications that are complete and in compliance with A.R.S. Title 36, Chapter 28.2 and this Chapter to participate in the allocation process than the Department is allowed to issue.
      - i. If the Department received more marijuana establishment license applications than the Department is allowed to issue, the Department shall allocate any available marijuana establishment licenses according to the priorities established in subsection (B).
      - ii. If the Department is allowed to issue a marijuana establishment license for each marijuana establishment license application the Department received, the Department shall allocate

the marijuana establishment licenses to those applicants.

2. If the Department determines that the Department is not allowed to issue additional marijuana establishment licenses, the Department shall, on the Department's website:
  - a. Post the information that the Department is not accepting marijuana establishment license applications, and
  - b. Maintain the information until the next review.
- B.** If the Department receives more marijuana establishment license applications according to R9-18-303 that are complete and compliant with A.R.S. Title 36, Chapter 28.2, and this Chapter to participate in the allocation process than the number of licenses the Department is allowed to issue, the Department shall allocate the marijuana establishment licenses based on random drawing.
- C.** If an entity is allocated a marijuana establishment license under subsection (A)(1)(c)(ii) or (B), the entity shall ensure that each principal officer and each board member, specified according to R9-18-301, obtains a marijuana facility agent license according to R9-18-201 before the entity submits an application for an approval to operate according to R9-18-304.
- D.** If the Department does not allocate a marijuana establishment license to an applicant that had submitted a marijuana establishment license application according to R9-18-303 that the Department determined was complete and compliant with A.R.S. Title 36, Chapter 28.2, and this Chapter to participate in the allocation process, the Department shall provide a written notice to the applicant that states that, although the applicant's marijuana establishment license application was complete and compliant with A.R.S. Title 36, Chapter 28.2, and this Chapter, the Department did not allocate the applicant a marijuana establishment license under the processes in this Section.
- E.** If the Department receives a marijuana establishment license application at a time other than during the application period stated in subsection (A)(1), the Department shall return the application, including the application fee, to the entity that submitted the application.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 897, effective June 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-303. Applying for an Initial Marijuana Establishment License**

- A.** To apply for an initial marijuana establishment license, an applicant shall electronically submit to the Department, during the application period specified according to R9-18-302(A)(1):
1. The following information in a Department-provided format:
    - a. The legal name of the proposed marijuana establishment;
    - b. The physical address of the proposed marijuana establishment's retail site;
    - c. The county in which the proposed marijuana establishment's retail site is located;
    - d. The following information for the applicant:
      - i. Name of the entity applying,

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- ii. Type of business organization,
- iii. Arizona mailing address,
- iv. Telephone number, and
- v. Email address;
- e. The name, residence address, and date of birth of each principal officer and each board member, according to R9-18-301;
- f. The name, residence address, and, if applicable, date of birth of any person who is entitled to 10% or more of the profits of the proposed marijuana establishment;
- g. Whether the applicant agrees to allow the Department to submit supplemental requests for information;
- h. An attestation that, if the applicant is issued a marijuana establishment license, the proposed marijuana establishment will not operate until the proposed marijuana establishment is inspected and obtains an approval to operate from the Department;
- i. An attestation that the applicant understands and will comply with the requirements in A.R.S. Title 36, Chapter 28.2, and this Chapter;
- j. An attestation that information provided to the Department to apply for a marijuana establishment license is true and correct; and
- k. The signatures of each principal officer and each board member of the proposed marijuana establishment according to R9-18-301 and the date signed;
- 2. Documentation that the applicant is in good standing with the Arizona Corporation Commission;
- 3. For each principal officer and each board member listed according to subsection (A)(1)(e), documentation of the principal officer's or board member's marijuana facility agent license;
- 4. An attestation, in a Department-provided format, from each principal officer and each board member listed according to subsection (A)(1)(e) that the principal officer or board member:
  - a. Does not have an excluded felony offense, as defined in A.R.S. § 36-2801;
  - b. Does not have a direct or indirect familial or financial relationship with a marijuana testing facility; and
  - c. Has not had an ownership interest in a licensed marijuana business that had the license revoked in another state;
- 5. The application fee in R9-18-102 for a marijuana establishment license.
- B.** An applicant shall ensure that no principal officer or board member of the applying entity is a principal officer or board member on more than four other marijuana establishment license applications, for a total of no more than five marijuana establishment license applications, submitted according to subsection (A).
- C.** Before an entity with a marijuana establishment license begins operating a marijuana establishment, the entity shall apply for and obtain an approval to operate a marijuana establishment from the Department.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 897, effective June 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 27 A.A.R. 2604 (November 5, 2021), with an immediate

effective date of October 13, 2021; amended by exempt rulemaking at 27 A.A.R. 2764 (November 26, 2021) with an immediate effective date of November 5, 2021; amended by exempt rulemaking at 27 A.A.R. 2862 (December 10, 2021) with an effective date of November 5, 2021. Refer to Register publication dates to view versioning of amendments of this Section in the fourth quarter of 2021 (Supp. 21-4). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-304. Applying for Approval to Operate a Marijuana Establishment**

- A.** To apply for approval to operate a marijuana establishment, a principal officer or board member of the entity holding a marijuana establishment license shall electronically submit to the Department, within 18 months after the marijuana establishment license was issued:
  - 1. The following information in a Department-provided format:
    - a. The name and license number of the marijuana establishment;
    - b. The physical address of the marijuana establishment's retail site;
    - c. The county in which the marijuana establishment's retail site is located;
    - d. The marijuana establishment's Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
    - e. The marijuana establishment's proposed hours of operation;
    - f. Which of the following activities the marijuana establishment plans to provide at the retail site:
      - i. Cultivate marijuana;
      - ii. Manufacture marijuana products;
      - iii. Prepare marijuana-infused edible food products; or
      - iv. Sell marijuana-infused edible food products that are either:
        - (1) A time/temperature control for safety food, or
        - (2) Not prepared in individually packaged containers;
    - g. Whether the marijuana establishment agrees to allow the Department to submit supplemental requests for information;
    - h. Whether the marijuana establishment's retail site is ready for an inspection by the Department;
    - i. If the marijuana establishment's retail site is not ready for an inspection by the Department, the date the marijuana establishment's retail site will be ready for an inspection by the Department;
    - j. An attestation that the information provided to the Department to apply for approval to operate a marijuana establishment is true and correct; and
    - k. The signature of each principal officer and each board member of the marijuana establishment according to R9-18-301 and the date signed;
  - 2. A copy of documentation issued by the local jurisdiction to the marijuana establishment authorizing occupancy of the building as a marijuana establishment's retail site,

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such as a certificate of occupancy, a special use permit, or a conditional use permit;

3. Documentation, in a Department-provided format, of:
  - a. Ownership of the physical address of the marijuana establishment's retail location, signed and dated within 60 calendar days before the date of application; or
  - b. Permission from the owner of the physical address of the marijuana establishment's retail location for the applicant to operate a marijuana establishment at the physical address, signed, notarized, and dated within 60 calendar days before the date of application;
4. A copy of the marijuana establishment's license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, if the marijuana establishment plans to:
  - a. Prepare marijuana-infused edible food products, as specified in subsection (A)(1)(f)(iii); or
  - b. Sell marijuana-infused edible food products, as specified in subsection (A)(1)(f)(iv);
5. A site plan drawn to scale of the marijuana establishment's retail site showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains;
6. A floor plan drawn to scale of the building where the marijuana establishment's retail site is located showing the:
  - a. Layout and dimensions of each room,
  - b. Name and function of each room,
  - c. Location of each hand washing sink,
  - d. If planning to conduct any of the activities specified according to subsection (A)(1)(f), location of each piece of fixed equipment required to conduct the activity;
  - e. Location of each toilet room,
  - f. Means of egress,
  - g. Location of each video camera,
  - h. Location of each panic button, and
  - i. Location of natural and artificial lighting sources;
7. Documentation of the marijuana facility agent license for each principal officer and each board member according to R9-18-301; and
8. The applicable fee in R9-18-102 for applying for an approval to operate.

- B. The Department shall process, as provided in R9-18-103, a request submitted according to subsection (A) for approval to operate a marijuana establishment.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 27 A.A.R. 897, effective June 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 28 A.A.R. 2481 (September 23, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-305. Changes to a Marijuana Establishment License**

- A. A marijuana establishment that is a dual licensee may not separately transfer or assign the dispensary registration certificate or the marijuana establishment license.
- B. Except as provided in subsection (C), a marijuana establishment may change the location of the marijuana establishment's retail site, manufacturing site, or cultivation site to another location in the state.
- C. For a marijuana establishment that received a marijuana establishment license under A.R.S. § 36-2854(A)(1)(c), the marijuana establishment may only change the location of the marijuana establishment's retail site to another location in the same county for which the original marijuana establishment license was issued.
- D. A marijuana establishment shall not cultivate, manufacture, distribute, dispense, or sell marijuana or a marijuana product at a new location of the marijuana establishment's retail site, manufacturing site, or cultivation site or make a change in the activities conducted at a current location until the marijuana establishment:
  1. Submits an application for a change in R9-18-306; and
  2. Receives from the Department an amended marijuana establishment license or an approval for:
    - a. The new location of the marijuana establishment's retail site, manufacturing site, or cultivation site; or
    - b. The requested change in the activities conducted at a current location.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 897, effective June 1, 2021 (Supp. 21-2).

**R9-18-306. Applying to Change a Marijuana Establishment License**

- A. A marijuana establishment may submit an application to the Department according to subsections (B) and (C) to request any of the following:
  1. To change the location of the marijuana establishment's retail site, manufacturing site, or cultivation site;
  2. To add a manufacturing site or cultivation site; or
  3. To change what the marijuana establishment is approved to do at the retail site, cultivation site, or manufacturing site.
- B. A marijuana establishment shall submit a separate application to the Department for each request for one of the possible changes in subsection (A).
- C. To request any of the changes specified in subsection (A), a marijuana establishment shall submit to the Department:
  1. The following information in a Department-provided format:
    - a. The legal name of the marijuana establishment;
    - b. The marijuana establishment license number for the marijuana establishment;
    - c. Whether the request is for a change in the location of the marijuana establishment's:
      - i. Retail site,
      - ii. Cultivation site, or
      - iii. Manufacturing site;
    - d. As applicable, the anticipated date of the change of location;
    - e. Whether the marijuana establishment is requesting to add a:
      - i. Cultivation site and, if so, the physical address of the proposed cultivation site; or

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- ii. Manufacturing site and, if so, the physical address of the proposed manufacturing site;
  - f. The current physical address of the marijuana establishment's retail site, cultivation site, or manufacturing site, as applicable to the request;
  - g. Whether the marijuana establishment's proposed retail site or the marijuana establishment's proposed cultivation site or manufacturing site, as applicable, is ready for an inspection by the Department;
  - h. If the marijuana establishment's proposed retail site or the marijuana establishment's proposed cultivation site or manufacturing site, as applicable, is not ready for an inspection by the Department, the date the marijuana establishment's retail site or the marijuana establishment's proposed cultivation site or manufacturing site will be ready for an inspection by the Department;
  - i. Whether the marijuana establishment is requesting approval for a change in any of the following activities at a current location or include any of the following activities at a new location and, if so, whether the activity is planned to occur at the retail site, or cultivation site:
    - i. On-site cultivation;
    - ii. Manufacturing of marijuana products on-site;
    - iii. Preparation of marijuana-infused edible food products; or
    - iv. Sale of marijuana-infused edible food products that are either:
      - (1) A time/temperature control for safety food; or
      - (2) Not prepared in individually packaged containers;
  - j. Whether the marijuana establishment is requesting approval for a change in any of the following activities at the current location of the manufacturing site or include any of the following activities at a new location of a manufacturing site:
    - i. Packaging and storing marijuana or marijuana products;
    - ii. Manufacturing of marijuana products on-site, or
    - iii. Preparation of marijuana-infused edible food products;
  - k. If applicable, the anticipated date of the change of activities;
  - l. An attestation that the information provided to the Department as part of the application is true and correct; and
  - m. The signatures of each principal officer and each board member of the marijuana establishment according to R9-18-301 and the date signed;
2. A copy of documentation issued by the local jurisdiction to the marijuana establishment authorizing occupancy, as applicable, of the building as a marijuana establishment's proposed retail site or of the location as the marijuana establishment's proposed cultivation site or manufacturing site, such as a certificate of occupancy, a special use permit, or a conditional use permit;
  3. If requesting to change the location of a marijuana establishment's retail site, cultivation site, or manufacturing site, or when requesting to add a cultivation site or manufacturing site, documentation, in a Department-provided format, of:
    - a. Ownership of the physical address of the proposed marijuana establishment location, signed and dated within 60 calendar days before the days of application; or
    - b. Permission from the owner of the physical address of the proposed location for the marijuana establishment to operate a retail site, cultivation site, or manufacturing site, as applicable, at the physical address, signed, notarized, and dated within 60 calendar days before the days of application;
  4. For a change in location of the marijuana establishment's retail site, cultivation site, or manufacturing site, including when any of the activities specified according to subsection (C)(1)(i) or (j) is to be conducted at the new location:
    - a. A site plan drawn to scale of the proposed marijuana establishment location showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
    - b. A floor plan drawn to scale of the building of the proposed retail site, cultivation site, or manufacturing site, as applicable, showing the:
      - i. Layout and dimensions of each room;
      - ii. Name and function of each room;
      - iii. Location of each hand washing sink;
      - iv. If applicable, location of each piece of fixed equipment required to conduct the activity;
      - v. Location of each toilet room;
      - vi. Means of egress;
      - vii. Location of each video camera;
      - viii. Location of each panic button; and
      - ix. Location of natural and artificial lighting sources, as applicable;
  5. For changing an activity conducted at a current location, a floor plan drawn to scale of the building where the activity will occur showing the:
    - a. Layout and dimensions of each room,
    - b. Name and function of each room,
    - c. Location of each hand washing sink,
    - d. Location of each piece of fixed equipment required to conduct the activity,
    - e. Means of egress,
    - f. Location of each video camera,
    - g. Location of each panic button, and
    - h. Location of natural and artificial lighting sources;
  6. A copy of the marijuana establishment's license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, if the marijuana establishment plans to:
    - a. Prepare marijuana-infused edible food products, as specified in subsection (C)(1)(i)(iii) or (C)(1)(j)(iii); or
    - b. Sell marijuana-infused edible food products, as specified in subsection (C)(1)(i)(iv); and
  7. The applicable fee in R9-18-102 for applying for:
    - a. A change in location,
    - b. The addition of a cultivation site or manufacturing site, or
    - c. A change in approved activities at a location.
- D.** If the information and documents submitted by the marijuana establishment comply with A.R.S. Title 36, Chapter 28.2, and this Chapter, the Department shall issue an amended marijuana

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establishment license that includes the new address of the new location or amended approved activities, as applicable, and retains the expiration date of the previous marijuana establishment license.

- E. An application to request any of the possible changes in subsection (A) may not be combined with an application for renewing a marijuana establishment license. A separate application is required for each change, and the Department shall process each application separately according to the applicable time-frame established in R9-18-103 and Table 1.1.
- F. A marijuana establishment shall submit written notification to the Department when the marijuana establishment no longer uses a previously approved cultivation site or manufacturing site.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 28 A.A.R. 2481 (September 23, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-307. Renewing a Marijuana Establishment License**

To renew a marijuana establishment license, a marijuana establishment that has an approval to operate a marijuana establishment issued by the Department shall submit to the Department, at least 30 calendar days before the expiration date of the marijuana establishment's current marijuana establishment license, the following:

1. An application in a Department-provided format that includes:
  - a. The legal name of the marijuana establishment,
  - b. The marijuana establishment license number for the marijuana establishment,
  - c. An attestation that the information provided to the Department to renew the marijuana establishment license is true and correct, and
  - d. The signature of each principal officer and each board member of the marijuana establishment according to R9-18-301 and the date signed; and
2. The license fee in R9-18-102 for applying to renew a marijuana establishment license.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4).

**R9-18-308. Administration**

- A. A marijuana establishment shall:
  1. Ensure that the marijuana establishment's retail site is operating and available to provide marijuana and marijuana products to consumers:
    - a. At least 30 hours weekly between the hours of 7:00 a.m. and 10:00 p.m.; and
    - b. Within 18 months after receiving the marijuana establishment license;
  2. Develop, document, and implement policies and procedures regarding:
    - a. Job descriptions and employment contracts, including:
      - i. Personnel duties, authority, responsibilities, and qualifications; and
      - ii. Supervision;

- b. Training of marijuana facility agents, including the requirements of A.R.S. Title 36, Chapter 28.2, and this Chapter;
- c. Inventory control, including:
  - i. Tracking,
  - ii. Packaging,
  - iii. Acquiring marijuana or marijuana products from a dispensary or another marijuana establishment, and
  - iv. Providing marijuana or marijuana products to another marijuana establishment or a dispensary;
- d. Laboratory testing, including:
  - i. The analytes, including possible contaminants, to be tested for;
  - ii. The process for separating a batch of marijuana or of a marijuana product until laboratory testing has been completed and testing results received by the marijuana establishment, as specified in R9-18-311(B)(1);
  - iii. The process for collecting samples of marijuana or a marijuana product for laboratory testing, according to R9-18-311(B)(2), including:
    - (1) The amount to be collected from each batch,
    - (2) The method for ensuring that a sample collected is representative of the batch,
    - (3) The packaging of the sample,
    - (4) The method for documenting chain of custody for the sample, and
    - (5) Methods to deter tampering with the sample and to determine whether tampering has occurred;
  - iv. The process for specifying the analytes to be tested for, consistent with R9-18-311(A), and either:
    - (1) Providing samples of marijuana or marijuana products to a marijuana testing facility for testing, or
    - (2) Allowing a marijuana facility agent associated with a marijuana testing facility access to marijuana or marijuana product to collect samples;
  - v. The process for requesting retesting of the remaining portion of a sample of marijuana or a marijuana product; and
  - vi. Actions to be taken on the basis of laboratory testing results;
- e. Remediation, including:
  - i. Criteria for when a batch of marijuana or marijuana product can be remediated;
  - ii. The process by which each type of marijuana or marijuana product is remediated, including the methods for remediation and subsequent retesting; and
  - iii. Documentation of the remediation process;
- f. Disposal of marijuana or a marijuana product, including:
  - i. Destroying a batch of marijuana or a marijuana product that does not meet the requirements in Table 3.1 and documenting the destruction;
  - ii. Submitting marijuana that is not usable marijuana, as defined in A.R.S. § 36-2801, to a local



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- law enforcement agency and documenting the submission; or
- iii. Otherwise disposing of marijuana or a marijuana product such that the marijuana or marijuana product is unrecognizable or cannot otherwise be used and documenting the method of disposal, the marijuana facility agent overseeing the disposal, and the date of disposal;
- g. For a marijuana establishment that received the marijuana establishment license under A.R.S. § 36-2854(A)(1)(f), how the marijuana establishment will provide a benefit to one or more communities disproportionately affected by the enforcement of Arizona's previous marijuana laws, such as through:
  - i. Specific hiring or interning practices; or
  - ii. Donation of a percentage of gross profits to one or more non-profit, community-based organizations, not affiliated directly or indirectly with the marijuana establishment, that focus on social or health inequities in a community;
- h. Advertising that complies with the requirements in A.R.S. § 36-2859;
- i. Labeling of marijuana or a marijuana product provided by the marijuana establishment's retail site to a consumer, consistent with subsection (A)(13) and R9-18-310(A)(2); and
- j. If applicable, delivery to a consumer, including:
  - i. The process for taking an order from a consumer for delivery of marijuana, marijuana plants, or marijuana products;
  - ii. Ensuring that only marijuana facility agents associated with the marijuana establishment transport marijuana, marijuana plants, or marijuana products for delivery to a consumer;
  - iii. What to do if a vehicle transporting marijuana, marijuana plants, or marijuana products for delivery to a consumer breaks down or is in a traffic accident;
  - iv. How to update a trip plan, as required in R9-18-312(F)(1), if the wrong item is delivered, the marijuana facility agent cannot verify that an individual wanting to accept delivery is the ordering consumer and eligible to receive delivery, or any other event occurs that may require a change to the trip plan; and
  - v. Requiring the marijuana facility agent transporting marijuana, marijuana plants, or marijuana products for delivery to a consumer to return to the marijuana establishment's retail site if any marijuana, marijuana plants, or marijuana products remain in the vehicle at the completion of the trip plan specified according to R9-18-312(D)(1);
- 3. Maintain copies of the policies and procedures at the marijuana establishment's retail site and provide copies to the Department for review upon request;
- 4. Maintain at the marijuana establishment current and valid documentation of any certificate or permit issued by a local jurisdiction related to the operation of the marijuana establishment and provide copies to the Department for review upon request;
- 5. Review marijuana establishment policies and procedures at least once every 12 months from the issue date of the marijuana establishment license and update as needed;
- 6. Ensure that all principal officers, board members, employees and volunteers providing services for the marijuana establishment maintain valid marijuana facility agent licenses with the Department and that the marijuana facility agent licenses are linked to the marijuana establishment through the Department's electronic system;
- 7. Ensure that no principal officer or board member:
  - a. Has a direct or indirect familial or financial relationship with a marijuana testing facility, or
  - b. Had or has an ownership interest in a licensed marijuana business that had the license revoked in another state;
- 8. Ensure that each marijuana facility agent has the marijuana facility agent's license in the marijuana facility agent's immediate possession when the marijuana facility agent is:
  - a. Working or providing volunteer services at the marijuana establishment's retail site or the marijuana establishment's cultivation site or manufacturing site, or
  - b. Transporting marijuana for the marijuana establishment;
- 9. Not allow an individual who does not possess a marijuana facility agent license or who does not meet the requirements in A.R.S. § 36-2855(E) to:
  - a. Serve as a principal officer or board member for the marijuana establishment,
  - b. Be employed by the marijuana establishment, or
  - c. Provide volunteer services at or on behalf of the marijuana establishment;
- 10. Provide written notice to the Department, including the date of the event, within 10 working days after the date, when a marijuana facility agent no longer:
  - a. Serves as a principal officer or board member for the marijuana establishment,
  - b. Is employed by the marijuana establishment, or
  - c. Provides volunteer services at or on behalf of the marijuana establishment;
- 11. Provide written notice, in a Department-provided format, to the Department, including the date of the event, within 10 working days after the date that the marijuana establishment:
  - a. Ceases to use a cultivation site or manufacturing site specified according to R9-18-306(C); or
  - b. Discontinues an activity specified in R9-18-306(C)(1)(i), (j), or (k);
- 12. Document and report any loss or theft of marijuana or a marijuana product from the marijuana establishment's retail site, cultivation site, or manufacturing site to the appropriate law enforcement agency;
- 13. Maintain the quick response code link and webpage required in R9-18-310(A)(2)(h), as specified in policies and procedures, for at least 30 calendar days after the last date the marijuana establishment's retail site provides the marijuana or marijuana product to which the quick response code link and webpage pertain;
- 14. Maintain copies of any documentation required in this Chapter for at least 12 months after the date on the documentation and provide copies of the documentation to the Department for review upon request; and
- 15. Post the following information in a place that can be viewed by individuals entering the marijuana establishment's retail site:

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- a. If applicable, the marijuana establishment's approval to operate;
  - b. The marijuana establishment license;
  - c. A sign in a Department-provided format that contains the following language:
    - i. "WARNING: There may be potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breast-feeding," and
    - ii. "WARNING: Use of marijuana during pregnancy may result in a risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;" and
  - d. The hours of operation during which the marijuana establishment will sell or otherwise transfer marijuana or a marijuana product to a consumer.
- B.** If a marijuana establishment cultivates marijuana, the marijuana establishment shall cultivate the marijuana in a secure location according to R9-18-312.
- Historical Note**
- New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 897, effective June 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).
- R9-18-309. Selling or Otherwise Transferring Marijuana or a Marijuana Product**
- A.** Before a marijuana facility agent of a marijuana establishment sells or otherwise transfers marijuana or a marijuana product to a consumer, the marijuana facility agent shall:
- 1. Verify the consumer's age through one of the documents in A.R.S. § 4-241(K);
  - 2. Make available the results of testing of the marijuana or marijuana product required in R9-18-311, if requested by the consumer; and
  - 3. Ensure that the amount of marijuana or marijuana product to be sold or otherwise transferred to the consumer does not exceed one ounce of marijuana, with not more than five grams being in the form of a marijuana concentrate.
- B.** A marijuana establishment shall ensure that marijuana or a marijuana product provided by the marijuana establishment to a consumer is sold or otherwise transferred in a container made of material that will not react with or leach into the marijuana or marijuana product.
- C.** A marijuana establishment shall ensure that any marijuana or marijuana products sold to a consumer meets the requirements in A.A.C. R9-17-317.01.
- Historical Note**
- New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4).
- R9-18-310. Product Labeling and Packaging**
- A.** A marijuana establishment shall ensure that marijuana or a marijuana product provided by the marijuana establishment's retail site to a consumer:
- 1. Complies with packaging and labeling requirements in A.R.S. §§ 36-2854.01 and 36-2860(A);
  - 2. Is labeled with:
    - a. The marijuana establishment license number;
    - b. The amount, strain, and batch number of the marijuana or marijuana product;
    - c. The form of the marijuana or marijuana product;
    - d. As applicable, the weight of the marijuana or marijuana product;
    - e. In compliance with Table 3.1, the potency of the marijuana or marijuana product, based on the results of testing by a marijuana testing facility, including the number of milligrams per designated unit or percentage of:
      - i. Total tetrahydrocannabinol, reported according to R9-18-408(F)(3)(b)(i);
      - ii. Total cannabidiol, reported according to R9-18-408(F)(3)(b)(ii); and
      - iii. Any other cannabinoid for which the marijuana establishment is making a claim related to the effect of the cannabinoid on the human body;
    - f. The following statement: "ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Marijuana use can be addictive and can impair an individual's ability to drive a motor vehicle or operate heavy machinery. Marijuana smoke contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, and lung infection. Marijuana use may affect the health of a pregnant woman and the unborn child. KEEP OUT OF REACH OF CHILDREN";
    - g. For a marijuana product, the ingredients in order of abundance; and
    - h. As required by A.R.S. § 36-2854.01, a quick response code linking to a webpage that contains the following:
      - i. The strain of the marijuana;
      - ii. The following statement: Using marijuana during pregnancy could cause birth defects or other health issues to your unborn child;
      - iii. Distribution chain information, including:
        - (1) The name of the marijuana establishment;
        - (2) If not cultivated by the marijuana establishment, the name and the license number or registry identification number, as applicable, of the marijuana establishment or dispensary that cultivated the marijuana; and
        - (3) If not infused or prepared for sale by the marijuana establishment, the name and the license number or registry identification number, as applicable, of the marijuana establishment or dispensary that infused or prepared the marijuana product for sale;
      - iv. A link to the final report of testing marijuana or a marijuana product, specified in R9-18-410(B)(3), from a marijuana testing facility;
      - v. If applicable, the method used to extract tetrahydrocannabinol from the marijuana; and
      - vi. The date of:
        - (1) Harvest of the marijuana; and
        - (2) If applicable, manufacture of the marijuana product; and
  - 3. Is placed in child-resistant packaging on exit from the marijuana establishment.
- B.** If a marijuana establishment provides marijuana cultivated, or a marijuana product infused or prepared for sale, by the mari-

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juana establishment to another marijuana establishment or to a dispensary, the marijuana establishment shall ensure that:

1. The marijuana or marijuana product is labeled with:
  - a. The marijuana establishment license number;
  - b. The amount, strain, and batch number of the marijuana or marijuana product; and
  - c. The dates of:
    - i. Harvest or sale; and
    - ii. If applicable, manufacture; and
2. A copy of results of testing by a marijuana testing facility for the marijuana or marijuana product is provided to the receiving marijuana establishment or dispensary.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 29 A.A.R. 3532 (November 10, 2023), with an immediate effective date of October 18, 2023 (Supp. 23-4).

Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-311. Analysis of Marijuana or a Marijuana Product**

**A.** Before offering a batch of marijuana or of a marijuana product for sale or otherwise transferring marijuana or a marijuana product to a consumer, a marijuana establishment shall ensure that:

1. Except as provided in subsection (A)(2) or (3), each batch of marijuana is tested in compliance with requirements in R9-18-408 and Table 3.1;
2. Each batch of a marijuana product is tested according to requirements in R9-18-408 and Table 3.1 for, as applicable:
  - a. At least potency and microbial contaminants other than mycotoxins if the marijuana product was prepared from another marijuana product, such as a marijuana concentrate or tincture, that is in compliance with requirements in R9-18-408 and Table 3.1, using none of the following:
    - i. A temperature above which any analyte could chemically decompose or react with a component of the marijuana product;
    - ii. A pressure above which any analyte could chemically decompose or react with a component of the marijuana product;
    - iii. A process by which any analyte in the marijuana product that is in compliance with requirements in R9-18-408 and Table 3.1 may be further concentrated; or
    - iv. A solvent other than water; or
  - b. All analytes except:
    - i. Ethanol if the marijuana product is intended to contain ethanol; or
    - ii. For a marijuana product intended for topical application, isopropanol if the marijuana product is intended to contain isopropanol; and
3. If the results of testing of the marijuana establishment's marijuana and marijuana products for heavy metals, according to R9-18-408, indicate that the marijuana and marijuana products are in compliance with Table 3.1 for a period of at least six consecutive months:

- a. Each batch of marijuana or a marijuana product is tested according to requirements in R9-18-408 and Table 3.1 for all analytes except heavy metals; and
- b. At least once every three months, each batch of marijuana or a marijuana product is tested according to requirements in R9-17-408 and Table 3.1 for heavy metals.

**B.** A marijuana establishment shall ensure that:

1. Until testing of the marijuana or marijuana product has been completed and testing results received by the marijuana establishment that comply with requirements in R9-18-408 and Table 3.1, a batch of marijuana or of a marijuana product is stored in a location away from marijuana and marijuana products offered for sale or transfer;
2. Except as provided in subsection (D), only one sample of each batch of marijuana or marijuana product is collected according to ANSI/ASQ Standard Z1.4 (2018), General Inspection Level II, incorporated by reference, including no future editions, and available at <https://asq.org/quality-resources/z14-z19>, including:
  - a. Use, as applicable, of one of the following sampling methods:
    - i. Top, middle, and bottom sampling using a sample thief, a device consisting of two nested tubes with one or more aligned slots through which a sample may be collected and then sealed into the inner tube by rotating the outer tube;
    - ii. Star pattern sampling from the top, middle, and bottom of each storage container;
    - iii. Collecting discrete incremental units of a batch, such as every 10th unit or every 20th drop; or
    - iv. Quartering until the sample reaches the size specified in subsection (B)(3); and
  - b. For sampling methods specified in subsections (B)(2)(a)(i) through (iii), quartering the volume of the aggregated portions collected to obtain the sample size specified in subsection (B)(3);
3. The size of the sample provided to a marijuana testing facility is sufficient for testing and, if necessary, retesting;
4. Each sample in subsection (B)(3) is packaged in a container made of:
  - a. The same material that would be used for sale or transfer, or
  - b. Another material that will not react with or leach into the sample;
5. Each packaged sample is labeled with:
  - a. The marijuana establishment's license number;
  - b. The amount, strain, and batch number of the marijuana or marijuana product;
  - c. The analytes for which testing is being requested;
  - d. The storage temperature for the marijuana or marijuana product; and
  - e. The date of sampling;
6. A packaged sample in subsection (B)(4) is submitted to a marijuana testing facility that:
  - a. Has a marijuana testing facility license issued by the Department, and
  - b. Is approved for testing by the Department for each analyte for which testing is being requested;
7. Except as specified in subsections (A)(2) and (3) and (C)(1), as applicable, the samples in subsection (B)(4) are tested for each analyte specified in Table 3.1 by a mari-

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- juana testing facility that is approved by the Department for testing the analyte;
8. Only batches of marijuana or marijuana products for which testing results in subsection (B)(7) are in compliance with the requirements in R9-18-408 and Table 3.1 are offered for sale or transfer; and
  9. Except as provided in subsection (C), any batch of marijuana or marijuana product that does not comply with the requirements in R9-18-408 and Table 3.1 is remediated, if applicable, or destroyed according to policies and procedures.
- C. If a marijuana establishment receives a final report of testing, specified in R9-18-410(B)(3), from a marijuana testing facility that indicates that a batch of marijuana or marijuana product does not comply with the requirements in R9-18-408 and Table 3.1, the marijuana establishment:
1. Within seven days after receiving the final report of testing, may request retesting of the remaining portion of the sample in subsection (B)(4) for all analytes that do not comply with the requirements in R9-18-408 and Table 3.1 by no more than two other marijuana testing facilities that are independent of a marijuana testing facility conducting a test included in the final report of testing and that are approved by the Department for testing the analytes;
  2. If the final report of testing conducted according to subsection (C)(1) from another, independent marijuana testing facility indicates that any analyte tested for according to subsection (C)(1) does not comply with the requirements in R9-18-408 and Table 3.1, shall remediate, if applicable, or destroy the batch of marijuana or marijuana product according to policies and procedures; and
  3. If the final report of testing from each of the two other independent marijuana testing facilities, allowed according to subsection (C)(1), indicates that all analytes tested for according to subsection (C)(1) comply with the requirements in R9-18-408 and Table 3.1, may offer the batch of marijuana or marijuana product for sale or transfer.
- D. A marijuana establishment may request retesting of a batch of marijuana or marijuana product using a second sample if:
1. The batch of marijuana or marijuana product is still in the possession of the marijuana establishment;
  2. The marijuana establishment receives notification from the Department, another marijuana establishment, or a dispensary that indicates that the final report of testing from a marijuana testing facility, specified in R9-18-410(B)(3), or laboratory, specified in A.A.C. R9-17-404.06(B)(3), for the batch of marijuana or marijuana product may be inaccurate;
3. The marijuana establishment:
    - a. If the notification in subsection (D)(2) is from another marijuana establishment or a dispensary, informs the Department that the final report of testing may be inaccurate;
    - b. Collects the second sample according to subsections (B)(2) and (3);
    - c. Packages and labels the sample according to subsections (B)(4) and (5); and
    - d. Submits the sample to a second, independent marijuana testing facility that is approved by the Department for testing the analytes; and
  4. The marijuana establishment follows the requirements in subsections (C)(1) through (3) in determining whether the batch of marijuana or marijuana product:
    - a. May be offered for sale or transfer; or
    - b. Is required to be remediated, if applicable, or destroyed.
- E. A marijuana establishment shall ensure that remediation of a batch of marijuana or of a marijuana product that has undergone testing and does not comply with the requirements in R9-18-408 and Table 3.1:
1. Is performed according to policies and procedures,
  2. Uses a method that is appropriate to address an analyte not in compliance with Table 3.1, and
  3. Does not introduce or produce a substance in a concentration that is known to be harmful to humans.
- F. If a batch of marijuana or a marijuana product is remediated, a marijuana establishment shall submit samples from the remediated batch for testing according to subsection (B).
- G. A marijuana establishment shall provide to the Department upon request a sample of the marijuana establishment's inventory of marijuana or a marijuana product of sufficient quantity to enable the Department to conduct an analysis of the marijuana or marijuana product.

**Historical Note**

Section reserved by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**Table 3.1. Analytes**

Key:

CAS Number = Chemical Abstract Services Registry number

CFU = Colony-forming unit, a method to estimate the number of viable bacteria or fungal cells in a sample

\* = Required for marijuana products only

<b>A. Microbial Contaminants</b>		
<b>Analyte</b>	<b>Maximum Allowable Contaminants</b>	<b>Required Action</b>
<i>Escherichia coli</i>	10 CFU/g for edible marijuana or a marijuana-infused edible food product 100 CFU/g for all other medical marijuana and marijuana products	Remediate and retest, or Destroy
<i>Salmonella spp.</i>	Detectable in 1 gram	Destroy
<i>Aspergillus flavus</i> <i>Aspergillus fumigatus</i> <i>Aspergillus niger</i> <i>Aspergillus terreus</i>	Inhalable: Detectable in 1 gram	Remediate and retest Remediate and use for preparing an extract or a concentrate, or Destroy

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Key:

CAS Number = Chemical Abstract Services Registry number

CFU = Colony-forming unit, a method to estimate the number of viable bacteria or fungal cells in a sample

\* = Required for marijuana products only

A. Microbial Contaminants		
Analyte	Maximum Allowable Contaminants	Required Action
Mycotoxins: Aflatoxin B1, B2, G1, and G2 Ochratoxin A	Marijuana product, except a marijuana product intended for topical application, prepared from an extract or concentrate of marijuana: 20 µg/kg (ppb) of total aflatoxins 20 µg/kg (ppb) of ochratoxin	Destroy

B. Heavy Metals		
Analyte	Maximum Allowable Contaminants	Required Action
Arsenic	0.4 ppm	Remediate and retest, or Destroy
Cadmium	0.4 ppm	
Lead	1.0 ppm	
Mercury	0.2 ppm for inhalable medical marijuana or an inhalable marijuana product 1.2 ppm for non-inhalable medical marijuana and all other marijuana products 1.2 ppm	

C. *Residual Solvents			
Analyte	CAS Number	Maximum Allowable Concentration	Required Action
Acetone	67-64-1	1,000 ppm	Remediate and retest, or Destroy
Acetonitrile	75-05-8	410 ppm	
Benzene	71-43-2	2 ppm	
Butanes (measured as the cumulative residue of n-butane and iso-butane)	106-97-8 and 75-28-5, respectively	5,000 ppm	
Chloroform	67-66-3	60 ppm	
Dichloromethane	75-09-2	600 ppm	
Ethanol	64-17-5	5,000 ppm	
Ethyl Acetate	141-78-6	5,000 ppm	
Ethyl Ether	60-29-7	5,000 ppm	
Heptane	142-82-5	5,000 ppm	
Hexanes (measured as the cumulative residue of n-hexane, 2-methylpentane, 3-methylpentane, 2,2-dimethylbutane, and 2,3-dimethylbutane)	110-54-3, 107-83-5, 96-14-0, 75-83-2, and 79-29-8, respectively	290 ppm	
Isopropyl Acetate	108-21-4	5,000 ppm	
Methanol	67-56-1	3,000 ppm	
Pentanes (measured as the cumulative residue of n-pentane, iso-pentane, and neo-pentane)	109-66-0, 78-78-4, and 463-82-1, respectively	5,000 ppm	
2-Propanol (IPA)	67-63-0	5,000 ppm	
Toluene	108-88-3	890 ppm	
Xylenes (measured as the cumulative residue of 1,2-dimethylbenzene, 1,3-dimethylbenzene, and 1,4-dimethylbenzene, and the non-xylene, ethyl benzene)	1330-20-7 (95-47-6, 108-38-3, and 106-42-3, respectively, and 100-41-4)	2,170 ppm	

D. Pesticides, Fungicides, Growth Regulators			
Analyte	CAS Number	Maximum Allowable Concentration	Required Action
Abamectin (B1a)	71751-41-2	0.5 ppm	Remediate and retest, or Destroy
Acephate	30560-19-1	0.4 ppm	
Acetamiprid	135410-20-7	0.2 ppm	
Aldicarb	116-06-3	0.4 ppm	
Azoxystrobin	131860-33-8	0.2 ppm	
Bifenazate	149877-41-8	0.2 ppm	
Bifenthrin	82657-04-3	0.2 ppm	
Boscalid	188425-85-6	0.4 ppm	
Carbaryl	63-25-2	0.2 ppm	
Carbofuran	1563-66-2	0.2 ppm	

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Chlorantraniliprole	500008-45-7	0.2 ppm
Chlorfenapyr	122453-73-0	1.0 ppm
Chlorpyrifos	2921-88-2	0.2 ppm
Clofentezine	74115-24-5	0.2 ppm
Cyfluthrin	68359-37-5	1.0 ppm
Cypermethrin	52315-07-8	1.0 ppm
Daminozide	1596-84-5	1.0 ppm
DDVP (Dichlorvos)	62-73-7	0.1 ppm
Diazinon	333-41-5	0.2 ppm
Dimethoate	60-51-5	0.2 ppm
Ethoprophos	13194-48-4	0.2 ppm
Etofenprox	80844-07-1	0.4 ppm
Etoxazole	153233-91-1	0.2 ppm
Fenoxycarb	72490-01-8	0.2 ppm
Fenpyroximate	134098-61-6	0.4 ppm
Fipronil	120068-37-3	0.4 ppm
Flonicamid	158062-67-0	1.0 ppm
Fludioxonil	131341-86-1	0.4 ppm
Hexythiazox	78587-05-0	1.0 ppm
Imazalil	35554-44-0	0.2 ppm
Imidacloprid	138261-41-3	0.4 ppm
Kresoxim-methyl	143390-89-0	0.4 ppm
Malathion	121-75-5	0.2 ppm
Metalaxyl	57837-19-1	0.2 ppm
Methiocarb	2032-65-7	0.2 ppm
Methomyl	16752-77-5	0.4 ppm
Myclobutanil	88671-89-0	0.2 ppm
Naled	300-76-5	0.5 ppm
Oxamyl	23135-22-0	1.0 ppm
Paclobutrazol	76738-62-0	0.4 ppm
Permethrins (measured as the cumulative residue of cis- and trans- isomers)	52645-53-1 (54774-45-7 and 51877-74-8)	0.2 ppm
Phosmet	732-11-6	0.2 ppm
Piperonyl butoxide	51-03-6	2.0 ppm
Prallethrin	23031-36-9	0.2 ppm
Propiconazole	60207-90-1	0.4 ppm
Propoxur	114-26-1	0.2 ppm
Pyrethrins (measured as the cumulative residue of pyrethrin I and II)	8003-34-7 (121-21-1, 25402-06-6, and 4466-14-2)	1.0 ppm
Pyridaben	96489-71-3	0.2 ppm
Spinosad (measured as the cumulative residue of Spinosyn A and Spinosyn D)	168316-95-8	0.2 ppm
Spiromesifen	283594-90-1	0.2 ppm
Spirotetramat	203313-25-1	0.2 ppm
Spiroxamine	118134-30-8	0.4 ppm
Tebuconazole	107534-96-3	0.4 ppm
Thiacloprid	111988-49-9	0.2 ppm
Thiamethoxam	153719-23-4	0.2 ppm
Trifloxystrobin	141517-21-7	0.2 ppm

**E. Potency**

Analyte	Labeling	Required Action
Tetrahydrocannabinolic acid (THC-A)	Label claim is not within +/- 20% of tested value	Revise label as necessary
Delta-9-tetrahydrocannabinol (Δ9-THC)		
Cannabidiolic acid (CBD-A)		
Cannabidiol (CBD)		

**Historical Note**

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New Table 3.1 Analytes made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 28 A.A.R. 2481 (September 23, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-312. Security**

- A.** A marijuana establishment shall ensure that, if the marijuana establishment cultivates marijuana:
1. If cultivation takes place indoors, the marijuana is cultivated in a closed, locked room; and
  2. If cultivation takes place outdoors, the location:
    - a. Is surrounded by solid, 10-foot walls that are constructed of metal, concrete, or stone that prevent viewing of the marijuana plants; and
    - b. Has a one-inch thick metal gate.
- B.** A marijuana establishment shall ensure that access to the marijuana establishment's cultivation site or manufacturing site or to the portion of the marijuana establishment's retail site where marijuana is cultivated, processed, manufactured, or stored is limited to the marijuana establishment's principal officers, board members, and authorized marijuana facility agents, unless the individual is supervised by a marijuana facility agent associated with the marijuana establishment.
- C.** A marijuana facility agent may transport marijuana, marijuana plants, and marijuana products between:
1. The marijuana establishment's retail site, cultivation site, or manufacturing site;
  2. The marijuana establishment's retail site, cultivation site, or manufacturing site and another marijuana establishment;
  3. The marijuana establishment's retail site, cultivation site, or manufacturing site and a dispensary with a dispensary registration certificate issued under 9 A.A.C. 17;
  4. The marijuana establishment's retail site and a consumer:
    - a. Consistent with A.R.S. § 36-2854(D) and R9-18-312.01; and
    - b. If the owner of the property at the delivery address provided by the consumer, according to R9-18-312.01(B)(2)(c), has not posted or otherwise notified the marijuana establishment that no deliveries are allowed to the owner's property location; and
  5. The marijuana establishment's retail site, cultivation site, or manufacturing site and a marijuana testing facility that has a marijuana testing facility license issued by the Department or a laboratory with a laboratory registration certificate issued under 9 A.A.C. 17, Article 4.
- D.** Before transportation, a marijuana facility agent of a marijuana establishment shall:
1. Complete a trip plan that includes:
    - a. The name of the marijuana facility agent in charge of transporting the marijuana, marijuana plants, or marijuana products;
    - b. The license plate number of the vehicle being used to transport the marijuana, marijuana plants, or marijuana products;
    - c. The date and start time of the trip;
    - d. A description of the marijuana, marijuana plants, or marijuana products being transported;
    - e. Any anticipated stops during the trip, including the locations of the stops and estimated arrival time and departure time for each location; and
    - f. The anticipated route of transportation; and
  2. Provide a copy of the trip plan in subsection (D)(1) to the marijuana establishment.
- E.** During transportation, a marijuana facility agent shall:
1. Carry a copy of the trip plan in subsection (D)(1) with the marijuana facility agent for the duration of the trip;
  2. Use a vehicle that has a current registration with the Arizona Department of Motor Vehicles, issued according to A.R.S. Title 28, Chapter 7, Article 2:
    - a. Without any marijuana identification;
    - b. Equipped with a global positioning system or other means for the marijuana establishment to track the current location of the vehicle at any point in time;
    - c. Capable of providing electronic information about where the vehicle has been during at least the previous 90 days;
    - d. With operational video surveillance and recording equipment that:
      - i. Shows the interior of the vehicle, including the driver's seat and location of the marijuana, marijuana plants, or marijuana products being transported;
      - ii. Is turned on for the duration of a trip while marijuana or a marijuana product is in the vehicle; and
      - iii. Either stores the recording for at least 30 calendar days or transmits the recorded images at the time of recording to another location, where the recorded images are stored for at least 30 calendar days; and
    - e. With a locked compartment in which any marijuana, marijuana plants, or marijuana products being transported may be stored during a trip;
  3. Have a means of communication with the marijuana establishment;
  4. Notate the arrival time and departure time for each stop; and
  5. Ensure that the marijuana, marijuana plants, or marijuana products are stored in the locked compartment specified in subsection (E)(2)(e) and are not visible.
- F.** After transportation, a marijuana facility agent shall:
1. Enter the end time of the trip and any changes to the trip plan on the trip plan required in subsection (D)(1), and
  2. Ensure that the updated trip plan is provided to the marijuana establishment.
- G.** A marijuana establishment shall:
1. Maintain the documents required in subsection (D)(2) and (F) for at least two years after the date of the documentation;
  2. If transporting a sample to a marijuana testing facility for testing, provide a copy of the trip plan in subsection (D)(1) to the marijuana testing facility; and
  3. Provide a copy of the documents required in subsection (D)(2) and (F) to the Department for review upon request.
- H.** A marijuana establishment shall not transport marijuana, marijuana plants, or marijuana products to a consumer except as specified in R9-18-312.01.
- I.** To prevent unauthorized access to marijuana or a marijuana product at the marijuana establishment's retail site and, if applicable, the marijuana establishment's cultivation site or manufacturing site, the marijuana establishment shall have the following:
1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include:

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- a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio-frequency method, such as cellular, private radio signals, or other mechanical or electronic device;
- b. Exterior lighting to facilitate surveillance;
- c. Electronic monitoring including:
  - i. At least one 19-inch or greater call-up monitor;
  - ii. A printer capable of immediately producing a clear still photo from any video camera image;
  - iii. Video cameras:
    - (1) Providing coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and
    - (2) Having a recording resolution of at least 704 x 480 or the equivalent;
  - iv. A video camera at each point of sale location within the marijuana establishment's retail site allowing for the identification of any consumer purchasing marijuana or a marijuana product;
  - v. A video camera in each grow room capable of identifying any activity occurring within the grow room in low light conditions;
  - vi. Storage of video recordings from the video cameras for at least 30 calendar days;
  - vii. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; and
  - viii. Sufficient battery backup for video cameras and recording equipment to support at least five minutes of recording in the event of a power outage; and
- d. Panic buttons in the interior of each building; and
- 2. Policies and procedures:
  - a. That provide for the identification of authorized individuals;
  - b. That deter unauthorized removal of marijuana or marijuana products from the premises, including:
    - i. Restricting access to the areas of the marijuana establishment's retail site where marijuana is cultivated, processed or stored and, if applicable, the marijuana establishment's cultivation site or manufacturing site; and
    - ii. Ensuring that an individual other than a principal officer, board member, or marijuana facility agent associated with the marijuana facility is supervised by a marijuana facility agent associated with the marijuana establishment when in an area specified in subsection (I)(2)(b)(i);
  - c. That prevent loitering;
  - d. For conducting electronic monitoring; and
  - e. For the use of a panic button.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

tive date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-312.01. Delivery to Consumers**

- A. In addition to the requirements in R9-18-312(E)(2), for any vehicles used for delivery to a consumer, a marijuana establishment shall:
  - 1. Maintain a list of the vehicles used for delivery to a consumer, including the make, model, and license plate number of the vehicle;
  - 2. Keep a daily log of vehicle usage, including the date, time period of usage, and retail price of the marijuana, marijuana plants, or marijuana products transported during a trip; and
  - 3. Make a vehicle used for delivery to a consumer available at the retail location for the Department's inspection, within two hours after a Department request.
- B. A marijuana establishment shall ensure that no marijuana, marijuana plants, or marijuana products are transported to a consumer unless:
  - 1. The marijuana establishment's retail site has received an order for delivery of the marijuana, marijuana plants, or marijuana products from the consumer during the retail site's regular hours of operation, as posted according to R9-18-308(A)(15);
  - 2. The consumer provides:
    - a. The consumer's name and date of birth;
    - b. The identifying number on the document that will be used to verify the consumer's age upon delivery; and
    - c. The property address of the building and, if applicable, an apartment number for the delivery;
  - 3. A marijuana facility agent at the marijuana establishment's retail site documents the order and includes:
    - a. The date and time of the order;
    - b. The name of the marijuana facility agent taking the order;
    - c. The consumer's name, date of birth, identifying number on the document that will be used to verify the consumer's age, and delivery address;
    - d. The amount and retail price of the marijuana, marijuana plants, or marijuana products ordered; and
    - e. The total retail price of the marijuana, marijuana plants, or marijuana products in the order;
  - 4. A copy of the order is attached to the trip plan required in R9-18-312(D)(1);
  - 5. The delivery originates at the marijuana establishment's retail site; and
  - 6. Before transferring the delivered marijuana, marijuana plants, or marijuana products to the consumer, the marijuana facility agent providing delivery of the marijuana, marijuana plants, or marijuana products:
    - a. Ensures that the individual wanting to accept delivery is the ordering consumer,
    - b. Verifies the identity and age of the consumer according to the requirements in R9-18-309(A)(1),
    - c. Complies with the requirements in R9-18-309(A)(2) and (3), and
    - d. Obtains the hand-written signature of the consumer on the order.
- C. When transporting marijuana, marijuana plants, or marijuana products for delivery to a consumer, a marijuana establishment shall ensure that:
  - 1. No delivery is made to any property owned or leased by the United States, this state, a political subdivision of this state, or the Arizona Board of Regents;



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2. No delivery is made to any property address for which the property's owner has informed the marijuana establishment that delivery to a consumer is not permitted at the address;
3. No more than a total retail price of \$10,000 of marijuana, marijuana plants, and marijuana products for delivery to a consumer is in a vehicle providing transportation for delivery; and
4. Only marijuana, marijuana plants, or marijuana products associated with one or more orders made according to subsection (B)(1) are in a vehicle providing delivery to a consumer.

**D.** A marijuana establishment shall ensure that a marijuana facility agent providing delivery:

1. Returns to the marijuana establishment's retail site at the completion of the trip plan if any marijuana, marijuana plants, or marijuana products associated with one or more orders made according to subsection (B)(1) have not been transferred to the ordering consumer and remain in the vehicle; and
2. Does not pick up or otherwise receive marijuana, marijuana plants, or marijuana products from a consumer for transport to the marijuana establishment once a delivery has been completed according to subsection (B)(7).

**Historical Note**

New Section made by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-313. Edible Food Products**

**A.** A marijuana establishment that prepares, sells, or otherwise transfers marijuana-infused edible food products shall:

1. Before preparing, selling, or otherwise transferring a marijuana-infused edible food product, obtain a license or permit as a food establishment under 9 A.A.C. 8, Article 1;
2. If the marijuana establishment prepares the marijuana-infused edible food products, ensure that the marijuana-infused edible food products are prepared according to the applicable requirements in 9 A.A.C. 8, Article 1;
3. If the marijuana-infused edible food products are not prepared at the marijuana establishment, ensure that the other marijuana establishment or dispensary that prepares the marijuana-infused edible products for the marijuana establishment has a current license or permit as a food establishment under 9 A.A.C. 8, Article 1, to prepare marijuana-infused edible food products; and
4. If a marijuana establishment sells or otherwise transfers marijuana-infused edible food products, ensure that the marijuana-infused edible food products:
  - a. Are sold or otherwise transferred according to applicable requirements in 9 A.A.C. 8, Article 1;
  - b. In compliance with A.R.S. § 36-2854(A)(7), contain no more total tetrahydrocannabinol than:
    - i. 10 mg of per serving; or
    - ii. 100 mg per package; and
  - c. If packaged as more than one serving, are:
    - i. Scored or otherwise delineated into standard serving size, and
    - ii. Of homogeneous consistency to ensure uniform disbursement of total tetrahydrocannabinol throughout the edible food product.

- B.** A marijuana establishment is responsible for the content and quality of any edible food product sold or dispensed by the marijuana establishment.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). Amended by exempt rulemaking at 28 A.A.R. 2481 (September 23, 2022), with an immediate effective date of September 8, 2022 (Supp. 22-3). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-314. Inventory Control System**

- A.** A marijuana establishment shall designate in writing a marijuana facility agent associated with the marijuana establishment who has oversight of the marijuana establishment's marijuana inventory control system.

- B.** A marijuana establishment shall only acquire marijuana from:

1. The marijuana establishment's cultivation site or manufacturing site,
2. Another marijuana establishment, or
3. A dispensary with a dispensary registration certificate issued under 9 A.A.C. 17.

- C.** A marijuana establishment shall establish and implement an inventory control system for the marijuana establishment's marijuana and marijuana products that documents:

1. The following amounts:
  - a. Each day's beginning inventory of marijuana and marijuana products,
  - b. Acquisitions according to subsection (B),
  - c. Marijuana harvested by the marijuana establishment,
  - d. Marijuana and marijuana products provided to a dispensary or another marijuana establishment,
  - e. Marijuana and marijuana products sold,
  - f. Marijuana and marijuana products submitted to a marijuana testing facility for testing according to R9-18-311,
  - g. Marijuana and marijuana products that were disposed of, and
  - h. The day's ending marijuana and marijuana products inventory;
2. For acquiring marijuana or a marijuana product from another marijuana establishment or a dispensary:
  - a. A description of the marijuana or marijuana product acquired including:
    - i. The amount, batch number, and strain of the marijuana or marijuana product;
    - ii. For a marijuana product, the ingredients in order of abundance; and
    - iii. For an edible food product infused with marijuana or a marijuana product:
      - (1) The date of manufacture,
      - (2) The total weight of the marijuana-infused edible food product, and
      - (3) The estimated amount and batch number of the marijuana or marijuana product infused in the edible food product;
  - b. As applicable, either:
    - i. The name and license number of the marijuana establishment providing the marijuana or marijuana product, or

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- ii. The name and registry identification number of the dispensary providing the marijuana or marijuana product;
- c. The name and license number or registry identification number, as applicable, of the marijuana facility agent or dispensary agent providing the marijuana or marijuana product;
- d. The name and license number of the marijuana facility agent receiving the marijuana or marijuana product on behalf of the marijuana establishment; and
- e. The date of acquisition;
- 3. For each batch of marijuana cultivated:
  - a. The batch number;
  - b. Whether the batch originated from marijuana seeds or marijuana cuttings;
  - c. The origin and strain of the marijuana seeds or marijuana cuttings planted;
  - d. The number of marijuana seeds or marijuana cuttings planted;
  - e. The date the marijuana seeds or cuttings were planted;
  - f. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers used in the cultivation;
  - g. The number of plants grown to maturity; and
  - h. Harvest information including:
    - i. Date of harvest;
    - ii. Final yield weight of processed usable marijuana, as defined in A.R.S. § 36-2801; and
    - iii. Name and license number of the marijuana facility agent responsible for the harvest;
- 4. For transferring marijuana or a marijuana product to another marijuana establishment or a dispensary:
  - a. A description of the marijuana or marijuana product provided including:
    - i. The amount, batch number, and strain of the marijuana or marijuana product;
    - ii. For a marijuana product, the ingredients in order of abundance; and
    - iii. For an edible food product infused with marijuana or a marijuana product:
      - (1) The date of manufacture,
      - (2) The total weight of the marijuana-infused edible food product, and
      - (3) The estimated amount and batch number of the marijuana or marijuana product infused in the edible food product;
  - b. The name and marijuana establishment license number or registry identification number, as applicable, of the other marijuana establishment or the dispensary;
  - c. The name and license number or registry identification number, as applicable, of the marijuana facility agent or dispensary agent who received the marijuana or marijuana product on behalf of the other marijuana establishment or the dispensary; and
  - d. The date the marijuana or marijuana product was provided;
- 5. For submitting marijuana or marijuana products to a marijuana testing facility for testing:
  - a. The amount, strain, and batch number of the marijuana or marijuana product submitted;
  - b. The name and registry identification number of the marijuana testing facility;
  - c. The name and registry identification number of the marijuana facility agent who received the marijuana or marijuana product on behalf of the marijuana testing facility; and
  - d. The date the marijuana or marijuana product was submitted to the marijuana testing facility; and
- 6. For disposal of marijuana or a marijuana product that is not to be sold, transferred, or used for making a marijuana product:
  - a. Description of and reason for the marijuana or marijuana product being disposed of including, if applicable:
    - i. The number of failed or other unusable plants, and
    - ii. The results of laboratory testing;
  - b. Date of disposal;
  - c. Method of disposal; and
  - d. Name and license number of the marijuana facility agent responsible for the disposal.
- D. The individual designated in subsection (A) shall conduct and document an audit of the marijuana establishment's inventory that is accounted for according to generally accepted accounting principles at least once every 30 calendar days.
  - 1. If the audit identifies a reduction in the amount of marijuana or a marijuana product in the marijuana establishment's inventory not due to documented causes, the marijuana establishment shall determine and document where the loss has occurred and take and document corrective action.
  - 2. If the reduction in the amount of marijuana or a marijuana product in the marijuana establishment's inventory is due to suspected criminal activity by a marijuana facility agent, the marijuana establishment shall report the marijuana facility agent to the Department and to the local law enforcement authorities.
- E. A marijuana establishment shall:
  - 1. Maintain the documentation required in subsections (C) and (D) at the marijuana establishment for at least five years after the date on the document, and
  - 2. Provide the documentation required in subsections (C) and (D) to the Department for review upon request.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). R9-18-314 renumbered to R9-18-315; new Section made by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-315. Cleaning and Sanitation**

- A. A marijuana establishment shall ensure that:
  - 1. Any building or equipment used by a marijuana establishment for the cultivation, harvest, preparation, packaging, storage, infusion, or sale of marijuana or marijuana products is maintained in a clean and sanitary condition;
  - 2. Marijuana or marijuana products, in the process of production, preparation, manufacture, packing, storage, sale, distribution, or transportation, are protected from flies, dust, dirt, and all other contamination;
  - 3. Refuse or waste products incident to the manufacture, preparation, packing, selling, distributing, or transportation of marijuana or marijuana products are removed

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from the building used as a marijuana establishment's retail site and, if applicable, a building at the marijuana establishment's cultivation site or manufacturing site at least once every 24 hours or more often as necessary to maintain a clean condition;

4. All trucks, trays, buckets, other receptacles, platforms, racks, tables, shelves, knives, saws, cleavers, other utensils, or the machinery used in moving, handling, cutting, chopping, mixing, canning, packaging, or other processes are cleaned daily;
  5. Any equipment used in the preparation of marijuana products is clean, in good repair, and, if applicable, calibrated according to the manufacturer's recommendations;
  6. Any supplies used in the preparation of marijuana products, including flammable or volatile chemicals, are stored in a manner to avoid a hazardous condition from occurring; and
  7. All stored marijuana products are securely covered.
- B.** A marijuana establishment shall ensure that a marijuana facility agent at the marijuana establishment or the marijuana establishment's cultivation site or manufacturing site:
1. Cleans the marijuana facility agent's hands and exposed portions of the marijuana facility agent's arms in a hand washing sink:
    - a. Before preparing marijuana or marijuana products, including working with food, equipment, and utensils;
    - b. During preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks;
    - c. After handling soiled equipment or utensils;
    - d. After touching bare human body parts other than the marijuana facility agent's clean hands and exposed portions of arms; and
    - e. After using the toilet room;
  2. If working directly with the preparation of marijuana or the infusion of marijuana into non-edible products:
    - a. Keeps the marijuana facility agent's fingernails trimmed, filed, and maintained so that the edges and surfaces are cleanable;
    - b. Unless wearing intact gloves in good repair, does not have fingernail polish or artificial fingernails on the marijuana facility agent's fingernails; and
    - c. Wears protective apparel such as coats, aprons, gowns, or gloves to prevent contamination;
  3. Wears clean clothing appropriate to assigned tasks;
  4. Reports to the marijuana establishment, according to policies and procedures, any health condition experienced by the marijuana facility agent that may adversely affect the safety or quality of any marijuana or marijuana products with which the marijuana facility agent may come into contact; and
  5. If, according to the marijuana establishment's policies and procedures, a marijuana facility agent has a health condition that may adversely affect the safety or quality of the marijuana or marijuana products, the marijuana facility agent is prohibited from direct contact with any marijuana, marijuana products, or equipment or materials for processing marijuana or manufacturing marijuana products until the marijuana facility agent's health condition will not adversely affect the medical marijuana or marijuana products.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). R9-18-315 renumbered to R9-18-316; new Section R9-18-315 renumbered from R9-18-314 by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-316. Physical Plant**

- A.** A marijuana establishment shall ensure that the licensed premises are maintained free from hazards.
- B.** A marijuana establishment shall provide on-site parking or parking adjacent to the building used as the marijuana establishment's retail site.
- C.** A building used as a marijuana establishment's retail site or the location used as a marijuana establishment's cultivation site or manufacturing site shall have:
  1. At least one toilet room;
  2. Each toilet room shall contain:
    - a. A flushable toilet;
    - b. Mounted toilet tissue;
    - c. A sink with running water;
    - d. Soap contained in a dispenser; and
    - e. Disposable, single-use paper towels in a mounted dispenser or a mechanical air hand dryer;
  3. At least one hand washing sink not located in a toilet room, with running water, soap contained in a dispenser, and either disposable, single-use paper towels in a mounted dispenser or a mechanical air hand dryer;
  4. Designated storage areas for marijuana or materials used in direct contact with marijuana, separate from storage areas for toxic or flammable materials; and
  5. If preparation or packaging of marijuana is done in the building, a designated area for the preparation or packaging that:
    - a. Includes work space that can be sanitized, and
    - b. Is only used for the preparation or packaging of marijuana.
- D.** For each commercial device used at a marijuana establishment retail site, cultivation site, or manufacturing site, the marijuana establishment shall:
  1. Ensure that the commercial device is licensed or certified pursuant to A.R.S. § 3-3451,
  2. Maintain documentation of the commercial device's license or certification, and
  3. Provide a copy of the commercial device's license or certification to the Department for review upon request.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 140, effective January 15, 2021 (Supp. 20-4). R9-18-316 renumbered to R9-18-317; new Section R9-18-316 renumbered from R9-18-315 and amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-317. Denial, Suspension, or Revocation of a Marijuana Establishment License**

- A.** The Department shall deny an application for a marijuana establishment license or a renewal if:
  1. A principal officer or board member:
    - a. Has been convicted of an excluded felony offense, or
    - b. Is under 21 years of age; or

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2. The application or the marijuana establishment does not comply with the requirements in A.R.S. Title 36, Chapter 28.2, and this Chapter.
- B. The Department may deny an application for or renewal of a marijuana establishment license if a principal officer or board member of the marijuana establishment:
  1. Did not obtain an approval to operate the marijuana establishment or a dispensary, as applicable, within 18 months after the dispensary registration certificate or marijuana establishment license was issued;
  2. Has served as a principal officer or board member for a dispensary or marijuana establishment that had the dispensary registration certificate or marijuana establishment license, as applicable, revoked; or
  3. Provides false or misleading information to the Department.
- C. The Department may suspend or revoke a marijuana establishment license if:
  1. The marijuana establishment:
    - a. Provides false or misleading information to the Department;
    - b. Operates before obtaining approval to operate a marijuana establishment from the Department;
    - c. Diverts marijuana to an individual who or entity that is not allowed to possess marijuana, pursuant to A.R.S. Title 36, Chapter 28.1 or 28.2; or
    - d. Acquires marijuana from an entity that is not allowed to possess marijuana, pursuant to A.R.S. Title 36, Chapter 28.1 or 28.2;
  2. A principal officer or board member:
    - a. Has been convicted of an excluded felony offense, or
    - b. Provides false or misleading information to the Department; or
  3. The marijuana establishment does not:
    - a. Comply with the requirements in A.R.S. Title 36, Chapter 28.2, and this Chapter; or
    - b. Implement the policies and procedures or comply with the statements provided to the Department with the marijuana establishment's application.
- D. If the Department denies a marijuana establishment license application, the Department shall provide notice to the applicant that includes:
  1. The specific reason or reasons for the denial, and
  2. All other information required by A.R.S. § 41-1076.
- E. If the Department suspends or revokes a marijuana establishment license, the Department shall provide notice to the marijuana establishment that includes:
  1. The specific reason or reasons for the suspension or revocation; and
  2. The process for requesting a review of the Department's decision pursuant to A.R.S. Title 41, Chapter 6, Article 10.
1. If an individual is applying for a marijuana testing facility license, the individual;
2. If a corporation is applying for a marijuana testing facility license, two individuals who are officers of the corporation;
3. If a partnership is applying for a marijuana testing facility license, two of the individuals who are partners;
4. If a limited liability company is applying for a marijuana testing facility license, a manager or, if the limited liability company does not have a manager, an individual who is a member of the limited liability company;
5. If an association or cooperative is applying for a marijuana testing facility license, two individuals who are members of the governing board of the association or cooperative; and
6. If a business organization type other than those described in subsections (A)(2) through (5) is applying for a marijuana testing facility license, two individuals who are members of the business organization.
- B. When a marijuana testing facility is required by this Chapter to provide information, sign documents, or ensure actions are taken, the individual or individuals in subsection (A) shall comply with the requirement on behalf of the marijuana testing facility.
- C. For the purposes of this Chapter, an individual, with a laboratory agent registry identification card issued under 9 A.A.C. 17, Article 4, is considered to be a marijuana facility agent when working on behalf of a marijuana testing facility or a laboratory with a laboratory registration certificate issued under 9 A.A.C. 17, Article 4.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-402. Applying for a Marijuana Testing Facility License**

- A. To apply for a marijuana testing facility license, an applicant that does not have a current laboratory registration certificate issued under 9 A.A.C. 17, Article 4, shall submit to the Department the following:
  1. An application in a Department-provided format that includes:
    - a. The following information for the applicant:
      - i. The legal name of the proposed marijuana testing facility,
      - ii. Type of business organization,
      - iii. Arizona mailing address,
      - iv. Telephone number, and
      - v. E-mail address;
    - b. The physical address of the proposed marijuana testing facility;
    - c. The county in which the proposed marijuana testing facility is located;
    - d. For a business organization that is not a publicly traded corporation, the name, residence address, and date of birth of each owner;
    - e. For a business organization that is a publicly traded corporation, the name, residence address, and date of birth of each owner who is entitled to 10% or more of the profits of the proposed marijuana testing facility;

**Historical Note**

New Section R9-18-317 renumbered from R9-18-316 and amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**ARTICLE 4. MARIJUANA TESTING FACILITIES****R9-18-401. Owner and Laboratory Agents Acting as Marijuana Facility Agents**

- A. For the purposes of this Article, the following individuals are considered owners:

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- f. The name, residence address, and date of birth of the technical laboratory director designated according to R9-18-405(3);
  - g. Whether the applicant agrees to allow the Department to submit supplemental requests for information;
  - h. A statement that, if the applicant is issued a marijuana testing facility license, the marijuana testing facility will not begin testing marijuana pursuant to R9-18-311 until the marijuana testing facility has been inspected and issued an approval for testing by the Department;
  - i. An attestation that the applicant understands and will comply with the requirements in A.R.S. Title 36, Chapter 28.2 and this Chapter;
  - j. An attestation that the information provided to the Department to apply for a marijuana testing facility license is true and correct; and
  - k. The signatures of the owner of the proposed marijuana testing facility, according to R9-18-401(A), and the technical laboratory director and the date each signed;
2. Policies and procedures that comply with the requirements in this Chapter that contain:
    - a. Inventory control;
    - b. A chain of custody and sample requirement process;
    - c. A records retention process;
    - d. A secure method to transfer the portion of a sample remaining after testing to another marijuana testing facility with an approval for testing issued by the Department:
      - i. For testing of parameters or analytes that the marijuana testing facility receiving the sample from a marijuana establishment is not approved by the Department to conduct, or
      - ii. For retesting at the request of a marijuana establishment according to R9-18-311(C);
    - e. Security; and
    - f. A process for disposal of marijuana or marijuana products that are submitted to the marijuana testing facility for testing;
  3. If the applicant is one of the business organizations in R9-18-401(A)(2) through (6), a copy of the business organization's articles of incorporation, articles of organization, or partnership documents that include:
    - a. The name of the business organization,
    - b. The type of business organization, and
    - c. The names and titles of the individuals in R9-18-401(A);
  4. For each owner:
    - a. The owner's marijuana facility agent license number; and
    - b. An attestation signed and dated by the owner that the owner does not have a direct or indirect familial or financial relationship with or interest in a dispensary, marijuana establishment, or related marijuana business entity or management company;
  5. A statement, in a Department-provided format, signed and dated within 60 calendar days before the date of the application by a representative of the local jurisdiction:
    - a. Certifying that the proposed marijuana testing facility is in compliance with any local zoning restrictions; and
    - b. Including:
      - i. Information identifying the local jurisdiction and the local jurisdiction's representative,
      - ii. The legal name of the proposed marijuana testing facility, and
      - iii. The physical address of the proposed marijuana testing facility as specified according to subsection (A)(1)(b);
  6. A copy of documentation issued by the local jurisdiction to the applicant authorizing occupancy of the building as a marijuana testing facility, such as a certificate of occupancy, a special use permit, or a conditional use permit;
  7. A site plan drawn to scale of the location of the proposed marijuana testing facility showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains;
  8. A building plan drawn to scale of the building where the proposed marijuana testing facility is located showing the:
    - a. Layout and dimensions of each room;
    - b. Name and function of each room;
    - c. Fire ratings of the materials used for ceilings, walls, doors, and floors of rooms used to store flammable substances;
    - d. Location of each fire protection device;
    - e. Layout of heating, air conditioning, exhaust, and ventilation systems;
    - f. Location and layout of refrigerated rooms or freezer rooms;
    - g. Location of each sink, safety shower, other water supply, or plumbing fixture;
    - h. Location of fixed or movable equipment and instruments that require dedicated electrical, water, vacuum, gas, or other building systems;
    - i. Location of security measures or equipment to protect from diversion of marijuana or marijuana products; and
    - j. Means of egress;
  9. Documentation of accreditation of the location specified according to subsection (A)(1)(b) for which the applicant is applying for a marijuana testing facility license;
  10. The applicant's Transaction Privilege Tax Number issued by the Arizona Department of Revenue, if applicable; and
  11. The fee in R9-18-102 for applying for a marijuana testing facility license.
- B.** An entity holding a valid laboratory registration certificate issued by the Department under 9 A.A.C. 17, Article 4, may apply for an initial marijuana testing facility license by electronically submitting to the Department, in a Department-provided format:
    1. An attestation from each owner listed according to subsection (A)(1)(d) approving the application for a marijuana testing facility license;
    2. The license number on the applicant's laboratory registration certificate; and
    3. The applicable fee in R9-18-102 for applying for a marijuana testing facility license.
  - C.** A change in location of the marijuana testing facility's physical address or ownership requires a new application to be submitted according to subsection (A).
  - D.** A separate marijuana testing facility license is required for each noncontiguous portion of a marijuana testing facility.
  - E.** A marijuana testing facility license is valid for two years after the original date of issuance.

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**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-403. Applying for Approval for Testing**

A. Except as provided in subsection (C), to apply for approval for testing, an applicant shall submit to the Department, at least 60 calendar days before the expiration of the applicant's initial marijuana testing facility license, the following:

1. An application in a Department-provided format that includes:
  - a. The name and license number of the marijuana testing facility;
  - b. The physical address of the marijuana testing facility;
  - c. The name of the applicant;
  - d. The name of the technical laboratory director designated according to R9-18-405(3);
  - e. For each parameter for which approval for testing is being requested:
    - i. The analyte to be tested for;
    - ii. The instruments and equipment to be used for testing; and
    - iii. The software to be used at the marijuana testing facility for instrument control and data reduction interpretation;
  - f. The marijuana testing facility's proposed hours of operation;
  - g. Whether the marijuana testing facility agrees to allow the Department to submit supplemental requests for information;
  - h. Whether the marijuana testing facility is ready for an inspection by the Department;
  - i. If the marijuana testing facility is not ready for an inspection by the Department, the date the marijuana testing facility will be ready for an inspection by the Department;
  - j. An attestation that the information provided to the Department to apply for approval for testing is true and correct; and
  - k. The signatures of the owner of the marijuana testing facility, according to R9-18-401(A), and the technical laboratory director and the date each signed;
2. For each parameter and analyte listed according to subsection (A)(1)(e):
  - a. A copy of current accreditation;
  - b. The limit of quantitation for each matrix, according to A.A.C. R9-17-404.03(I);
  - c. A copy of a proficiency testing report;
  - d. A copy of the standard operating procedure; and
  - e. Documentation of the initial demonstration of capabilities for each matrix, according to A.A.C. R9-17-404.03(D);
3. Policies and procedures that comply with the requirements in this Chapter that include:
  - a. A quality assurance program and standards;
  - b. A process to ensure marijuana or marijuana products testing results are accurate, precise, and scientifically valid before reporting the results; and
  - c. A process to compile testing results into a single report to be provided to a marijuana establishment; and

4. If different from the building plan submitted according to R9-18-402(A)(8), a building plan drawn to scale of the building where the marijuana testing facility is located showing the:

- a. Layout and dimensions of each room;
- b. Name and function of each room;
- c. Fire ratings of the materials used for ceilings, walls, doors, and floors of rooms used to store flammable substances;
- d. Location of each fire protection device;
- e. Layout of heating, air conditioning, exhaust, and ventilation systems;
- f. Location and layout of refrigerated rooms or freezer rooms;
- g. Location of each sink, safety shower, other water supply, or plumbing fixture;
- h. Location of fixed or movable equipment and instruments that require dedicated electrical, water, vacuum, gas, or other building systems;
- i. Location of security equipment to protect from diversion of marijuana or marijuana products; and
- j. Means of egress.

B. The Department shall process, as provided in R9-18-103, a request submitted according to subsection (A) for approval to test.

C. If an entity receives a marijuana testing facility license according to R9-18-402(B), the entity may begin testing marijuana pursuant to R9-18-311 for any parameters for which the Department has given the entity an approval for testing under A.A.C. R9-17-402.01.

D. A marijuana testing facility's approval for testing shall have the same expiration date as the marijuana testing facility license associated with the marijuana testing facility's approval to test.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-404. Renewing a Marijuana Testing Facility License**

To renew a marijuana testing facility license, an applicant shall submit to the Department, at least 30 calendar days before the expiration date of the current marijuana testing facility license, but no more than 90 days before the expiration date of the current marijuana testing facility license, the following:

1. An application in a Department-provided format that includes:
  - a. The legal name of the marijuana testing facility;
  - b. The marijuana testing facility license number;
  - c. The name of each owner;
  - d. The name of the technical laboratory director designated according to R9-18-405(3);
  - e. Whether the marijuana testing facility agrees to allow the Department to submit supplemental requests for information;
  - f. An attestation that the information provided to the Department to renew the marijuana testing facility license is true and correct; and
  - g. The signatures of the owner of the marijuana testing facility, according to R9-18-401(A), and the technical laboratory director and the date each signed;
2. For each current parameter and analyte, documentation of current accreditation;

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3. If a change has been made to the standard operating procedure for a current parameter, a copy of the revised standard operating procedure;
4. If a change has been made in the quality assurance plan, required in R9-18-409(B), for a current parameter, a copy of the revised quality assurance plan; and
5. The fee in R9-18-102 for applying to renew a marijuana testing facility license.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2).

**R9-18-405. Administration**

An owner of a marijuana testing facility shall:

1. Comply with the:
  - a. Quality assurance requirements in R9-18-409,
  - b. Operation requirements in R9-18-410, and
  - c. Laboratory records and reports requirements in R9-18-410(B) and (C);
2. Maintain accreditation for each approved parameter and analyte;
3. Designate in writing a technical laboratory director who:
  - a. Has knowledge and experience in overseeing a marijuana testing facility as documented by:
    - i. A doctoral degree in chemistry, biochemistry, microbiology, or a similar laboratory science;
    - ii. A master's degree in chemistry, biochemistry, microbiology, or a similar laboratory science and at least two years of experience working in a laboratory and providing testing; or
    - iii. A bachelor's degree in chemistry, biochemistry, microbiology, or a similar laboratory science and at least four years of experience working in a laboratory and providing testing; and
  - b. Is responsible for:
    - i. Ensuring that all services and tests provided by the marijuana testing facility are performed in compliance with the requirements in this Article;
    - ii. Directing and supervising services and tests provided by the marijuana testing facility;
    - iii. Overseeing the work of all personnel in the marijuana testing facility;
    - iv. Providing ongoing training to marijuana facility agents, as applicable to the functions performed by a marijuana facility agent; and
    - v. Ensuring safety and hazardous substance control in the marijuana testing facility;
4. Notify the Department in writing within 20 business working days after any change in the technical laboratory director, providing the name and contact information for the new technical laboratory director;
5. Develop, document, and implement policies and procedures regarding:
  - a. Job descriptions and employment contracts, including:
    - i. Personnel duties, authority, responsibilities, and qualifications;
    - ii. Personnel supervision;
    - iii. Ongoing training, applicable to the functions performed by a marijuana facility agent;
    - iv. Training in and adherence to confidentiality requirements;
  - v. Periodic performance evaluations, including proficiency testing on a rotating basis among all marijuana facility agent performing similar functions; and
  - vi. Disciplinary actions;
- b. Business records, such as manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers;
- c. Inventory control, including:
  - i. Tracking;
  - ii. Accepting marijuana or marijuana products for testing;
  - iii. Transferring a portion of a sample prepared or selected according to subsection (5)(e)(v) to another marijuana testing facility for testing of parameters or analytes that the marijuana testing facility is not approved by the Department to conduct;
  - iv. Testing marijuana and marijuana products;
  - v. Providing a representative portion of the sample of tested marijuana or a marijuana product, which had been prepared or selected according to subsection (5)(e)(v), to up to two other marijuana testing facilities, with an approval for testing issued by the Department, at the request of a marijuana establishment according to R9-18-311(C);
  - vi. Retaining the residual portion of a sample accepted for testing from a marijuana establishment for at least 14 days after sending the final report of testing required in R9-18-410(B)(3) to the marijuana establishment; and
  - vii. Disposing of marijuana or a marijuana product such that the marijuana or marijuana product is unrecognizable or cannot otherwise be used and documenting:
    - (1) The method of disposal;
    - (2) Whether the marijuana or marijuana product was tested;
    - (3) If not tested, the reason for not testing;
    - (4) The marijuana facility agent overseeing the disposal; and
    - (5) The date of disposal;
- d. Standard operating procedures, including:
  - i. The review and updating of standard operating procedures;
  - ii. Requirements for a marijuana facility agent to review current, new, or updated standard operating procedures applicable to the functions performed by the marijuana facility agent; and
  - iii. Documenting the review of standard operating procedures by applicable marijuana facility agents;
- e. Marijuana testing facility records, including:
  - i. Maintenance and monitoring of instruments and equipment;
  - ii. Acceptance of marijuana and marijuana products for testing, including the specification of the analytes to be tested for;
  - iii. The chain of custody and applicable trip plan, according to R9-18-413, for a sample accepted by the marijuana testing facility for testing;

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- iv. The storage of a submitted sample prior to testing to maintain the integrity of the sample and analyte;
- v. The process for ensuring that a homogeneous portion of a submitted sample is prepared or selected for testing, including:
  - (1) The aseptic removal of a homogeneous portion of the sample for testing according to R9-18-408; and
  - (2) Further preparation of a homogeneous portion of the sample, if necessary, for testing according to R9-18-408;
- vi. Ensuring testing results are accurate, precise, and scientifically valid before reporting the results;
- vii. Reporting of testing results, including:
  - (1) Testing results obtained from another marijuana testing facility for testing of parameters or analytes that the marijuana testing facility is not approved by the Department to conduct, or
  - (2) Testing results provided to another marijuana testing facility from which the marijuana testing facility had received a portion of a sample for testing of parameters or analytes that the other marijuana testing facility is not approved by the Department to conduct;
- viii. If applicable, transfer of a portion of a sample, according to subsection (5)(c)(v), to another marijuana testing facility with an approval for testing issued by the Department for testing of parameters or analytes that the marijuana testing facility is not approved by the Department to conduct, including:
  - (1) The name and marijuana establishment license number of the marijuana establishment from which the sample was obtained,
  - (2) The name and marijuana testing facility license number of the marijuana testing facility to which the portion of the sample is being transferred,
  - (3) The date of the transfer,
  - (4) The amount of sample being transferred,
  - (5) The name and marijuana facility agent license number of the marijuana facility agent receiving the marijuana or marijuana products on behalf of the other marijuana testing facility;
  - (6) The parameters or analytes being tested by the other marijuana testing facility, and
  - (7) The testing results obtained from the other marijuana testing facility;
- ix. If applicable, transfer of the portion of a sample remaining after testing, according to subsection (5)(c)(v), to no more than two other marijuana testing facilities with an applicable approval for testing issued by the Department at the request of a marijuana establishment according to R9-18-311(C), including:
  - (1) The name and marijuana establishment license number of the marijuana establishment,
  - (2) The name and marijuana facility agent license number of the marijuana facility agent requesting the transfer on behalf of the marijuana establishment,
  - (3) The date of the request,
  - (4) The amount of sample being transferred,
  - (5) The name and marijuana testing facility license number of each other marijuana testing facility, and
  - (6) The name and marijuana facility agent license number of the marijuana facility agent receiving the marijuana or marijuana products on behalf of each receiving marijuana testing facility;
  - x. Confidentiality; and
  - xi. Sample retention;
- f. A quality assurance program and standards;
- g. A records retention process; and
- h. Security;
- 6. Review and document the review of marijuana testing facility policies and procedures at least once every 12 months after the issue date of the marijuana testing facility license and update as needed;
- 7. Ensure that each marijuana facility agent has the marijuana facility agent's license in the marijuana facility agent's immediate possession when the marijuana facility agent is working or providing volunteer services related to marijuana or marijuana products testing at the marijuana testing facility;
- 8. Ensure that a marijuana facility agent accompanies any individual other than another marijuana facility agent associated with the marijuana testing facility when the individual is present in the area of the marijuana testing facility where marijuana or marijuana products are being tested or stored for testing;
- 9. Not allow an individual who does not possess a marijuana facility agent license to:
  - a. Serve as an owner for the marijuana testing facility,
  - b. Be employed by the marijuana testing facility, or
  - c. Provide volunteer services at or on behalf of the marijuana testing facility;
- 10. Provide written notice to the Department, including the date of the event, within 10 working days after the date, when a marijuana facility agent no longer:
  - a. Serves as an owner for the marijuana testing facility,
  - b. Is employed by the marijuana testing facility, or
  - c. Provides volunteer services at or on behalf of the marijuana testing facility; and
- 11. Unless otherwise specified, maintain copies of any documentation required in this Chapter for at least two years after the date on the documentation and provide copies of the documentation to the Department for review upon request.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-406. Compliance Monitoring**

- A. Submission of an application for a marijuana testing facility license constitutes permission for:
  - 1. The Department's entry to and inspection of the marijuana testing facility, and



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2. The Department to conduct proficiency testing according to R9-18-407.
- B.** The Department shall conduct:
  1. Except for a marijuana testing facility licensed pursuant to R9-18-402(B), an initial marijuana testing facility inspection; and
  2. A follow-up marijuana testing facility inspection, at least annually.
- C.** The Department shall comply with A.R.S. § 41-1009 in conducting a marijuana testing facility inspection or investigation.
- D.** The Department shall not accept allegations of a marijuana testing facility's noncompliance with A.R.S. Title 36, Chapter 28.2 or this Chapter from an anonymous source.
- E.** If the Department receives an allegation of a marijuana testing facility's noncompliance with A.R.S. Title 36, Chapter 28.2 or this Chapter, the Department may conduct an unannounced inspection of the marijuana testing facility.
- F.** If the Department determines that a marijuana testing facility is not in compliance with the requirements of A.R.S. Title 36, Chapter 28.2, or this Chapter, the Department:
  1. Shall provide the owner, according to R9-18-401(A), and technical laboratory director with a written notice that includes the specific rule or statute that was violated; and
  2. May:
    - a. Take an enforcement action as described in R9-18-415; or
    - b. Require that the technical laboratory director submit to the Department, within 30 calendar days after written notice from the Department, a corrective action plan to address issues of compliance that do not directly affect the health or safety of a consumer or marijuana facility agent that:
      - i. Describes how each identified instance of noncompliance will be corrected and reoccurrence prevented, and
      - ii. Includes a date for correcting each instance of noncompliance that is appropriate to the actions necessary to correct the instance of noncompliance.
- G.** Under A.R.S. § 41-1009(G) and (I), the Department's decision regarding whether a technical laboratory director may submit a corrective action plan on behalf of a marijuana testing facility or whether a deficiency has been corrected or has been corrected within a reasonable period of time is not an appealable agency action as defined by A.R.S. § 41-1092.
3. If the marijuana testing facility has been approved or has requested approval to test an analyte by different methods, may use the same proficiency testing sample for each method.
- B.** To demonstrate competence in testing for a parameter, testing results reported for the parameter shall be within acceptance limits established by the Department, according to R9-18-408, or the proficiency testing service, as applicable.
- C.** A technical laboratory director shall ensure that:
  1. Each sample for proficiency testing accepted at the marijuana testing facility is analyzed at the marijuana testing facility;
  2. Each sample for proficiency testing is tested according to R9-18-408, using the same procedures and techniques employed for routine sample testing;
  3. A proficiency testing service provides the results for each proficiency testing sample directly to the marijuana testing facility and the Department;
  4. If proficiency testing is provided by the Department, the marijuana testing facility submits to the Department payment for the actual costs of the materials for proficiency testing;
  5. If proficiency testing is not provided by the Department, the marijuana testing facility selects a proficiency testing service and contracts with and pays the proficiency testing service directly for proficiency testing; and
  6. For any analyte not within the acceptance limit established by the Department or the proficiency testing service in subsection (C)(5), as applicable:
    - a. A corrective action plan:
      - i. Is submitted to the Department within 10 calendar days after failing to demonstrate competency in proficiency testing,
      - ii. Describes how each identified instance of failing to demonstrate competency will be corrected, and
      - iii. Includes a date for correcting the failure to demonstrate competency that is appropriate to the actions necessary to correct the instance of noncompliance; and
    - b. If the marijuana testing facility fails to demonstrate competency in proficiency testing for any analyte twice in a row, the marijuana testing facility does not test for the analyte until the marijuana testing facility has demonstrated competency in testing for the analyte by repeat proficiency testing.
- D.** The Department may submit blind proficiency testing samples to a marijuana testing facility at any time during the certification period.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2).

**R9-18-407. Proficiency Testing**

- A.** At least once in each 12-month period, and more often if requested by the Department, a technical laboratory director shall have at least one marijuana facility agent, selected according to policies and procedures, participate in proficiency testing provided by the Department or a proficiency testing service that:
  1. Includes at least one proficiency testing sample, in a matrix similar to the marijuana or marijuana products accepted for testing, for each parameter and analyte for which the marijuana testing facility has been approved or is requesting approval;
  2. Demonstrates the marijuana facility agent's competence in testing for the parameter; and

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-408. Method Criteria and References for Laboratory Analyses**

- A.** In addition to the definitions in A.R.S. § 36-2850 and R9-18-101, the definitions in A.A.C. R9-17-404.03(A) apply in this Section unless otherwise stated.
- B.** A technical laboratory director shall ensure that the marijuana testing facility complies with the requirements in A.A.C. R9-17-404.03(B) through (O) when using chemical analytical methods for any of the analytes in Table 3.1.

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- C. A technical laboratory director may release testing results that are scientifically valid and defensible from analyses using chemical analytical methods, according to R9-18-410(B)(3) and (C), with the following data qualifier notations if:
- The target analyte detected in the calibration blank required in A.A.C. R9-17-404.03(F)(1)(c) or the method blank specified in A.A.C. R9-17-404.03(K)(1) is at or above the limit of quantitation, but the sample result:
    - For potency testing, is below the limit of quantitation – B1; or
    - When testing for pesticides, fungicides, growth regulators, mycotoxins, heavy metals, or residual solvents, is below the maximum allowable concentration in Table 3.1 for the analyte – B2;
  - The limit of quantitation and the sample results were adjusted to reflect sample dilution – D1;
  - The relative intensity of a characteristic ion in a sample analyte exceeded the acceptance criteria in A.A.C. R9-17-404.03(L)(1) with respect to the reference spectra, indicating interference – I1;
  - When testing for pesticides, fungicides, growth regulators, mycotoxins, heavy metals, or residual solvents, the percent recovery of a laboratory control sample is greater than the acceptance limits in A.A.C. R9-17-404.03(K)(2)(d), but the sample's target analytes were not detected above the maximum allowable concentrations in Table 3.1 for the analytes in the sample – L1;
  - The recovery from the matrix spike in A.A.C. R9-17-404.03(K)(4) was:
    - High, but the recovery from the laboratory control sample in A.A.C. R9-17-404.03(K)(2) was within acceptance criteria – M1,
    - Low, but the recovery from the laboratory control sample in A.A.C. R9-17-404.03(K)(2) was within acceptance criteria – M2, or
    - Unusable because the analyte concentration was disproportionate to the spike level, but the recovery from the laboratory control sample in A.A.C. R9-17-404.03(K)(2) was within acceptance criteria – M3;
  - The analysis of a spiked sample required a dilution such that the spike recovery calculation does not provide useful information, but the recovery from the associated laboratory control sample in A.A.C. R9-17-404.03(K)(2) was within acceptance criteria – M4;
  - The analyte concentration was determined by the method of standard addition, in which the standard is added directly to the aliquots of the analyzed sample – M5;
  - A description of the variance is described in the final report of testing according to R9-18-410(B)(3) and (C) – N1;
  - The relative percent difference for the laboratory control sample and duplicate exceeded the limit in A.A.C. R9-17-404.03(K)(3), but the recovery in A.A.C. R9-17-404.03(K)(2)(d) was within acceptance criteria – R1;
  - The relative percent difference for a sample and duplicate exceeded the limit in A.A.C. R9-17-404.03(O) – R2; or
  - The recovery from continuing initial calibration verification standards or continuing calibration verification standards is greater than the acceptance limits in A.A.C. R9-17-404.03(H)(2) or (J)(1)(b) as applicable, but the sample's target analytes were not detected above the maximum allowable concentrations in Table 3.1 for the analytes in the sample – V1.
- D. A technical laboratory director shall include in the final report of testing from analyses using chemical analytical methods, according to R9-18-410(B)(3) and (C), the following data qualifier notations if:
- Sample integrity was not maintained – Q1;
  - The sample is heterogeneous, and sample homogeneity could not be readily achieved using routine laboratory practices – Q2; or
  - Testing result is for informational purposes only and cannot be used to satisfy marijuana establishment testing requirements in R9-18-311(A) or labeling requirements in R9-18-310 – Q3.
- E. For batch analysis of samples to determine potency, a technical laboratory director may check precision by using either a duplicate laboratory control sample or a duplicate sample prepared from the marijuana or marijuana product being tested, according to requirements in A.A.C. R9-17-404.03(K)(2) and (3).
- F. A technical laboratory director shall ensure that the reporting units for:
- Pesticides, fungicides, growth regulators, heavy metals, or residual solvents is in parts per million (ppm); and
  - Mycotoxins are according to A.A.C. R9-17-404.04(I)(4); and
  - Potency are:
    - In either:
      - Percent (w/w) relative to the bulk plant material or marijuana product, as applicable; or
      - Number of milligrams per designated unit; and
    - For:
      - Total tetrahydrocannabinol, the sum of tetrahydrocannabinolic acid (THC-A), multiplied by 0.877, and delta-9-tetrahydrocannabinol ( $\Delta$ 9-THC); and
      - Total cannabidiol, the sum of cannabidiolic acid (CBD-A), multiplied by 0.877, and cannabidiol (CBD).
- G. To perform testing for the microbial contaminants in Table 3.1, a marijuana testing facility shall:
- Use an applicable method described in A.A.C. R9-17-404.04(A)(1) and validated according to A.A.C. R9-17-404.04(A)(2), and
  - Comply with A.A.C. R9-17-404.04(A)(3) and (4), as applicable.
- H. A technical laboratory director shall ensure that the marijuana testing facility complies with the requirements in A.A.C. R9-17-404.04(B) through (G) when performing testing for the microbial contaminants in Table 3.1.
- I. A technical laboratory director shall include in the final report of testing for the microbial contaminants in Table 3.1, according to R9-18-410(B)(3) and (C), the following data qualifier notations if:
- The limit of quantitation and the sample results were adjusted to reflect sample dilution – D1;
  - A description of the variance is described in the final report of testing according to A.A.C. R9-17-410(B)(3) and (C) – N1;
  - Sample integrity was not maintained – Q1;
  - The sample is heterogeneous, and sample homogeneity could not be readily achieved using routine laboratory practices – Q2; or
  - Testing result is for informational purposes only and cannot be used to satisfy marijuana establishment testing

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requirements R9-18-311(A) or labeling requirements in R9-18-310 – Q3.

- J.** A technical laboratory director shall ensure that:
1. The reporting units for *Escherichia coli* are colony forming units per gram (CFU/g);
  2. Reporting for *Salmonella* is “Detected” or “Not detected” in one gram;
  3. Reporting for *Aspergillus* is “Detected” or “Not detected” in one gram; and
  4. Reporting for mycotoxins includes:
    - a. Total aflatoxins in units of micrograms per kilogram (µg/kg), and
    - b. Ochratoxin A in units of micrograms per kilogram (µg/kg).

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3). Amended by exempt rulemaking at 30 A.A.R. 3451 (November 15, 2024), with a delayed effective date of November 1, 2024; filed October 25, 2024 (Supp. 24-4).

**R9-18-409. Quality Assurance**

- A.** An owner of a marijuana testing facility or applicant shall ensure that the analytical data produced at the owner’s or applicant’s marijuana testing facility are of known and acceptable precision and accuracy, as prescribed by the method criteria for each analyte in R9-18-408, and are scientifically valid and defensible.
- B.** An owner holding a marijuana testing facility license or applicant shall establish, implement, and comply with a written quality assurance plan that contains the following and is available at the marijuana testing facility for Department review:
1. A title page identifying the marijuana testing facility and date of review and including the technical laboratory director’s signature of approval;
  2. A table of contents;
  3. An organization chart or list of the marijuana testing facility personnel, including names, lines of authority, and identification of principal quality assurance personnel;
  4. A copy of the current marijuana testing facility license and a list of approved parameters;
  5. A statement of quality assurance objectives, including data quality objectives with precision and accuracy goals and the criteria for determining the acceptability of each testing;
  6. Specifications for the preservation of samples;
  7. A procedure for documenting receipt of samples by the marijuana testing facility and tracking of samples during testing;
  8. A procedure for analytical instrument calibration, including frequency of calibration and complying with the requirements for calibration in subsection (D);
  9. A procedure for testing data reduction and validation and reporting of final results, including the identification and treatment of data outliers, the determination of the accuracy of data transcription, and all calculations;
  10. If using control limits derived by the marijuana testing facility as a basis for determining acceptance of a testing result, a procedure to ensure that the control limits are:
    - a. Statistically significant, valid, and defensible; and
    - b. Updated at least every 12 months;
  11. A statement of the frequency of all quality control checks;
  12. A statement of the acceptance criteria for all quality control checks;
  13. Preventive maintenance procedures and schedules;
  14. Assessment procedures for data acceptability, including appropriate procedures for manual integration of chromatograms and when manual integration is inappropriate;
  15. Corrective action procedures to be taken when results from analytical quality control checks are unacceptable, including steps to demonstrate the presence of any interference if the precision, accuracy, or limit of quantitation of the reported testing result is affected by the interference; and
  16. Procedures for chain-of-custody documentation, including procedures for the documentation and reporting of any deviation from the sample handling or preservation requirements.
- C.** An owner holding a marijuana testing facility license or applicant shall ensure that the written quality assurance plan is a separate document available at the marijuana testing facility and includes all of the components required in subsection (B), but an owner or applicant may satisfy the components required in subsections (B)(3) through (16) through incorporating by reference provisions in separate documents, such as standard operating procedures.
- D.** An owner holding a marijuana testing facility license or applicant shall:
1. Have available at the marijuana testing facility all methods, equipment, reagents, and supplies necessary for the testing for which the owner or applicant is approved or is requesting approval;
  2. Use only reagents of a grade equal to or greater than that required by the applicable method criteria in R9-18-408, and document the use of the reagents;
  3. Maintain and require each marijuana facility agent performing testing on marijuana or a marijuana product to comply with a complete and current standard operating procedure that meets the requirements for each method, as specified in R9-18-408, which shall include at least:
    - a. A description of all procedures to be followed, including the recording of the information required according to R9-18-410(B)(1)(g) and (k), when the method is performed;
    - b. A list of the concentrations for calibration standards, check standards, and spikes;
    - c. Requirements for instrumental conditions and set up;
    - d. A requirement for frequency of calibration;
    - e. The quantitative methods to be used to calculate the final concentration of an analyte in samples, including any factors used in the calculations and the calibration algorithm used; and
    - f. Requirements for preventative maintenance;
  4. Calibrate each instrument as required by the standard operating procedure, as specified in R9-18-408, for which the equipment is used;
  5. Maintain calibration documentation, including documentation that demonstrates the calculations performed using each calibration model;
  6. Develop, document, and maintain a current limit of quantitation, as specified in R9-18-408, for each compliance parameter for each instrument;

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7. For each parameter and analyte tested at the marijuana testing facility, use the quality control acceptance criteria specified according to R9-18-408 and Table 3.1;
  8. Discard or segregate all expired standards or reagents;
  9. Maintain a record showing the traceability of reagents; and
  10. Ensure that a calibration model is not used or changed to avoid necessary instrument maintenance.
- E.** Except as provided in subsection (F), an owner holding a marijuana testing facility license or applicant shall ensure that each standard operating procedure is a separate document available at the marijuana testing facility and includes all of the components required in subsection (D)(3).
- F.** An owner holding a marijuana testing facility license or applicant may satisfy the components required in subsections (D)(3)(e) and (f) through incorporating by reference provisions in separate documents, such as other standard operating procedures.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-410. Operations**

- A.** A technical laboratory director shall ensure that:
1. A sample of marijuana or a marijuana product accepted at the technical laboratory director's marijuana testing facility is analyzed:
    - a. Either:
      - i. At the marijuana testing facility with methods approved by the Department; or
      - ii. For testing of parameters or analytes that the marijuana testing facility is not approved by the Department to conduct, at another marijuana testing facility with an approval for testing issued by the Department;
    - b. As received; and
    - c. Within 10 calendar days after receipt;
  2. If an instrument or equipment used for testing marijuana or a marijuana product has a mechanism to track any changes made to testing results, the tracking mechanism is installed and activated;
  3. The facility and utilities required to operate equipment and perform testing of marijuana or marijuana products are maintained;
  4. Environmental controls are maintained within the marijuana testing facility to ensure that marijuana testing facility environmental conditions do not affect analytical results beyond quality control limits established for the methods performed at the marijuana testing facility;
  5. Storage, handling, and disposal of hazardous materials at the marijuana testing facility are in accordance with all state and federal regulations;
  6. The marijuana testing facility complies with all applicable federal, state, and local occupational safety and health regulations; and
  7. The following information is maintained for all marijuana facility agents providing supervisory, quality assurance, or analytical functions related to testing of marijuana or a marijuana product:
    - a. A summary of each marijuana facility agent's education and professional experience;
    - b. Documentation of each marijuana facility agent's applicable certifications and specialized training;
    - c. Information related to the marijuana facility agent's license;
    - d. Documentation of each marijuana facility agent's review of the quality assurance plan required under R9-18-409(B) and the methods and standard operating procedures for all testing of marijuana or marijuana products performed by the marijuana facility agent or for which the marijuana testing facility agent has supervisory or quality assurance responsibility;
    - e. Documentation of each marijuana facility agent's completion of training on the use of equipment and of proper laboratory technique, including the name of the marijuana facility agent, the name of the instructor, the duration of the training, and the date of completion of the training;
    - f. Documentation of each marijuana facility agent's completion of training classes, continuing education courses, seminars, and conferences that relate to the testing procedures used by the marijuana facility agent for testing of marijuana or marijuana products;
    - g. Documentation of each marijuana facility agent's completion of initial demonstration of capability, as required according to R9-18-408, for each approved method performed by the marijuana facility agent;
    - h. Documentation of each marijuana facility agent's performance of proficiency testing; and
    - i. Documentation of each marijuana facility agent's completion of training related to instrument calibration that includes:
      - i. Instruction on each calibration model that the marijuana facility agent will use or for which the marijuana facility agent will review data;
      - ii. For each calibration model in subsection (A)(7)(i)(i), description of the specific aspects of the calibration model that might compromise the data quality, such as detector saturation, lack of detector sensitivity, the calibration model's not accurately reflecting the calibration points, inappropriate extension of the calibration range, weighting factors, and dropping of mid-level calibration points without justification; and
      - iii. Instruction that a calibration model shall not be used or changed to avoid necessary instrument maintenance.
- B.** A technical laboratory director shall ensure that:
1. A testing record for marijuana or marijuana products contains:
    - a. Sample information, including the following:
      - i. A unique sample identification assigned at the marijuana testing facility;
      - ii. A description of the marijuana or marijuana product from which the submitted sample was taken, including the amount, strain, and batch number;
      - iii. The sample collection date and time;
      - iv. The type of testing to be performed, including whether the testing is to satisfy the requirement in R9-18-311(A) or for a marijuana establishment's information only; and

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- v. The analytes to be tested for, as specified by the marijuana establishment or individual submitting the sample to the marijuana testing facility according to subsection (B)(1)(c);
  - b. A color picture of the sample as submitted;
  - c. The name and one of the following, as applicable, for the marijuana establishment or individual submitting the sample to the marijuana testing facility:
    - i. The marijuana establishment license number, or
    - ii. The number on the document used to identify the individual;
  - d. If applicable, name and the marijuana facility agent license number of the marijuana facility agent submitting the sample to the marijuana testing facility on behalf of a marijuana establishment;
  - e. The date and time of receipt of the sample at the marijuana testing facility;
  - f. The name and registry identification number of the marijuana facility agent who received the sample at the marijuana testing facility;
  - g. The dates and times of testing, including the date and time of each critical step;
  - h. Whether testing results related to a sample were changed;
  - i. If testing results related to a sample were changed, what was changed, the name of the marijuana facility agent who changed the testing results, the time and date the data were changed, and why the testing results were changed;
  - j. If testing results were changed due to retesting:
    - i. What was used or done to the sample, and
    - ii. The original and changed testing results;
  - k. The actual results of testing, including all raw data, work sheets, and calculations performed;
  - l. The actual results of quality control data validating the testing results, including the calibration and calculations performed;
  - m. The name of each marijuana facility agent who performed the testing; and
  - n. A copy of the final report;
2. A testing result for marijuana or a marijuana product that is known to be inaccurate is not reported; and
  3. Except as specified in subsection (C) or (D) as applicable, a final report of testing of marijuana or marijuana products contains:
    - a. The name, address, and telephone number of the marijuana testing facility;
    - b. The marijuana testing facility license number issued by the Department;
    - c. Actual scientifically valid and defensible results of testing of a sample of marijuana or a marijuana product in appropriate units of measure, obtained in accordance with R9-18-408, and the quality assurance plan;
    - d. As applicable:
      - i. A statement that testing results were obtained according to requirements in the quality assurance plan in R9-18-409(B), in the applicable standard operating procedure, and in R9-18-408;
      - ii. A description of any variances from the requirements in the quality assurance plan in R9-18-409(B), the applicable standard operating procedure, or R9-18-408 made to ensure scientifically valid and defensible testing results, and the reason for the variance; or
    - iii. A qualifier, according to R9-18-408(C), (D), or (I), as applicable, located adjacent to the name of the analyte or testing result to which the qualifier pertains;
    - e. A list of each method used to obtain the reported results;
    - f. Sample information, including the following:
      - i. The unique sample identification assigned at the marijuana testing facility;
      - ii. A color picture of the sample as submitted;
      - iii. A description of the marijuana or marijuana product from which the submitted sample was taken, including the strain and batch number;
      - iv. The sample collection date and time;
      - v. The name and identifying number recorded for the marijuana establishment or individual submitting the sample to the marijuana testing facility according to subsection (B)(1)(c); and
      - vi. Any changes made to the information recorded according to subsection (B)(1)(a) since sample submission;
    - g. The date of testing for each parameter reported;
    - h. The date of the final report; and
    - i. The technical laboratory director's or designee's signature.
  - C. If a sample of marijuana or a marijuana product accepted at a marijuana testing facility is analyzed at another marijuana testing facility, as allowed according to subsection (A)(1)(a)(ii), a technical laboratory director shall ensure that the final report of testing required in subsection (B)(3) includes a copy of the final report of testing from each marijuana testing facility to which the marijuana testing facility accepting the sample from a marijuana establishment sent a portion of the sample for testing of parameters or analytes that the marijuana testing facility is not approved by the Department to conduct.
  - D. If a final report of testing issued according to subsection (B)(3) needs to be changed, amended, or reissued, a technical laboratory director shall ensure that a changed, amended, or reissued report of testing is generated by the marijuana testing facility and includes:
    1. The date of the changed, amended, or reissued report of testing;
    2. A statement that the changed, amended, or reissued report is an amendment to the original final report of testing, including any unique number or other designator given by the marijuana testing facility to the original final report of testing;
    3. If it is necessary to issue a completely new final report of testing, the information required in subsection (B)(3); and
    4. The change to the information provided in the original final report of testing and, where appropriate, the reason for the change, located either:
      - a. Adjacent to the testing result to which the change pertains, or
      - b. On the same page of the final report of testing with an indicator located adjacent to the testing result to which the change pertains.
  - E. For a sample of marijuana or a marijuana product accepted at the technical laboratory director's marijuana testing facility, a technical laboratory director shall ensure that the final report of testing in subsection (B)(3):

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1. For a sample received from a marijuana establishment, is sent to the marijuana establishment within 10 calendar days after receipt of the sample;
  2. For a sample received from a marijuana testing facility according to subsection (A)(1)(a)(ii), is sent to the marijuana testing facility from which the sample was sent within seven calendar days after receipt of the sample;
  3. For a sample received from a marijuana testing facility according to R9-18-311(C), to the marijuana establishment within seven calendar days after receipt of the sample; and
  4. For a sample received from an individual as recorded according to subsection (B)(1)(c), is sent to the individual within 10 calendar days after receipt of the sample.
3. If applicable, any changes to the quality assurance plan in R9-18-409(B) made due to the addition or removal of the parameter.
  - C. The Department may conduct an inspection of the marijuana testing facility during the substantive review period for a request to have one or more parameters added to a marijuana testing facility license.
  - D. The Department shall process a request to have one or more parameters added to a marijuana testing facility license as provided in R9-18-103.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-411. Adding or Removing Parameters for Testing**

- A. During the term of a marijuana testing facility license, an owner may request to have one or more parameters:
  1. Added to the marijuana testing facility license, or
  2. Removed from the marijuana testing facility license.
- B. To request a change to one or more parameters, an applicant shall submit to the Department:
  1. The following information in a Department-provided format:
    - a. The name, address, and telephone number of the applicant;
    - b. The name, address, and telephone number of the marijuana testing facility for which the change is requested;
    - c. If requesting the removal of a parameter, identification of the parameter to be removed;
    - d. If requesting the addition of a parameter:
      - i. The analyte to be tested for;
      - ii. The instruments and equipment to be used for testing;
      - iii. The software to be used at the marijuana testing facility for instrument control and data reduction interpretation; and
      - iv. The limit of quantitation, if applicable;
    - e. Whether the marijuana testing facility is ready for an inspection by the Department;
    - f. If the marijuana testing facility is not ready for an inspection by the Department, the date the marijuana testing facility will be ready for an inspection by the Department;
    - g. An attestation that the information provided to the Department to apply for the addition of a parameter is true and correct; and
    - h. The signatures of the owner of the marijuana testing facility, according to R9-18-401(A), and the technical laboratory director and the date each signed;
  2. The following for each parameter requested to be added:
    - a. A copy of current accreditation;
    - b. A copy of a proficiency testing report;
    - c. A copy of the standard operating procedure; and
    - d. Documentation of the initial demonstration of capabilities, according to A.A.C. R9-17-404.03(D); and

**Inventory Control System**

- A. A marijuana testing facility shall not accept submissions of marijuana or marijuana products for testing from an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1 or Chapter 28.2.
- B. A technical laboratory director shall designate in writing a marijuana facility agent who has oversight of the marijuana testing facility's inventory control system.
- C. A technical laboratory director shall establish and implement an inventory control system for the marijuana testing facility's marijuana and marijuana products that documents:
  1. The following amounts in appropriate units:
    - a. Each day's beginning inventory of marijuana and marijuana products;
    - b. Marijuana and marijuana products accepted for testing, including verifying the amount of each sample of marijuana or marijuana product accepted for testing;
    - c. The portions of a sample of marijuana or a marijuana product removed for testing with the name of the marijuana facility agent removing each portion;
    - d. Marijuana and marijuana products transferred to or from another marijuana testing facility for testing of parameters or analytes that the marijuana testing facility receiving a sample from a marijuana establishment is not approved by the Department to conduct;
    - e. Marijuana and marijuana products transferred to another marijuana testing facility at the request of a marijuana establishment according to R9-18-311(C);
    - f. Marijuana or marijuana products that were disposed of, including verifying that the amount of marijuana or marijuana product being disposed of is consistent with the original amount accepted for testing minus the amounts used for testing or transferred to another marijuana testing facility; and
    - g. The day's ending marijuana and marijuana products inventory;
  2. The chain of custody for each sample of marijuana or a marijuana product submitted to the marijuana testing facility for testing;
  3. Any damage to a sample's container or possible tampering;
  4. As applicable, for submissions of marijuana and marijuana products for testing:
    - a. A description of the submitted marijuana or marijuana products including the amount, strain and batch number;

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- b. The name and marijuana establishment license number of the marijuana establishment that submitted the marijuana or marijuana products;
  - c. The name and marijuana facility agent license number of the marijuana facility agent that submitted the marijuana or marijuana products;
  - d. The name and identifying number recorded for the individual that submitted the marijuana or marijuana products according to R9-18-410(B)(1)(c);
  - e. The name and marijuana facility agent license number of the marijuana facility agent receiving the marijuana or marijuana products on behalf of the marijuana testing facility; and
  - f. The date of acquisition; and
5. For disposal of the remaining sample of marijuana or a marijuana product after testing:
- a. The unique sample identification assigned to the sample of medical marijuana or a marijuana product, according to R9-410(B)(1)(a);
  - b. The amount of the marijuana or marijuana product being disposed of;
  - c. Date of disposal;
  - d. Method of disposal; and
  - e. Name and marijuana facility agent license number of the marijuana facility agent responsible for the disposal.
- D.** The individual designated in subsection (B) shall conduct and document an audit of the marijuana testing facility's inventory that is accounted for according to generally accepted accounting principles at least once every 30 calendar days.
- 1. If the audit identifies a reduction in the amount of marijuana or marijuana products in the marijuana testing facility's inventory not due to documented causes, the technical laboratory director shall determine where the loss has occurred and take and document corrective action.
  - 2. If the reduction in the amount of marijuana or marijuana products in the marijuana testing facility's inventory is due to suspected criminal activity by a marijuana facility agent, the technical laboratory director shall report the marijuana facility agent to the Department and to the local law enforcement authorities and document the report.
- E.** A marijuana testing facility shall:
- 1. Maintain the documentation required in subsections (C) and (D) at the marijuana testing facility for at least five years after the date on the document, and
  - 2. Provide the documentation required in subsections (C) and (D) to the Department for review upon request.
- Historical Note**
- New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).
- R9-18-413. Security**
- A.** Except as provided in R9-18-405(8), a marijuana testing facility shall ensure that access to the area of the marijuana testing facility where marijuana or marijuana products are being tested or stored for testing is limited to a marijuana testing facility's owners and authorized marijuana facility agents.
- B.** A marijuana facility agent associated with a marijuana testing facility may only transport marijuana or marijuana products submitted for testing to a marijuana testing facility licensed under this Chapter.
- C.** Before transportation to a marijuana testing facility, a marijuana facility agent associated with the marijuana testing facility shall:
- 1. Complete a trip plan that includes:
    - a. The name of the marijuana facility agent in charge of transporting the marijuana or marijuana products;
    - b. The date and start time of the trip;
    - c. A description of the marijuana or marijuana products being transported;
    - d. Any anticipated stops during the trip, including the locations of the stops and arrival time and departure time for each location; and
    - e. The anticipated route of transportation; and
  - 2. Provide a copy of the trip plan in subsection (C)(1) to the marijuana testing facility.
- D.** During transportation to the marijuana testing facility, a marijuana facility agent associated with the marijuana testing facility shall:
- 1. Carry a copy of the trip plan in subsection (C)(1) with the marijuana facility agent for the duration of the trip;
  - 2. Use a vehicle:
    - a. Without any marijuana identification;
    - b. Equipped with a global positioning system or other means of tracking the location of the vehicle;
    - c. With an operational video surveillance system and recording equipment that:
      - i. Shows the interior of the vehicle, including the driver's seat and location of the marijuana, marijuana plants, or marijuana products being transported;
      - ii. Is turned on for the duration of a trip while marijuana or a marijuana product is in the vehicle; and
      - iii. Either stores the recording for at least 30 calendar days or transmits the recorded images at the time of recording to another location, where the recorded images are stored for at least 30 calendar days; and
    - d. With a locked compartment in which any marijuana or marijuana products being transported may be stored during a trip;
  - 3. Have a means of communication with the marijuana testing facility;
  - 4. Notate the arrival and departure time for each stop; and
  - 5. Ensure that the marijuana or marijuana products are stored in the locked compartment specified in subsection (D)(2)(d) and are not visible.
- E.** After transportation, a marijuana facility agent associated with a marijuana testing facility shall enter the end time of the trip and any changes to the trip plan on the trip plan required in subsection (C)(1).
- F.** If a marijuana facility agent associated with a marijuana establishment transports marijuana or a marijuana product to a marijuana testing facility for testing, the marijuana testing facility shall require that a copy of the trip plan be provided by the marijuana establishment before accepting the marijuana or marijuana product for testing.
- G.** A marijuana testing facility shall:
- 1. Maintain the documents required in subsections (C)(2), (E), and (F); and

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2. Provide a copy of the documents required in subsections (C)(2), (E), and (F) to the Department for review upon request.
- H.** To prevent unauthorized access to marijuana or marijuana products at the marijuana testing facility for testing, the marijuana testing facility shall have the following:
1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include:
    - a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio frequency method, such as cellular, private radio signals, or other mechanical or electronic device;
    - b. Exterior lighting to facilitate surveillance;
    - c. Electronic monitoring including:
      - i. At least one 19-inch or greater call-up monitor;
      - ii. A printer capable of immediately producing a clear still photo from any video camera image;
      - iii. Video cameras:
        - (1) Providing coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and
        - (2) Having a recording resolution of at least 704 x 480 or the equivalent;
      - iv. A video camera in each area of the marijuana testing facility where marijuana or marijuana products are being tested or stored for testing capable of identifying any activity occurring within the area in low light conditions;
      - v. Storage of video recordings from the video cameras for at least 30 calendar days;
      - vi. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; and
      - vii. Sufficient battery backup for video cameras and recording equipment to support at least five minutes of recording in the event of a power outage; and
    - d. Panic buttons in the interior of each building; and
  2. Policies and procedures that:
    - a. Restrict access to the areas of the marijuana testing facility that contain marijuana or marijuana products and, if applicable, to authorized individuals only;
    - b. Provide for the identification of authorized individuals; and
    - c. Prevent loitering.
- B.** A marijuana testing facility shall ensure that:
1. Storage areas are designated for:
    - a. Marijuana and marijuana products awaiting testing;
    - b. Reagents, standards, and other testing related chemicals or materials; and
    - c. The remaining portions of tested marijuana and marijuana products retained according to R9-18-405(5)(c)(vi);
  2. Designated storage areas are monitored to ensure that a:
    - a. Room temperature storage area is maintained between 20°C and 28°C,
    - b. Refrigerated storage area is maintained between 2°C and 8°C, and
    - c. Freezer storage area is maintained at or less than -20°C;
  3. A storage area for the storage of marijuana or marijuana product awaiting testing is labelled to indicate the temperature range and types of marijuana or marijuana products to be stored in the storage area;
  4. Marijuana or a marijuana product awaiting testing is stored at an appropriate temperature, as specified on the packaged sample;
  5. Reagents, standards, and other testing related chemicals or materials are stored according to manufacturer's directions; and
  6. The remaining portions of tested marijuana and marijuana products are stored in a refrigerated storage area or a freezer storage area to reduce microbial proliferation.
- C.** A marijuana testing facility shall ensure that a designated area for testing marijuana or a marijuana product for microbial contaminants is maintained in a manner to prevent exposure of the marijuana or marijuana product to external microbial contaminants.
- D.** A marijuana testing facility shall ensure that a designated area for testing marijuana or a marijuana product for pesticides, fungicides, mycotoxins, growth regulators, heavy metals, or residual solvents is maintained in a manner to prevent exposure of the marijuana or marijuana product to external contamination.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-415. Denial, Suspension, or Revocation of a Marijuana Testing Facility License**

- A.** The Department shall deny an application for or renewal of a marijuana testing facility license if:
1. An owner:
    - a. Has been convicted of an excluded felony offense, or
    - b. Is under 21 years of age; or
  2. The application or the marijuana testing facility does not comply with the requirements in A.R.S. Title 36, Chapter 28.2 and this Chapter.
- B.** The Department may deny an application for or renewal of a marijuana testing facility license if an owner of the marijuana testing facility provides false or misleading information to the Department.
- C.** The Department may deny an application for approval of a parameter for testing, submitted according to R9-18-403 or R9-18-411, if the applicant does not demonstrate compliance

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

**R9-18-414. Physical Plant**

- A.** A marijuana testing facility shall ensure that designated storage areas for marijuana or marijuana products or materials used in direct contact with marijuana or marijuana products are:
1. Separate from storage areas for toxic or flammable materials; and
  2. Maintained in a manner to prevent:
    - a. Microbial contamination and proliferation, and
    - b. Contamination or infestation by insects or rodents.



## TITLE 9. HEALTH SERVICES

## CHAPTER 18. DEPARTMENT OF HEALTH SERVICES - ADULT-USE MARIJUANA PROGRAM

with the requirements of this Article related to the parameter or testing of an analyte.

**D.** The Department may suspend or revoke a marijuana testing facility license if:

1. The marijuana testing facility:
  - a. Provides false or misleading information to the Department;
  - b. Begins testing marijuana to satisfy requirements in R9-18-311 before obtaining approval for testing from the Department;
  - c. Diverts marijuana to an individual who or entity that is not allowed to possess marijuana, pursuant to A.R.S. Title 36, Chapter 28.1 or 28.2; or
  - d. Acquires marijuana from an individual who or entity that is not allowed to possess marijuana, pursuant to A.R.S. Title 36, Chapter 28.1 or 28.2;
2. An owner:
  - a. Has been convicted of an excluded felony offense, or
  - b. Provides false or misleading information to the Department; or
3. The marijuana testing facility does not:
  - a. Comply with:
    - i. The requirements in A.R.S. Title 36, Chapter 28.2, and this Chapter; or
    - ii. The provisions in a corrective action plan submitted according to R9-18-406(F)(6)(b); or

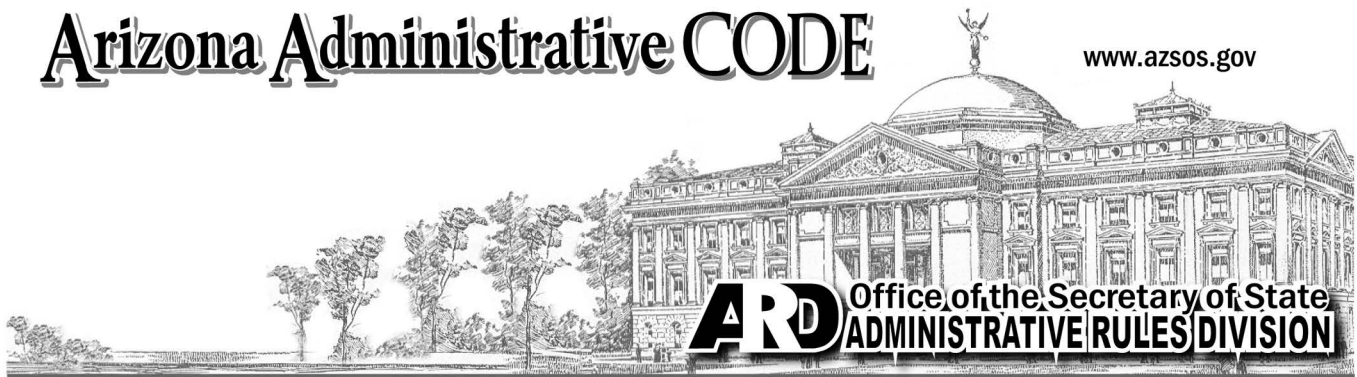
- b. Implement the policies and procedures or comply with the statements provided to the Department with the marijuana testing facility's application.

- E.** The Department may revoke a marijuana testing facility's approval of a parameter for testing if the marijuana testing facility does not continue to demonstrate compliance with the requirements of this Article related to the parameter or testing of an analyte.
- F.** If the Department denies a marijuana testing facility license application, the Department shall provide notice to the applicant that includes:
  1. The specific reason or reasons for the denial, and
  2. All other information required by A.R.S. § 41-1076.
- G.** If the Department suspends or revokes a marijuana testing facility license, the Department shall provide notice to the marijuana testing facility that includes:
  1. The specific reason or reasons for the revocation; and
  2. The process for requesting a review of the Department's decision pursuant to A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

New Section made by exempt rulemaking at 27 A.A.R. 696, effective May 1, 2021 (Supp. 21-2). Amended by exempt rulemaking at 29 A.A.R. 2453 (October 13, 2023), effective October 1, 2023 (Supp. 23-3).

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9 A.A.C. 22

Supp. 24-4

## TITLE 9. HEALTH SERVICES

### CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

The table of contents on page one contains links to the referenced page numbers in this Chapter.  
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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**The release of this Chapter in Supp. 24-4 replaces Supp. 24-3, 1-156 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided under A.R.S. § 41-1001. “*Rule*’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 9. HEALTH SERVICES

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

Authority: A.R.S. § 36-2901 et seq.

## Supp. 24-4

*Editor's Note: Historical notes for Sections made, repealed or amended in Supp. 14-1 were updated to reflect the effective date as immediate per the original notice filed by the agency. A number of other publication errors have been corrected in Supplement 20-4 that should have been made in Supp. 14-1. These include: adding new Sections R9-22-301 and R9-22-302; correcting a punctuation error in R9-22-1401; repealing Sections R9-22-1407 and R9-22-1443; and the amending of R9-22-1501 (Supp. 20-4).*

*Editor's Note: The Office of the Secretary of State prints all Code Chapters on white paper (Supp 01-3).*

*Editor's Note: This Chapter contains rules which were adopted or amended under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6), under Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1993, Ch. 6, § 34. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; the Governor's Regulatory Review Council did not review these rules; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.*

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*Article 22, consisting of Sections R9-22-901 through R9-22-908, adopted effective August 29, 1985.*

*Former Article 22, consisting of Section R9-22-901, repealed effective October 1, 1983.*

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*Article 10, consisting of Section R9-22-1001 through R9-22-1002, adopted effective November 7, 1997 (Supp. 97-4).*

*Article 10, consisting of Section R9-22-1001 through R9-22-1002, repealed effective November 7, 1997 (Supp. 97-4).*

*Article 10 consisting of Sections R9-22-1001 and R9-22-1002 adopted effective October 1, 1985.*

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*Article 12, consisting of Sections R9-22-1201 through R9-22-1208, repealed; new Article 12, consisting of Sections R9-22-1201 through R9-22-1208 adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4).*

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*Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-*



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Article 14, consisting of Sections R9-22-1401 through R9-22-1436, repealed; new Article 14, consisting of Sections R9-22-1401 through R9-22-1433 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Article 14, consisting of Sections R9-22-1401 through R9-22-1436, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

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Article 15, consisting of Sections R9-22-1501 through R9-22-1508, repealed; new Article 15, consisting of Sections R9-22-1501 through R9-22-1505 made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Article 15, consisting of Sections R9-22-1501 through R9-22-1508, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

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Article 16, consisting of Section R9-22-1601 made by final rulemaking at 20 A.A.R. 3436, effective January 1, 2015 (Supp. 14-4).

Article 16, consisting of Sections R9-22-1601 through R9-22-1612, R9-22-1614 through R9-22-1616, and R9-22-1618 through R9-22-1619, expired at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

Article 16, consisting of Sections R9-22-1601 through R9-22-1636, repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Article 16, consisting of Sections R9-22-1601 through R9-22-1613, R9-22-1615 through R9-22-1620, R9-22-1622 through R9-22-1631, R9-22-1633, R9-22-1634, and R9-22-1636, adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

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*New Article 18, consisting of Sections R9-22-1801 through R9-22-1806, made by final rulemaking at 30 A.A.R. 1977 (May 31, 2024), effective June 26, 2024. AHCCCS was granted an earlier effective date one day before the renewed emergency was due to expire to maintain continuity of administering this Article (Supp. 24-2).*

*Article 18, consisting of Sections R9-22-1801 through R9-22-1806, emergency renewed at 30 A.A.R. 69 (January 12, 2024) with an immediate effective date of December 21, 2023 (Supp. 23-4).*

*Article 18, consisting of Sections R9-22-1801 through R9-22-1806, made by emergency rulemaking at 29 A.A.R. 1577 (July 14, 2023), with an immediate effective date of July 3, 2023 (Supp. 23-3).*

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*Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).*

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- A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-701
"Active treatment"	R9-22-1301
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Adult behavioral health therapeutic home"	9 A.A.C. 10, Article 1
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Agency"	R9-22-1201
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary service"	R9-22-101
"Anticipatory guidance"	R9-22-201
"Annual enrollment choice"	R9-22-1701
"APC"	R9-22-701
"Applicant"	R9-22-101 or R9-22-301
"Application"	R9-22-101
"Assessment"	R9-22-1101 or R9-22-1201
"Assignment"	R9-22-101
"Attending physician"	R9-22-101 or R9-22-202
"Authorized representative"	R9-22-101
"Authorization"	R9-22-202
"Auto-assignment algorithm"	R9-22-1701
"AZ-NBCCEDP"	R9-22-2001
"Behavior management services"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health paraprofessional"	R9-22-101
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"Behavioral health recipient"	R9-22-201
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"Calculated inpatient costs"	R9-22-712.07
"Capital costs"	R9-22-701
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"Child"	R9-22-1503
"Children's Rehabilitative Services" or "CRS"	R9-22-101 or R9-22-301
"Chronic"	R9-22-1301
"Claim"	R9-22-1101
"Claims paid amount"	R9-22-712.07
"Clean claim"	A.R.S. § 36-2904
"Clinical oversight"	9 A.A.C. 10
"CMDP"	R9-22-1701
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contract year"	R9-22-101
"Contractor"	A.R.S. § 36-2901 or R9-22-210.01

"Copayment"	R9-22-701
"Cost avoid"	R9-22-1201
"Cost-To-Charge Ratio" or "CCR"	R9-22-701 or R9-22-712
"Court-ordered evaluation"	R9-22-1201
"Court-ordered pre-petition screening"	R9-22-1201
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"Covered charges"	R9-22-701
"Covered services"	R9-22-101
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"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"Crisis services"	R9-22-1201
"Critical Access Hospital"	R9-22-701
"CRS application"	R9-22-1301
"CRS condition"	R9-22-1301
"CRS provider"	R9-22-1301
"Cryotherapy"	R9-22-2001
"Customized DME"	R9-22-212
"Day"	R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action"	R9-22-1441
"DBHS"	R9-22-101
"DCSS"	R9-22-301
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101 or R9-22-1401
"DES"	R9-22-101
"Diagnostic services"	R9-22-101
"Direct graduate medical education costs" or "direct program costs"	R9-22-701
"Direct supervision"	R9-22-1201
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	R9-22-1701
"DME"	R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligibility posting"	R9-22-701
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"Emergency behavioral health condition for a non-FES member"	R9-22-201
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**B. General definitions.** In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or non-contracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Ancillary service" means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

"Applicant" means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Behavioral health paraprofessional" means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution,

If the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33,

If the behavioral health services were provided in a setting other than a licensed health care institution; and

Are provided under supervision by a behavioral health professional R9-10-101.

"Behavioral Health Professional" has the same meaning as defined A.A.C. R9-10-101 excluding subsection (g).

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Children's Rehabilitative Services" or "CRS" means the program that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Contract year" means the period beginning on October 1 of a year and continuing until September 30 of the following year.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

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“Day” means a calendar day unless otherwise specified.

“DBHS” means the Division of Behavioral Health Services within the Arizona Department of Health Services.

“DES” means the Department of Economic Security.

“Diagnostic services” means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

“Director” means the Director of the Administration or the Director’s designee.

“Discussion” means an oral or written exchange of information or any form of negotiation.

“DME” means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

“Equity” means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

“Facility” means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

“FBR” means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

“Fee-For-Service” or “FFS” means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

“FES member” means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

“FESP” means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

“FQHC” means federally qualified health center.

“GSA” means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

“Hospital” means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

“IHS” means Indian Health Service.

“IMD” or “Institution for Mental Diseases” means an Institution for Mental Diseases as described in 42 CFR 435.1010 that is licensed by ADHS.

“Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.

“License” or “licensure” means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

“Mailing date” when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

“Medical record” means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

“Medical supplies” means consumable items that are designed specifically to meet a medical purpose.

“Medically necessary” means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

“Medicare claim” means a claim for Medicare-covered services for a member with Medicare coverage.

“Non-FES member” means an eligible person who is entitled to full AHCCCS services.

“Offeror” means an individual or entity that submits a proposal to the Administration in response to an RFP.

“Physician” means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

“Practitioner” means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

“Prescription” means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

“Primary care provider” or “PCP” means an individual who meets the requirements of A.R.S. § 36-2901 (14), and who is responsible for the management of a member’s health care.

“Prior authorization” means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment.

“Prior period coverage” means the period prior to the member’s enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, which-

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ever is later, and continues until the day the member is enrolled with a contractor.

“Proposal” means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

“Radiology” means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

“Referral” means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

“Rehabilitation services” means physical, occupational, and speech therapies, and items to assist in improving or restoring a person’s functional level.

“Responsible offeror” means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

“Responsive offeror” means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

“Review” means a review of all factors affecting a member’s eligibility.

“Review month” means the month in which the individual’s or family’s circumstances and case record are reviewed.

“RFP” means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

“Service location” means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

“Service site” means a location designated by a contractor as the location at which a member is to receive covered services.

“S.O.B.R.A.” means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

“Specialist” means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

“Spouse” means a person who has entered into a contract of marriage recognized as valid by this state.

“SSN” means Social Security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

“Subcontract” means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor’s obligation to the Administration under the terms of a contract.

“Taxi” is as defined in A.R.S. § 28-101(53).

### Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-101 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-101 repealed, former Sections R9-22-102 and R9-22-301 renumbered as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency by adding new paragraphs (24), (46), (84) and (91) and renumbering accordingly effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency by adding new paragraphs (2) and (15) and renumbering accordingly effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment added paragraphs (2) and (15) and renumbered accordingly effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended paragraphs (10) and (15) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended by deleting paragraphs (39) and (62) and renumbering accordingly effective July 1, 1988 (Supp. 88-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking



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at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4).

Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3830, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-102. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-102 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1092 (Supp. 82-4). Former Section R9-22-102 renumbered together with former Section R9-22-301 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section adopted effective December 8, 1997 (Supp. 97-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Section repealed by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3).

**R9-22-103. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-104. Reserved****R9-22-105. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final

rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-106. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

**R9-22-107. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

**R9-22-108. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-109. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. effective 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-110. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-111. Reserved****R9-22-112. Repealed****Historical Note**

Adopted effective December 8, 1997 (Supp. 97-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Repealed by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

**R9-22-113. Reserved****R9-22-114. Repealed****Historical Note**

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New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

**R9-22-115. Repealed****Historical Note**

Final Section adopted at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 11 A.A.R. 5467, effective December 6, 2005 (Supp. 05-4).

**R9-22-116. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-117. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-118. Reserved****R9-22-119. Reserved****R9-22-120. Repealed****Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**ARTICLE 2. SCOPE OF SERVICES****R9-22-201. Scope of Services-related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Anticipatory guidance” means a person responsible for a child receives information and guidance of what the person should expect of the child’s development and how to help the child stay healthy.

“Behavioral health recipient” means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

“Benefit year” means a one-year time period of October 1st through September 30th.

“Emergency behavioral health condition for a non-FES member” means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health

and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

“Emergency behavioral health services for a non-FES member” means those behavioral health services provided for the treatment of an emergency behavioral health condition.

“Emergency medical condition for a non-FES member” means treatment for a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

Placing the member’s health in serious jeopardy,

Serious impairment to bodily functions, or

Serious dysfunction of any bodily organ or part.

“Emergency medical services for a non-FES member” means services provided for the treatment of an emergency medical condition.

“Hearing aid” means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

“Home health services” means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, rehabilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

“Occupational therapy” means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual’s ability to perform tasks required for independent functioning.

“Pharmaceutical service” means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

“Physical therapy” means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

“Post-stabilization services” means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

“Primary care provider services” means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

“Psychosocial rehabilitation services” means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

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Living skills training,

Cognitive rehabilitation,

Health promotion,

Supported employment, and

Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

Prevent the progression of disease, disability, or adverse health conditions; or

Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older

#### Historical Note

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-201 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

#### R9-22-202. General Requirements

A. For the purposes of this Article, the following definitions apply:

1. "Authorization" means written, verbal, or electronic authorization by:
  - a. The Administration for services rendered to a fee-for-service member, or
  - b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase "attending physician" applies only to the fee-for-service population.

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. A member may receive physical and behavioral health services as specified in Articles 2 and 12.
7. The Administration or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
8. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
  - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
  - b. Services or items furnished gratuitously, and
  - c. Personal care items except as specified under R9-22-212.
10. Medical or behavioral health services are not covered services if provided to:
  - a. An inmate of a public institution; or
  - b. A person who is in residence at an institution for the treatment of tuberculosis.

C. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.

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- D. Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- E. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F. A service is not a covered service if provided outside the GSA unless one of the following applies:
  1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
  2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
  3. The contractor authorizes placement in a nursing facility located out of the GSA; or
  4. Services are provided during prior period coverage or during the prior quarter coverage.
- G. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- H. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor electing to provide noncovered services.
  1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
  2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
  3. If a member requests a service that is not covered or is not authorized by a contractor, or the Administration, an AHCCCS-registered service provider may provide the service according to R9-22-702.
- K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
  1. R9-22-205(A)(8),
  2. R9-22-206,
  3. R9-22-207,
  4. R9-22-212(C),
  5. R9-22-212(D),
  6. R9-22-212(E)(8),
  7. R9-22-215(C)(5), (C)(6), and
  8. R9-22-215(C)(4).

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-202 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective July 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 22, 1995 (Supp. 95-3). Amended effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

**R9-22-203. Experimental Services**

- A. Experimental services are not covered. A service is not experimental if:
  1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.
  2. The service does not meet the standard in subsection (A)(1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
  3. The service does not meet the standard in subsection (A)(2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.
- B. The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:
  1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services.
  2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services.
  3. The frequency with which the service has been performed in the past.
  4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.

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5. The reputation and experience of the authors and/or specialists and their record in related areas.
6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-203 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1987; amended effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2).

Amended effective April 13, 1990 (Supp. 90-2).

Amended effective September 29, 1992 (Supp. 92-3).

Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed effective September 22, 1997 (Supp. 97-3). New Section made by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Section amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3).

**R9-22-204. Inpatient General Hospital Services**

- A. The following limitations apply to inpatient general hospital services that are provided by FFS providers.
  1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
    - a. Nonemergency and elective admission, including psychiatric hospitalization;
    - b. Elective surgery; and
    - c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
  2. The Administration or a contractor may deny a claim if a provider fails to obtain prior authorization.
  3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
    - a. Voluntary sterilization,
    - b. Dialysis shunt placement,
    - c. Arteriovenous graft placement for dialysis,
    - d. Angioplasties or thrombectomies of dialysis shunts,
    - e. Angioplasties or thrombectomies of arteriovenous graft for dialysis,
    - f. Hospitalization for vaginal delivery that does not exceed 48 hours,
    - g. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
    - h. Other services identified by the Administration through the Provider Participation Agreement.
  4. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization. A provider shall notify the Administration no later than 72 hours after an emergency admission.
- B. Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21

and older for claims with discharge dates on or before September 30, 2014. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

1. For purposes of calculating the limit:
  - a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
  - b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
  - c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
  - d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services,
  - e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
  - f. After 25 days of inpatient hospital services have been paid as provided for in this rule Section:
    - i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
    - ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
    - iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.
2. The following inpatient days are not included in the inpatient hospital limitation described in this Section:
  - a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
  - b. Days related to Behavioral Health:
    - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
    - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
    - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
  - c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
  - d. Same Day Admit Discharge services are excluded from the 25 day limit; and
  - e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-204 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective

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tive December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1745, effective October 1, 2012 (Supp. 12-2). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014 (Supp. 14-3). The incorrect label C was changed to B (Supp. 22-3).

**R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services**

- A.** A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examination and assessment;
  2. Evaluation and diagnostic workup;
  3. Medically necessary treatment;
  4. Prescriptions for medication and medically necessary supplies and equipment;
  5. Referral to a specialist or other health care professional if medically necessary;
  6. Patient education;
  7. Home visits if medically necessary; and
  8. Preventive health services, such as, well visits, immunizations, colonoscopies, mammograms and PAP smears.
- B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
  2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
    - a. Qualification for insurance,
    - b. Pre-employment physical evaluation,
    - c. Qualification for sports or physical exercise activities,
    - d. Pilot's examination for the Federal Aviation Administration,
    - e. Disability certification to establish any kind of periodic payments,
    - f. Evaluation to establish third-party liabilities, or
    - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
  3. Orthognathic surgery is covered only for a member who is less than 21 years of age;

4. The following services are excluded from AHCCCS coverage:
  - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
  - b. Pregnancy termination counseling services;
  - c. Pregnancy terminations, unless required by state or federal law.
  - d. Services or items furnished solely for cosmetic purposes; and
  - e. Hysterectomies unless determined medically necessary.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-205 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A), paragraph (15) and added paragraph (20) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(2) effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

*Editor's Note: The following Section was renumbered and a new Section adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not published as a proposed rule in the Arizona Administrative Register; the rule was not reviewed or approved by the Governor's Regulatory Review Council; and the agency was not required to hold public hearings on the rule. This Section was subsequently amended through the regular rulemaking process.*

**R9-22-206. Organ and Tissue Transplant Services**

- A.** Organ and tissue transplant services are covered for a member if prior authorized and coordinated with the member's contractor, or the Administration. Only the following transplants are covered for individuals 21 years of age or older:
1. Heart, including transplants for the treatment of non-ischemic cardiomyopathy;
  2. Liver, including transplants for patients with hepatitis C;
  3. Kidney (cadaveric and live donor);
  4. Simultaneous Pancreas/Kidney (SPK);
  5. Autologous and Allogeneic related and unrelated Hematopoietic Cell transplants;
  6. Cornea;
  7. Bone;
  8. Lung; and
  9. Pancreas after a kidney transplant (PAK).
- B.** The following transplants are not covered for members 21 years of age or older:

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1. Pancreas only transplants if it is not performed simultaneously with or following a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with or following a kidney transplant.
  2. Intestine transplants, and
  3. Any other type of transplant not specifically listed in subsection (A).
- C. When there is a transplant of multiple organs, reimbursement will only be made for those covered.
- D. Organ and tissue transplant services are not covered for non-qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-206 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-206 renumbered to R9-22-218, new Section R9-22-206 adopted effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by exempt rulemaking at 16 A.A.R. 1386, effective July 15, 2010 (Supp. 10-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 1122, April 1, 2011 (Supp. 11-2).

**R9-22-207. Dental Services**

- A. The Administration or a contractor shall cover dental services for a member less than 21 years of age under R9-22-213.
- B. For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
  1. Except as specified in subsection (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
  2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

- C. For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
  2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-207 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-207 repealed, new Section R9-22-207 adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

**R9-22-208. Laboratory, Radiology, and Medical Imaging Services**

Laboratory, radiology, and medical imaging services are covered services if:

1. Prescribed by the member's attending physician, practitioner, primary care provider or a dentist, or prescribed by a physician or practitioner upon referral from the primary care provider or dentist.
2. Provided by licensed health care providers in a:
  - a. Hospital,
  - b. Clinic,
  - c. Physician's office, or
  - d. Other health care facility.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-208 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-208 repealed, new Section R9-22-208 adopted effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2).

**R9-22-209. Pharmaceutical Services**

- A. An inpatient or outpatient provider, including a hospital, clinic, other appropriately licensed health care facility, and pharmacy may provide covered pharmaceutical services.
- B. The Administration or a contractor shall require a provider to make pharmaceutical services:
  1. Available during customary business hours, and
  2. Located within reasonable travel distance of a member's residence.
- C. Pharmaceutical services are covered if:

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1. Prescribed for a member by the member's primary care provider, attending physician, practitioner, or dentist;
  2. Prescribed by a specialist upon referral from the primary care provider or attending physician; or
  3. The contractor or its designee authorizes the service.
- D.** The following limitations apply to pharmaceutical services:
1. A medication personally dispensed by a physician, dentist, or a practitioner within the individual's scope of practice is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
  2. A new prescription or refill in excess of a 30 day supply is not covered unless:
    - a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 90 day supply; or
    - b. The Contractor authorizes the prescription for an extended time period not to exceed a 90-day supply.
  3. An over-the-counter medication, in place of a covered prescription medication, is covered only if the over-the-counter medication is appropriate, equally effective, safe, and less costly than the covered prescription medication.
- E.** A contractor shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well being.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-209 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 24, 1986 (Supp. 86-5). Amended subsections (A) and (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C)(3), effective May 30, 1989 (Supp. 89-2). Amended under an exemption from the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-210. Emergency Medical Services for Non-FES Members****A. General provisions.**

1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definitions.
  - a. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS or a subcontractor of ADHS/DBHS.

- b. For the purposes of this Section and R9-22-210.01, "fiscal agent" means a person who bills and accepts payment for a hospital or emergency room provider.
  3. Verification. A provider of emergency medical services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
  4. Prior authorization.
    - a. Emergency medical services. A provider is not required to obtain prior authorization for emergency medical services.
    - b. Non-emergency medical services. If a non-FES member's medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider's subcontract with the contractor, whichever is applicable.
  5. Prohibition against denial of payment. Neither the Administration nor a contractor shall:
    - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms,
    - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services,
    - c. Deny or limit payment because the provider does not have a subcontract.
  6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
    - a. The claim was not a clean claim;
    - b. The claim was not submitted timely; and
    - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.
- B.** Additional requirements for emergency medical services for non-FES members enrolled with a contractor.
1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
  2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
  3. Contractor notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member's contractor within 10 days from the day that the member presented for the emergency medical service.
  4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital's, emergency room provider's, or fiscal agent's failure to provide timely notice, under this subsection.
- C.** Post-stabilization services for non-FES members enrolled with a contractor.
1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall



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request prior authorization from the contractor for post-stabilization services.

2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
  - a. The contractor does not respond to a request for prior authorization within one hour;
  - b. The contractor authorized to give the prior authorization cannot be contacted; or
  - c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
    - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care,
    - ii. A contractor physician assumes responsibility for the member's care through transfer,
    - iii. The contractor's representative and the treating physician reach agreement concerning the member's care, or
    - iv. The member is discharged.
5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

**D. Additional requirements for FFS members.**

1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-210 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-210 repealed, new Section R9-22-210 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), para-

graph (1) effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members**

**A. General provisions.**

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
  - a. Members enrolled with a contractor. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor.
  - b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses unless services are provided in an IHS or tribally operated 638 facility.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-201.
6. Prior authorization.
  - a. Emergency behavioral health services. A provider is not required to obtain prior authorization for emergency behavioral health services.
  - b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor

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and ADHS/DBHS or a subcontractor of ADHS/DBHS.

7. Prohibition against limitation or denial of payment. A contractor, TRBHA, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
    - a. On the basis of lists of diagnoses or symptoms;
    - b. Prior authorization was not obtained;
    - c. The provider does not have a contract;
    - d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
    - e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
  8. Grounds for denial. A contractor, the Administration, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
    - a. The claim was not a clean claim;
    - b. The claim was not submitted timely; or
    - c. The provider failed to provide timely notification under subsection (A)(9) to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS or the Administration.
  9. Notification.
    - a. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
    - b. A hospital, emergency room provider, or fiscal agent shall notify the Administration no later than 72 hours after a FFS member receiving emergency behavioral health services presents to a hospital for inpatient services.
  10. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
- B. Post-stabilization requirements for non-FES members.**
1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
  2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;

3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
  - a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
  - b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
  - c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
    - i. A contracted physician with privileges at the treating hospital assumes responsibility for the member's care;
    - ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
    - iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
    - iv. The member is discharged.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-211. Transportation Services**

- A. Emergency ambulance services.**
1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
    - a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
    - b. If no other appropriate means of transportation is available.
  2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
    - a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
    - b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
    - c. No prior authorization is required for reimbursement of these transports.
  3. The member's medical condition at the time of transport determines whether the transport is medically necessary.

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4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to provide notification is cause for denial.
  5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim that justifies the service.
- B.** The Administration or a contractor covers air ambulance services only if at least one criterion in subsection (B)(1) is met and at least one criterion in subsection (B)(2), or the criterion in subsection (B)(3) is met. The criteria are:
1. The air ambulance transport is initiated at the request of:
    - a. An emergency response unit,
    - b. A law enforcement official,
    - c. A clinic or hospital medical staff member, or
    - d. A physician or practitioner, and
  2. The point of pickup:
    - a. Is inaccessible by ground ambulance, or
    - b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance service will not suffice, or
  3. The medical condition of the member requires immediate intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.
- C.** Coverage of medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.
1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
  2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.
- D.** For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:
1. The transportation services are authorized by the Administration or the member's contractor or designee,
  2. The individual is an AHCCCS registered provider, and
  3. No other means of appropriate transportation is available.
- E.** The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved health care service site outside of the member's service area or county of residence.
- F.** The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:
1. A family member accompanying a member if:
    - a. The member is traveling to or returning from an approved health care service site outside of the member's service area or county of residence; and
    - b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
  2. An escort who is not a family member as follows:
    - a. If the member is traveling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence;
    - b. If the escort services are authorized by the Administration or the member's contractor or designee; and
    - c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.
- G.** A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
  2. All meals, lodging, and services of an escort accompanying the member under this Section.
- H.** A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-211 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3).

**R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies**

- A.** Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter; and
1. Prescribed by the primary care provider, attending physician, or practitioner; or
  2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner; and
  3. Authorized as required by the Administration, contractor, or contractor's designee.
- B.** Covered medical supplies are consumable items that are designed specifically to meet a medical purpose, are disposable, and are essential for the member's health.
- C.** Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic; and
1. Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
  2. Can withstand repeated use, and
  3. Is generally reusable by others.
- D.** Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portion of the body. Only those prosthetics

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that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.

E. The following limitations on coverage apply:

1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:
  - a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
  - b. If the member is no longer eligible for AHCCCS services; or
  - c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
  - a. The member is over 3 years old and under 21 years old;
  - b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
  - c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
  - d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
  - e. The member obtains incontinence briefs from providers in the contractor's network;
  - f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:

- i. The member is over age 3 and under age 21;
- ii. The member has a disability that causes incontinence of bladder or bowel, or both;
- iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
- iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

7. First aid supplies are not covered unless they are provided in accordance with a prescription.
8. The following services are not covered for individuals 21 years of age or older:
  - a. Hearing aids;
  - b. Prescriptive lenses unless they are the sole visual prosthetic device used by the member after a cataract extraction;
  - c. Bone Anchor Hearing Aid (BAHA);
  - d. Cochlear implant;
  - e. Percussive vest;
  - f. Insulin pump;
  - g. Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
  - h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.

F. Liability and ownership.

1. Purchased DME that is provided to a member and no longer needed by the member may be disposed of in accordance with each contractor's policy.
2. The Administration shall retain title to purchased DME provided to a member who becomes ineligible or no longer requires use of the DME.
3. If customized DME is purchased by the Administration or contractor for a member, the equipment shall remain with the person during times of transition to a different contractor, or upon loss of eligibility. For purposes of this subsection, customized DME refers to equipment that is altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.
4. A member shall return DME obtained fraudulently to the Administration or the contractor.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-212 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-212 repealed, new Section R9-22-212 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (2), and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp.

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07-3). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3).

**R9-22-213. Early and Periodic Screening, Diagnosis, and Treatment Services (E.P.S.D.T.)**

**A.** The following E.P.S.D.T. services are covered for a member less than 21 years of age:

1. Screening services including:
  - a. Comprehensive health and developmental history;
  - b. Comprehensive unclothed physical examination;
  - c. Appropriate immunizations according to age and health history;
  - d. Laboratory tests; and
  - e. Health education, including anticipatory guidance;
2. Vision services including:
  - a. Diagnosis and treatment for defects in vision;
  - b. Eye examinations for the provision of prescriptive lenses;
  - c. Prescriptive lenses; and
  - d. Frames.
3. Hearing services including:
  - a. Diagnosis and treatment for defects in hearing;
  - b. Testing to determine hearing impairment; and
  - c. Hearing aids;
4. Dental services including:
  - a. Emergency dental services as specified in R9-22-207;
  - b. Preventive services including screening, diagnosis, and treatment of dental disease; and
  - c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Medically necessary, nutritional assessment and nutritional therapy as specified in contract to provide complete daily dietary requirements or supplement a member's daily nutritional and caloric intake;
7. Behavioral health services under 9 A.A.C. 22, Article 12;
8. Hospice services do not include home-delivered meals or services provided and covered through Medicare. The following hospice services are covered:
  - a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
  - b. Services available to a member receiving hospice care are limited to those allowable under 42 CFR 418.202, October 1, 2006, incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments;
9. Incontinence briefs as specified under R9-22-212; and
10. Other necessary health care, diagnostic services, treatment, and measures required by 42 U.S.C. 1396d(r)(5).

**B.** Providers of E.P.S.D.T. services shall meet the following standards:

1. Ensure that services are provided by or under the direction of the member's primary care provider, attending physician, practitioner, or dentist.
2. Perform tests and examinations under 42 CFR 441 Subpart B, October 1, 2006, which is incorporated by reference and on file with the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer a member as necessary for dental diagnosis and treatment and necessary specialty care.

4. Refer a member as necessary for behavioral health evaluation and treatment services.

**C.** Contractors shall meet other E.P.S.D.T. requirements as specified in contract.

**D.** A primary care provider, attending physician, or practitioner shall refer a member with special health care needs under R9-7-301 to CRS.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-213 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-213 repealed, new Section R9-22-213 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September 11, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-214. Repealed**

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-214 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-214 repealed, new Section R9-22-214 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraph (4) and added subsection (C), paragraph (2) effective October 1, 1986 (Supp. 86-5). Correction to subsection (C), paragraph (2) (Supp. 87-4). Section repealed effective September 22, 1997 (Supp. 97-3).

**R9-22-215. Other Medical Professional Services**

**A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office:

1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:
  - a. Medications,
  - b. Supplies,
  - c. Devices, and
  - d. Surgical procedures;
3. Family planning services are limited to:
  - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
  - b. Sterilization; and
  - c. Natural family planning education or referral;
4. Midwifery services provided by a certified nurse practitioner in midwifery;
5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
6. Respiratory therapy;

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7. Ambulatory and outpatient surgery facilities services;
  8. Home health services under A.R.S. § 36-2907(D);
  9. Private or special duty nursing services;
  10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
  11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract; and
  12. Chemotherapy.
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(3)(b), and (A)(4) through (11); except for:
1. Voluntary sterilization;
  2. Dialysis shunt placement;
  3. Arteriovenous graft placement for dialysis;
  4. Angioplasties or thrombectomies of dialysis shunts;
  5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
  6. Eye surgery for the treatment of diabetic retinopathy;
  7. Eye surgery for the treatment of glaucoma;
  8. Eye surgery for the treatment of macular degeneration;
  9. Home health visits following an acute hospitalization (limited up to five visits);
  10. Hysteroscopies (up to two, one before and one after) when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization;
  11. Physical therapy subject to the limitation in subsection (C);
  12. Facility services related to wound debridement;
  13. Apnea management and training for premature babies up to the age of 1; and
  14. Other services identified by the Administration through the Provider Participation Agreement.
- C.** The following are not covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
  2. Abortion counseling;
  3. Services or items furnished solely for cosmetic purposes;
  4. Services provided by a podiatrist; or
  5. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored.
  6. More than 15 outpatient physical therapy visits per benefit year for persons age 21 years or older for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-215 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by exempt rulemaking at 16 A.A.R. 1638, effective October 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by final

rulemaking at 20 A.A.R. 1949, effective September 6, 2014 (Supp. 14-3).

**R9-22-216. NF, Alternative HCBS Setting, or HCBS**

- A.** Services provided in a NF, including room and board, an alternative HCBS setting as defined in R9-28-101, or a HCBS as defined in A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.
- B.** Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
1. Nursing services, including:
    - a. Administering medication;
    - b. Tube feedings;
    - c. Personal care services, including but not limited to assistance with bathing and grooming;
    - d. Routine testing of vital signs; and
    - e. Maintenance of a catheter;
  2. Basic patient care equipment and sickroom supplies, including:
    - a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
    - b. Bathing and grooming supplies;
    - c. Identification device;
    - d. Skin lotion;
    - e. Medication cup;
    - f. Alcohol wipes, cotton balls, and cotton rolls;
    - g. Rubber gloves (non-sterile);
    - h. Laxatives;
    - i. Bed and accessories;
    - j. Thermometer;
    - k. Ice bags;
    - l. Rubber sheeting;
    - m. Passive restraints;
    - n. Glycerin swabs;
    - o. Facial tissue;
    - p. Enemas;
    - q. Heating pad; and
    - r. Incontinence briefs.
  3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;
  4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal or state licensure standard or county certification requirement;
  5. Physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
  6. Physical therapy prescribed only as a maintenance regimen; and
  7. Assistive devices and non-customized durable medical equipment.
- C.** A provider shall obtain prior authorization from the Administration for a NF admission for a FFS member.

**Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Subsection (C) amended to correct a typographical error (Supp. 00-4). Amended by final rulemaking at 8 A.A.R. 2325, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 13 A.A.R. 3272, effective September

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11, 2007 (Supp. 07-3). Amended by final rulemaking at 13 A.A.R. 4122, effective November 6, 2007 (Supp. 07-4).

**R9-22-217. Services Included in the Federal Emergency Services Program**

- A.** Definition. Notwithstanding the definition in R9-22-201, for the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, 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:
1. Placing the member's health in serious jeopardy,
  2. Serious impairment to bodily functions,
  3. Serious dysfunction of any bodily organ or part, or
  4. Serious physical harm to another person.
- B.** Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for a FES member with End Stage Renal Disease (ESRD) where a treating physician has certified for the month in which services are received that in the physician's opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the member's health in serious jeopardy, or
  2. Serious impairment of bodily function, or
  3. Serious dysfunction of a bodily organ or part.
- C.** Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered. The Administration shall determine whether an emergency condition exists on a case-by-case basis.
- D.** Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).
- E.** Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

**Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3351, effective November 10, 2007 (Supp. 07-3). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1868, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended

by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-218. Repealed**

**Historical Note**

Section R9-22-218 renumbered from R9-22-206 effective January 1, 1996, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Third Special Session, Ch. 1, § 5; filed with the Office of the Secretary of State December 28, 1995 (Supp. 95-4). Section repealed effective September 22, 1997 (Supp. 97-3).

**ARTICLE 3. GENERAL ELIGIBILITY REQUIREMENTS**

**R9-22-301. General Eligibility Definitions**

Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 14 and Article 15 have the following meanings unless the context explicitly requires another meaning:

"Applicant," notwithstanding R9-22-101, means a person listed on an application for whom AHCCCS coverage is being sought.

"BHS" means the division of Behavioral Health Services within the Arizona Department of Health Services.

"CRS" means the program administered by the Administration or its designee that provides covered medical services and covered support services in accordance with A.R.S. 36-261.

"DCSS" means the Division of Child Support Services, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.

"FAA" means the Family Assistance Administration, the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to a member and for determining eligibility for AHCCCS medical coverage.

"Income" means combined earned and unearned income.

"Medical support" means to provide health care coverage in the form of health insurance or court-ordered payment for medical care.

"Member" means an applicant who has been determined to qualify for AHCCCS coverage by the Administration or its designee.

"Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.

"Resources" means real and personal property, including liquid assets.

"Sponsor" means an individual who signs the USCIS I-864 Affidavit of Support agreeing to support a non-citizen as a condition of the non-citizen's admission for permanent residence in the United States.

"Sponsor deemed income" means the unearned income deemed available to the applicant named on the USCIS I-864 Affidavit of Support.

"SVES" means the State Verification and Exchange System, a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social

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Security Administration, and State Wage and Unemployment Insurance Benefit data files.

“USCIS” means the United States Citizen and Immigration Services.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-301 renumbered together with former Section R9-22-102 as Section R9-22-101 and amended effective October 1, 1983 (Supp. 83-5). New Section R9-22-301 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5).

Amended subsection (B), paragraph (8), subsection (E), paragraph (3), and subsection (J), paragraph (5) effective October 1, 1986 (Supp. 86-5). Amended subsections (C) and (E) effective January 1, 1987, filed December 31,

1986 (Supp. 86-6). Amended subsections (B) and (C) effective October 1, 1987; amended subsection (D) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

**R9-22-302. AHCCCS Eligibility Application****Application Process**

1. Right to apply. A person may apply for AHCCCS medical coverage by submitting an Administration-approved application to the Administration or its designee, an FAA office, or one of the following outstation locations:
  - a. A BHS site;
  - b. A Federally Qualified Health Center or disproportionate share hospital under 42 U.S.C. 1396r-4; or
  - c. Any other site, including a hospital, approved by the Administration or its designee.
2. Application. To initiate the application process, the Administration or its designee will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant by submitting a written or online application under 42 CFR 435.907.
  - a. A phone or written application must contain at least the following to be submitted to the Administration or its designee:
    - i. Applicant's legible name,
    - ii. Address or location where the applicant can be reached,
    - iii. Signature of the person submitting the application,
    - iv. Date the application was signed.
    - v. The Administration or its designee shall require that a third party witness the signing and attest

by signing the application if the individual signing the application signs with a mark.

- b. An online application must be completed in full in order to be submitted to the Administration or its designee.
3. Incomplete application. If the application is incomplete, the Administration or its designee shall do at least one of the following:
  - a. Contact an applicant or an applicant's representative by telephone or electronic medium to obtain the missing information required for an eligibility determination;
  - b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information; or
  - c. Meet with the applicant, representative, or household member.
4. Date of application. The date of application is the date application is received by the Administration or its designee either on-line or at a location listed in subsection (1).
5. Complete application form. The Administration or its designee shall consider an application complete when all questions are answered. The same person as listed under subsection (2) is the person that must sign the completed application. The application shall be witnessed and signed by a third party if the individual signing the application signs with a mark.
6. Assistance with application. The Administration or its designee shall allow a person of the applicant's choice to accompany, assist, and represent the applicant in the application process.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-302 repealed, new Section R9-22-302 adopted effective November 20, 1984 (Supp. 84-6). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section reserved by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). New Section made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; the adoption of this Section was slated to be codified in Supp. 14-1 but due to a clerical error, was not published. The new Section was published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

**R9-22-303. Prior Quarter Eligibility**

- A. Subject to CMS approval, prior quarter coverage eligibility shall be limited to applicants who meet the requirements in subsection (B) and who also:
  1. Are eligible during any of the three months prior to application; and
  2. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month; and
  3. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made.



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- B.** Prior quarter coverage eligibility is limited to applicants who are:

1. Under the age of 19, or
2. Pregnant, or
3. In the 60 day post-partum period beginning with the last day of the pregnancy.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-303 repealed, new Section R9-22-303 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5).

Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 1849, with an immediate effective date of July 1, 2019 (Supp. 19-3).

**R9-22-304. Verification of Eligibility Information**

- A.** Except as provided in subsection (E), if information provided by or on behalf of an applicant or member on an application, renewal form or otherwise does not conflict with information obtained by the agency through an electronic data match, the Administration or its designee shall determine or renew eligibility based on such information.
- B.** The Administration or its designee shall not require an applicant, member, or representative to provide additional verification unless the verification cannot be obtained electronically or the verification obtained electronically conflicts with information provided by or on behalf of the applicant or member.
- C.** If information provided by or on behalf of an applicant or member does conflict with information obtained through an electronic data match, the applicant or member shall provide the Administration or its designee with information or documentation necessary to verify eligibility, including evidence originating from an agency, organization, or an individual with actual knowledge of the information.
- D.** Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both meet or both exceed the applicable income limit.
- E.** The Administration or its designee shall not accept the applicant's or member's statement by itself as verification of:
1. SSN;
  2. Qualified alien status, except as described under 42 USC 1320b-7(d)(4)(A); or
  3. Citizenship, except as described under 42 USC 1396a(ee)(1).
- F.** The Administration or its designee shall give an applicant or member at least 10 days from the date of a written or electronic request for information to provide required verification. The Administration or its designee may deny the application or discontinue eligibility if an applicant or a member does not provide the required information timely.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-304 repealed, new Section R9-22-304 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-304

made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-305. Eligibility Requirements**

As a condition of eligibility, the Administration or its designee must require applicants, and members to do the following:

1. Take all necessary steps to obtain any annuities, pensions, retirement, disability benefits to which they are entitled, unless they can show good cause for not doing so.
2. Furnish a SSN under 42 CFR 435.910 and 435.920, or in the absence of an SSN, provide proof of a submitted application of SSN. The Administration or its designee will assist in obtaining or verifying the applicant's SSN under 42 CFR 435.910 if an applicant cannot recall the applicant's SSN or has not been issued a SSN. An applicant is not required to furnish an SSN if the applicant is not able to legally obtain a SSN. The Administration or its designee shall determine eligibility notwithstanding the applicant's lack of a SSN, if the applicant is cooperating with the Administration or its designee to obtain a SSN and obtain a SSN prior to the next scheduled review of eligibility.
3. Provide proof of residency of Arizona. An applicant or a member is not eligible unless the applicant or member is a resident of Arizona under 42 CFR 435.403 effective October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
4. A written declaration, signed under penalty of perjury, must be provided for each person for whom benefits are being sought stating whether the individual is a citizen or national of the United States, and, if that individual is not a citizen or national of the United States, that the individual is a qualified alien. The declaration must be provided by the individual for whom eligibility is being sought or an adult member of the individual's family or household.
5. Each applicant who claims qualified alien status must provide either:
  - a. Alien registration documentation or other proof of immigration registration from the Immigration and Naturalization Service that contains the individual's alien admission number or alien file number (or numbers if the individual has more than one number), or
  - b. Other documents that the Administration or its designee accepts as evidence of immigration status, such as:
    - i. A Form I-94 Departure Record issued by the USCIS,
    - ii. A Foreign Passport,
    - iii. A USCIS Parole Notice,
    - iv. A Victim of Trafficking Certification or Eligibility Letter issued by the US DHHS Office of Refugee Resettlement,
    - v. Other documentation consistent with 42 CFR 435.406 or 435.407.
  - c. Sufficient information for the Administration or its designee to obtain electronic verification of immigration status from the USCIS.
6. If a person for whom eligibility is being sought, states that they are an alien, that person is not required to comply with subsections (4) and (5); however, if they do not

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comply with those sections, and if they meet all other eligibility criteria, benefits will be limited to those necessary to treat an emergency medical condition.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-305 repealed, new Section R9-22-305 adopted effective November 20, 1984 (Supp. 84-6). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-305 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-306. Administration, Administration's designee or Member Responsibilities**

A. The Administration or its designee is responsible for the following:

1. The Administration or its designee shall determine eligibility within 90 days for an applicant applying on the basis of disability and 45 days for all other applicants, unless:
  - a. The agency cannot reach a decision because the applicant or an examining physician delays or fails to take a required action, or
  - b. When there is an administrative or other emergency beyond the agency's control.
2. If an applicant dies while an application is pending, the Administration or its designee shall complete an eligibility determination for the deceased applicant.
3. The Administration or its designee shall complete an eligibility determination on an application filed on behalf of a deceased applicant.
4. During the application process the Administration or its designee shall provide information to the applicant or member explaining the requirements to:
  - a. Cooperate with DCSS in establishing paternity and enforcing medical support, except in circumstances when good cause under 42 CFR 433.147 exists for not cooperating;
  - b. Establish good cause for not cooperating with DCSS in establishing paternity and enforcing medical support, when applicable;
  - c. Report a change listed under subsection (B)(3)(c) no later than 10 days from the date the applicant or member knows of the change;
  - d. Send to the Administration or its designee any medical support payments resulting from a court order;
  - e. Cooperate with the Administration or its designee's assignment of rights and securing payments received from any liable party for a member's medical care.
5. Offer to help the applicant or member to complete the application form and to obtain the required verification;
6. Provide the applicant or member with information explaining:
  - a. The eligibility and verification requirements for AHCCCS medical coverage;
  - b. The requirement that the applicant or member obtain and provide a SSN to the Administration or its designee;
  - c. How the Administration or its designee uses the SSN;

7. Explain to the applicant or member the practice of exchange of eligibility and income information through the electronic service established by the Secretary;
8. Explain to the applicant and member the right to appeal an adverse action under R9-22-315;
9. Use any information provided by the member to complete data matches with potentially liable parties;
10. Explain the eligibility review process;
11. Explain the AHCCCS pre-enrollment process;
12. Use the Systematic Alien Verification for Entitlements (SAVE) process to verify qualified alien status;
13. Provide information regarding the penalties for perjury and fraud on the application;
14. Review any verification items provided by the applicant or member and inform the member of any additional verification items and time-frames within which the applicant or member shall provide information to the Administration or its designee;
15. Explain to the applicant or member the applicant's and member's responsibilities under subsection (B);
16. Transfer the applicant's information to other insurance affordability programs as described under 42 CFR 435.1200(e) when the applicant does not qualify for Medicaid;
17. Attain a written record of a collateral contact: such as a verbal statement from a representative of an agency or organization, or an individual with actual knowledge of the information;
18. Complete a review of eligibility:
  - a. Any time there is a change in a member's circumstance that may affect eligibility,
  - b. For a member approved for the MED program under R9-22-1435 through R9-22-1440 before the end of the six-month eligibility period,
  - c. Of each member's continued eligibility for AHCCCS medical coverage once every 12 months;
19. The Administration or its designee shall discontinue eligibility and notify the member of the discontinuance under R9-22-307 if the member:
  - a. Fails to comply with the review of eligibility,
  - b. Fails to comply under 42 CFR 433.148 with the requirements and conditions of eligibility under this Article regarding assignment of rights and cooperation of establishing paternity and obtaining medical support, or
  - c. Does not meet the eligibility requirements; and
20. Redetermine eligibility for a person terminated from the SSI cash program.
  - a. Continuation of AHCCCS medical coverage. The Administration shall continue AHCCCS medical coverage for a person terminated from the SSI cash program until a redetermination of eligibility is completed.
  - b. Coverage group screening. Before terminating a person from the SSI cash program, the Administration shall determine if the person is eligible for coverage as a person described in A.R.S. §§ 36-2901(6)(a)(i) through (vi) or 36-2934.
  - c. Eligibility decision.
    - i. If a person is eligible under this Article or 9 A.A.C. 28, Article 4, the Administration shall send a notice informing the applicant that AHCCCS medical coverage is approved.

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- ii. If a person is ineligible, the Administration shall send a notice to deny AHCCCS medical coverage.
  - B. Applicant and Member Responsibilities.**
    - 1. An applicant or a member shall authorize the Administration or its designee to obtain verification for initial eligibility or continuation of eligibility.
    - 2. As a condition of eligibility, an applicant or a member shall:
      - a. Provide the Administration or its designee with complete and truthful information. The Administration or its designee may deny an application or discontinue eligibility if:
        - i. The applicant or member fails to provide information necessary for initial or continuing eligibility;
        - ii. The applicant or member fails to provide the Administration or its designee with written authorization or electronic authorization to permit the Administration or its designee to obtain necessary initial or continuing eligibility verification;
        - iii. The applicant or member fails to provide verification under R9-22-304 after the Administration or its designee made an effort to obtain the necessary verification but has not obtained the necessary information; or
        - iv. The applicant or member does not assist the Administration or its designee in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility;
      - b. Cooperate with the Division of Child Support Services (DCSS) in establishing paternity and enforcing medical support obligations when requested unless good cause exists for not cooperating under 42 CFR 433.147 as of October 1, 2012, which is incorporated by reference, on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments. The Administration or its designee shall not deny AHCCCS eligibility to an applicant who would otherwise be eligible, is a minor child, and whose parent or legal representative does not cooperate with the medical support requirements or first- and third-party liability requirements under Article 10 of this Chapter; and
      - c. Provide the information needed to pursue third party coverage for medical care, such as:
        - i. Name of policyholder,
        - ii. Policyholder's relationship to the applicant or member,
        - iii. Name and address of the insurance company, and
        - iv. Policy number.
    - 3. A member or an applicant shall:
      - a. Send to the Administration or its designee any medical support payments received while the member is eligible that result from a medical support order;
      - b. Cooperate with the Administration or its designee regarding any issues arising as a result of Eligibility
- Quality Control described under A.R.S. § 36-2903.01; and
  - c. Inform the Administration or its designee of the following changes within 10 days from the date the applicant or member knows of a change:
    - i. In address;
    - ii. In the household's composition;
    - iii. In income;
    - iv. In resources, when required under the Medical Expense Deduction (MED) program;
    - v. In Arizona state residency;
    - vi. In citizenship or immigrant status;
    - vii. In first- or third-party liability that may contribute to the payment of all or a portion of the person's medical costs;
    - viii. That may affect the member's or applicant's eligibility, including a change in a woman's pregnancy status;
    - ix. Death;
    - x. Change in marital status; or
    - xi. Change in school attendance.
  - 4. As a condition of eligibility, an applicant or a member shall cooperate with the assignment of rights as required by R9-22-311. If the applicant or member receives medical care and services for which a first or third party is or may be liable, the applicant or member shall cooperate with the Administration or its designee in assisting, identifying and providing information to assist the Administration or its designee in pursuing any first or third party who is or may be liable to pay for medical care and services.
  - 5. A pregnant woman under A.R.S. § 36-2901(6)(a)(ii) is not required to provide the Administration or its designee with information regarding paternity or medical support from a father of a child born out of wedlock.
- C. Administration or its designee responsibilities at Eligibility Renewal.**
  - 1. The Administration or its designee shall renew eligibility without requiring information from the individual if able to do so based on reliable information available to the agency, including through an electronic data match. If able to renew eligibility based on such information, the Administration or its designee shall send the member notice of:
    - a. The eligibility determination; and
    - b. The member's requirement to notify the Administration or its designee if any of the information contained in the renewal notice is inaccurate.
  - 2. If unable to renew eligibility, the Administration or its designee shall:
    - a. Send a pre-populated renewal form listing the information needed to renew eligibility,
    - b. Give the member 30 days from the date of the renewal form to submit the signed renewal form and the information needed,
    - c. Send the member notice of the renewal decision under R9-22-312 or R9-22-1413(B) as applicable.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-306 repealed, new Section R9-22-306 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B), paragraphs (1) and (6) effective October 1, 1986 (Supp. 86-5). Amended subsection (B),

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paragraph (1) and added a new subsection (N) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6).

Amended subsection (B) effective October 1, 1987; amended subsection (N) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-306 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-307. Approval or Denial of Eligibility**

**A.** Approval. If the applicant meets all the eligibility requirements and conditions of eligibility of this Article, the Administration or its designee shall approve the application and provide the applicant with an approval notice. The approval notice shall contain:

1. The name of each approved applicant,
2. The effective date of eligibility for each approved applicant,
3. The reason and the legal citations if a member is approved for only emergency medical services, and
4. The applicant's right to appeal the decision.

**B.** Denial. If an applicant fails to meet the eligibility requirements or conditions of eligibility of this Article, the Administration or its designee shall deny the application and provide the applicant with a denial notice. The denial notice shall contain:

1. The name of each ineligible applicant,
2. The specific reason why the applicant is ineligible,
3. The income and resource calculations for the applicant compared to the income or resource standards for eligibility when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard,
4. The legal citations supporting the reason for the ineligibility,
5. The location where the applicant can review the legal citations,
6. The date of the application being denied; and
7. The applicant's right to appeal the decision and request a hearing.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (C), added subsection (G) and (H) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-307 repealed, new Section R9-22-307 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5).

Amended subsection (A) as an emergency effective December 4, 1985 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 85-6). Permanent amendment to subsection (A) effective February 5, 1986 (Supp. 86-1).

Amended subsections (E) and (F) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective February 26, 1988 (Supp. 88-1).

Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Pro-

cedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-307 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-308. Reinstating Eligibility**

The Administration or its designee shall reopen an application or reinstate eligibility of a member when any of the following conditions are met:

1. The denial or discontinuance of eligibility was due to an administrative error,
2. The discontinuance of eligibility was due to noncompliance with a condition of eligibility and the applicant or member complies prior to the effective date of the discontinuance,
3. The member informs the Administration or its designee of a change of circumstances prior to the effective date of the discontinuance, that would allow for continued eligibility, or
4. Following a discontinuance, the member qualifies for continuation of medical coverage pending an appeal.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4).

Amended effective October 1, 1983 (Supp. 83-5).

Amended by adding subsection (C) effective March 2, 1984 (Supp. 84-2). Former Section R9-22-308 repealed, new Section R9-22-308 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-308 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-309. Confidentiality and Safeguarding of Information**

The Administration or its designee shall maintain the confidentiality of an applicant or member's records and limit the release of safeguarded information under R9-22-512 and 6 A.A.C. 12, Article 1. In the event of a conflict between R9-22-512 and 6 A.A.C. 12, Article 1, R9-22-512 prevails.

**Historical Note**

Adopted effective August 30, 1984 (Supp. 82-4).

Amended (D)(1)(d) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-309 repealed, new Section R9-22-309 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5).

Amended effective October 1, 1986 (Supp. 86-5).

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Amended subsection (F) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A), (B) and (C) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-309 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-310. Ineligible Person**

A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution, or
2. Over age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except as allowed in 42 USC 1396d(h) or as allowed under the Administration's Section 1115 waiver.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended (B)(7) and added subsections (C) and (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-310 repealed, new Section R9-22-310 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) and deleted subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (7) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-310 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-311. Assignment of Rights Under Operation of Law**

By operation of law and under A.R.S. § 36-2903, a person determined eligible assigns rights to the system medical benefits to which the person is entitled.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-311 repealed, new Section R9-22-311 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-311 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-312. Member Notices**

- A.** Contents of notice. The Administration or its designee shall issue a notice by mail, personal delivery, or electronic means when an action is taken regarding a person's eligibility or premiums. The notice shall contain the following information:
1. The date of the notice issued;

2. A statement of the action being taken;
3. The effective date of the action;
4. The specific reason for the intended action;
5. If eligibility is being discontinued due to income in excess of the income standards, the actual figures used in the eligibility determination and the amount by which the person exceeds income standards;
6. If a premium is imposed or increased, the actual figures used in determining the premium amount;
7. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
8. An explanation of the member's rights to an appeal and continued benefits.

- B.** Advance notice of changes in eligibility or premiums. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of the change. Except as specified in subsection (C), advance notice shall be issued whenever the following adverse action is taken:

1. To discontinue or suspend or reduce eligibility or covered services; or
2. To impose a premium or increase a person's premium.

- C.** The Administration or its designee shall issue a Notice of Adverse Action to a member no later than the effective date of action if:

1. The Administration or its designee receives a request to withdraw;
2. A person provides information that requires termination of eligibility or an increase or imposition of the premium and the person signs a clear written statement waiving advance notice;
3. A person cannot be located and mail sent to that person has been returned as undeliverable;
4. A person has been admitted to a public institution where the person is ineligible under R9-22-310;
5. A person has been approved for Medicaid or CHIP in another state; or
6. The Administration or its designee has information that confirms the death of the person.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended subsections (A) and (B), added subsection (D) effective October 1, 1983 (Supp. 83-5). Former Section R9-22-312 repealed, new Section R9-22-312 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-312 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-313. Withdrawal of Application**

- A.** An applicant may withdraw an application at any time before the Administration or its designee completes an eligibility determination by making an oral or written request for withdrawal to the Administration or its designee and stating the reason for withdrawal.

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- B. If an applicant orally requests withdrawal of the application, the Administration or its designee shall document the:
  1. Date of the request,
  2. Name of the applicant for whom the withdrawal applies, and
  3. Reason for the withdrawal.
- C. An applicant may withdraw an application in writing by:
  1. Completing an Administration-approved voluntary withdrawal form; or
  2. Submitting a written, signed, and dated request to withdraw the application.
- D. The effective date of the withdrawal is the date of the application.
- E. If an applicant requests to withdraw an application, the Administration or its designee shall:
  1. Deny the application, and
  2. Notify the applicant of the denial following the notice requirements under R9-22-307.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4).  
 Amended effective October 1, 1983 (Supp. 83-5).  
 Amended subsections (C) and (D) as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended subsections (D) and (E) as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-313 repealed, new Section R9-22-313 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E) and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B) and (C) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4).  
 Amended effective December 13, 1993 (Supp. 93-4).  
 Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-313 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-314. Withdrawal from AHCCCS Medical Coverage**

- A. A member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Administration or its designee. The member or the member's legal or authorized representative shall provide the Administration or its designee with:
  1. The reason for the withdrawal,
  2. The date the notice is effective, and
  3. The name of the member for whom AHCCCS medical coverage is being withdrawn.
- B. If a notice of withdrawal does not identify specific members the Administration or its designee shall discontinue eligibility

for any members that the person submitting the withdrawal has legal authority to act on behalf of.

- C. The Administration or its designee shall notify the member of the discontinuance as required by R9-22-312.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4).  
 Amended subsection (A) and added subsection (F) as an emergency effective February 28, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1).  
 Amended subsection (A) and added subsection (F) as a permanent rule effective May 16, 1983; text of the amended rule identical to the emergency (Supp. 83-3).  
 Former Section R9-22-314 repealed, new Section R9-22-314 adopted effective November 20, 1984 (Supp. 84-6).  
 Amended effective October 1, 1985 (Supp. 85-5).  
 Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-314 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-315. Notice of Adverse Action**

- A. Adverse actions. An applicant or member may appeal, as described under Chapter 34, by requesting a hearing from the Administration or its designee concerning any of the following adverse actions:
  1. Complete or partial denial of eligibility under R9-22-307 and R9-22-313(E);
  2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-307, R9-22-312 and R9-22-314;
  3. Delay in the eligibility determination beyond the timeframes under this Article;
  4. The imposition of or increase in a premium or copayment; or
  5. The effective date of eligibility.
- B. Notice of Adverse Action. The Administration or its designee shall personally deliver or send, by mail, or electronic means a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C. Automatic change and hearing rights.
  1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
  2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-315 repealed, new Section R9-22-315 adopted effective November 20, 1984 (Supp. 84-6).  
 Repealed effective October 1, 1985 (Supp. 85-5). New Section R9-22-315 adopted effective February 5, 1986 (Supp. 86-1). Amended effective February 26, 1988 (Supp. 88-1). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking

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at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-315 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-316. Exemptions from Sponsor Deemed Income**

- A.** An applicant shall provide proof to the Administration or its designee when claiming an exemption from sponsor deemed income.
- B.** The Administration or its designee shall grant an exemption from deeming a sponsor's income for a Lawful Permanent Resident applicant if the applicant:
  1. Adjusted immigration status to Lawful Permanent Resident from status as a refugee or asylee;
  2. Is the spouse or dependent child of the sponsor and lives with the sponsor;
  3. Is indigent as specified in subsection (C);
  4. Is a victim of domestic violence or extreme cruelty as specified in subsection (D); or
  5. Has acquired 40 qualified quarters of work credit based on earnings as specified in subsection (E).
- C.** Exemption from sponsor deeming based on indigence.
  1. The Administration or its designee shall consider the applicant indigent and grant an exemption from sponsor deemed income for an applicant, for a period of 12 months beginning with the first month of eligibility if all the following are met:
    - a. An applicant is indigent if all of the following are met:
      - i. The applicant does not reside with the applicant's sponsor;
      - ii. The applicant does not receive free room and board; and
      - iii. The applicant's total gross income including monies received from the sponsor and the value of any vendor payments received for food, utilities, or shelter does not exceed 100% of the FPL for the size of the income group.
    2. The Administration or its designee shall send a notice under 8 U.S.C. 1631(e)(2) to the Attorney General's Office when approving an applicant who is exempt from sponsor deemed income due to indigence.
- D.** The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who is a victim of domestic violence or extreme cruelty under 8 CFR 204.2 for a period of 12 months beginning with the first month of eligibility. The Administration or its designee shall redetermine the exemption status at each renewal.
  1. The Administration or its designee considers an applicant to be a victim of domestic violence or extreme cruelty when all of the following are met:
    - a. The applicant is the victim, the parent of a child victim, or the child of a parent victim;
    - b. The perpetrator of the domestic violence or extreme cruelty was the spouse or parent of the victim or other family member related by blood, marriage or adoption to the victim;
    - c. The perpetrator was residing in the same household as the victim when the abuse occurred;
    - d. The abuse occurred in the United States;
    - e. The applicant did not participate in the domestic violence or cruelty; and
    - f. The victim does not currently live with the perpetrator.
2. The applicant shall provide proof that the applicant or the applicant's child is a victim of domestic violence or extreme cruelty by presenting one of the following:
  - a. USCIS form I-360 Petition for Amerasian, Widow, or Special Immigrant;
  - b. USCIS form I-797 USCIS approval of the I-360 petition;
  - c. Reports or affidavits concerning the domestic violence or cruelty documented by police, judges, or other court officials, medical personnel, school officials, clergy, social workers, counseling or mental health personnel, or other social service agency personnel;
  - d. Legal documentation, such as an order of protection against the perpetrator or an order convicting the perpetrator of committing an act of domestic violence or extreme cruelty that chronicles the existence of domestic violence or extreme cruelty;
  - e. Evidence that indicates that the applicant sought safe haven in a battered women's shelter or similar refuge because of the domestic violence or extreme cruelty against the applicant or the applicant's child; or
  - f. Photographs of the applicant or applicant's child showing visible injury.
- E.** The Administration or its designee shall grant an exemption from sponsor deemed income for an applicant who has reached 40 qualifying quarters of work credit.
  1. The Administration or its designee shall not count quarters credited after January 1, 1997 that were earned while the applicant was receiving any federal means-tested benefits.
  2. The Administration or its designee shall not count the 40 qualifying quarters of work credit unless the credited quarters are:
    - a. Quarters that the applicant worked;
    - b. Quarters worked by the applicant's spouse or deceased spouse during their marriage; or
    - c. Quarters worked by the applicant's parents when the applicant was under age 18.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as an emergency effective February 9, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of permanent rule identical to the emergency (Supp. 83-3). Amended effective October 1, 1983 (Supp. 83-5). Correction subsection (A), paragraph (1) amended effective October 1, 1983, (Supp. 83-6). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-316 repealed, new Section R9-22-316 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (C) effective October 1986 (Supp. 86-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-316

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made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-317. Sponsor Deemed Income**

- A. The Administration or its designee shall use income of a USCIS sponsor to determine eligibility for a non-citizen applicant, whether or not the income is available, to the non-citizen applicant unless exempt under R9-22-316.
- B. Counting the income from a sponsor.
  1. This Section applies to non-citizen applicants who:
    - a. Are Lawful Permanent Residents under 8 CFR 101.3;
    - b. Applied for Lawful Permanent Resident Status on or after December 19, 1997;
    - c. Are sponsored by an individual who signed a USCIS I-864 Affidavit of Support; and
    - d. Are eligible for full AHCCCS medical coverage.
  2. Sponsor deemed income shall be considered the income of the non-citizen applicant only.
  3. The Administration or its designee shall not use the provisions of this Section when:
    - a. The applicant becomes a naturalized U.S. citizen;
    - b. The applicant qualifies for an exemption listed in R9-22-316; or
    - c. The sponsor dies.
- C. Determining income from a sponsor.
  1. For an applicant who is exempt from sponsor deeming under R9-22-316, only cash contributions actually received from the sponsor are countable income to the applicant.
  2. For an applicant to whom the sponsor's income is deemed, the Administration or its designee shall exclude any cash contributions received from the sponsor.
- D. Calculation of income from a sponsor.
  1. The Administration or its designee shall include the total gross income of the sponsor and the sponsor's spouse, when living with the sponsor;
  2. The Administration or its designee shall subtract an amount equal to 100% of the FPL for the sponsor's household size from the total gross income under (D)(1); and
  3. The amount calculated under subsection (D)(2) is deemed as income to the applicant for purposes of determining eligibility.

**Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-317 repealed, new Section R9-22-317 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). New Section R9-22-317 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-318. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-318 repealed, new Section R9-22-318 adopted

effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) and added subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (B) effective October 1, 1987; amended subsection (A) effective December 22, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective December 13, 1993 (Supp. 93-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-319. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-319 repealed, new Section R9-22-319 adopted effective November 20, 1984 (Supp. 84-6). Amended effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-320. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-320 repealed, new Section R9-22-320 adopted effective November 20, 1984 (Supp. 84-6). Amended effective April 13, 1990 (Supp. 90-2). Repealed effective December 13, 1993 (Supp. 93-4).

**R9-22-321. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-321 repealed, new Section R9-22-321 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (E) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-322. Repealed****Historical Note**



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Adopted effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective May 27, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-3). Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-322 repealed, new Section R9-22-322 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective September 29, 1992 (Supp. 92-3). Amended December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-323. Repealed****Historical Note**

Adopted effective August 30, 1982 (Supp. 82-4). Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective October 1, 1983 (Supp. 83-5). Amended as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-323 repealed, new Section R9-22-323 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (B) and (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (B), (D) and (E) effective October 1, 1987 (Supp. 87-4). Amended subsections (B) and (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-324. Repealed****Historical Note**

Adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-4). Former Section R9-22-324 adopted as an emergency renumbered as Section R9-22-327. New Section R9-22-324 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-324 repealed, former Section R9-22-323 renumbered as Section R9-22-324 and adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Former Section R9-22-324 repealed, new Section R9-22-324 adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. Former Section R9-22-324 repealed, new Section R9-22-324 adopted effective November 20, 1984 (Supp. 84-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective Septem-

ber 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-325. Repealed****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-325 repealed, new Section R9-22-325 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-326. Repealed****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-326 repealed, new Section R9-22-326 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Change in heading only effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-327. Repealed****Historical Note**

Former Section R9-22-324 adopted as an emergency effective July 27, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days renumbered as Section R9-22-327 and adopted as a permanent rule effective October 1, 1983 (Supp. 83-5). Former Section R9-22-327 repealed, new Section R9-22-327 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A), (D), (E), (G), (H), and (I) effective October 1, 1986 (Supp. 86-5). Amended subsection (D) and added a new subsection (J) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (A) and (E) effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-328. Repealed****Historical Note**

Adopted as an emergency effective October 6, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-5). Emergency Expired. New Section R9-22-328 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsections (A) and (E) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (D) effective October 1, 1987 (Supp. 87-4). Amended subsection (D) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2).

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Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-329. Repealed****Historical Note**

Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-329 adopted effective November 20, 1984 (Supp. 84-6).

Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-330. Repealed****Historical Note**

Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Emergency expired. New Section R9-22-330 adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended subsection (A) effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended subsection (A) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-331. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective October 1, 1987 (Supp. 87-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-332. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-333. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed by

**R9-22-334. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-335. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-336. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective September 16, 1987 (Supp. 87-3). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-337. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Correction to subsection (B), paragraph (1) (Supp. 87-3). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-338. Repealed****Historical Note**

Adopted effective November 20, 1984 (Supp. 84-6). Heading changed effective October 1, 1985 (Supp. 85-5). Change in heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-339. Repealed****Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp.

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97-1). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-340. Reserved****Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-341. Repealed****Historical Note**

Adopted effective March 1, 1987, filed December 31, 1986 (Supp. 86-6). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-342. Repealed****Historical Note**

Adopted effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-343. Repealed****Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**R9-22-344. Repealed****Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective October 8, 1996; filed with the Office of the Secretary of State November 6, 1996 (Supp. 96-4). Section repealed by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1).

**ARTICLE 4. PENALTY FOR OBTAINING ELIGIBILITY BY FRAUD****R9-22-401. Definitions**

Definitions. The following definitions apply specifically to terms used within this Article:

“Amounts incurred by the system” include capitation payments, costs incurred by any contractor in excess of capitation, reinsurance, and other administrative, legal or investigative costs associated with a person who obtained eligibility contrary to A.R.S. §§ 36-2905.04 and/or A.R.S. § 36-2991.

“Application for eligibility” means any request for benefits administered by AHCCCS under the authority of A.R.S. Title 36, Chapter 29, including applications for presumptive eligibility submitted to hospitals as described under Article 16 of this Chapter.

“Penalty” means an amount not to exceed the amounts incurred by the system during any time period that the person would have been ineligible for benefits but for the false or fraudulent information provided on the application for eligibility. A penalty does not include, and does not need to be reduced by, the amount of any overpayments that AHCCCS

may be entitled to recoup from a person who violated A.R.S. § 36-2905.04 and/or A.R.S. § 36-2991.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-401 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 31, 1997 (Supp. 97-1). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-402. Determining the Amount of the Penalty**

- A. AHCCCS shall determine the amount of a penalty according to A.R.S. § 36-2905.04(B) or A.R.S. § 36-2991(B), whichever is applicable, and this Article.
- B. In addition to any penalty imposed pursuant to ARS §§ 36-2905.04 or 36-2991, and this Article, the Administration may also recoup from the person the amounts incurred by the system as a part of the notice and appeal process described in this Article.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-402 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-403. Mitigating and Aggravating Circumstances**

- A. AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.
  1. Degree of culpability. The degree of culpability of a person is a mitigating circumstance if the person did not intend to provide or cause to be provided false information on the application for eligibility but was negligent as to the truthfulness of the information provided.
  2. Prior Offenses. At the time of the submittal of the application the person:
    - a. Did not have any prior criminal convictions; and
    - b. Had not been held civilly liable for defrauding a public assistance program.
  3. Financial condition. The financial condition of a person who violates A.R.S. §§ 36-2905.04 or 36-2991 is a mitigating circumstance if the imposition of a penalty without reduction will render the person incapable of obtaining necessities of life such as food, clothing, and shelter. AHCCCS may consider the resources available to the person when determining the amount of the penalty.
  4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice; the circumstances require a reduction of the penalty.

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**B. AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.**

1. Degree of culpability. The degree of culpability of a person who provides or causes to be provided false information on the application for eligibility is an aggravating circumstance if the person knows or had reason to know that the information provided on the application for eligibility was false, or the person failed to correct the false information prior to AHCCCS incurring a financial loss as a result of the application for eligibility.
2. Prior offenses. At any time before the submittal of the application for eligibility, the person was held criminally or civilly liable for committing any fraud, waste, or abuse against any public assistance program.
3. Financial Loss. The person's violation of A.R.S. §§ 36-2905.04 or 36-2991 caused a loss to the system equal to or exceeding \$5,000.00.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice; the circumstances require an increase of the penalty.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-403 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-404. Notice of Intent**

- A. If AHCCCS imposes a penalty pursuant to this Article, AHCCCS shall hand deliver or send by certified mail, return receipt requested, or Federal Express to the person, a written Notice of Intent to impose a penalty.
- B. The Notice of Intent shall include:
  1. The legal and factual basis for AHCCCS' determination that there has been a violation of A.R.S. §§ 36-2905.04 and/or 36-2991;
  2. The penalty;
  3. The amounts incurred by the system as a result of the violation of A.R.S. §§ 36-2905.04 and/or 36-2991, if AHCCCS intends to recoup those amounts through this process; and
  4. The procedure for requesting a State Fair Hearing.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-404 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-405. Failure to Respond to the Notice of Intent**

If a person fails to respond to the Notice of Intent within the time-frame described in A.A.C. § R9-22-406(A), AHCCCS shall uphold the penalty and recoupment amounts described in the Notice of Intent.

**Historical Note**

Adopted as an emergency effective May 20, 1982 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-405 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule similar to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-406. Request for State Fair Hearing**

- A. To dispute the agency action described in the Notice of Intent, the person shall file a written Request for State Fair Hearing with AHCCCS within sixty (60) days from the date of receipt of the Notice of Intent.
- B. If AHCCCS receives a timely request for a State Fair Hearing from the person, AHCCCS shall mail a Notice of Hearing pursuant to the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.
- C. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-406 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-406 repealed, new Section R9-22-406 adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Former Section R9-22-316 repealed, new Section R9-22-316 adopted as a permanent rule effective May 16, 1983; text of the Section identical to the emergency (Supp. 83-3). Amended effective January 31, 1986 (Supp. 86-1). Amended effective January 14, 1997 (Supp. 97-1). Section repealed by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-407. Burden of Proof**

- A. In any State Fair Hearing conducted under this Article, AHCCCS shall prove a violation of A.R.S. §§ 36-2905.04 and/or 36-2991, and any aggravating circumstances by a preponderance of the evidence.
- B. AHCCCS does not have to prove any specific intent to defraud.
- C. A person shall bear the burden of producing and proving by a preponderance of the evidence any affirmative defense or any

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circumstance that would justify reducing the amount of the penalty.

**Historical Note**

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**R9-22-408. Rescission of the Notice of Intent**

AHCCCS may rescind the Notice of Intent at any time prior to the State Fair Hearing without prejudice.

**Historical Note**

New Section made by final rulemaking at 22 A.A.R. 3191, effective October 19, 2016 (Supp. 16-4).

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS****R9-22-501. General Provisions and Standards - Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Quality management” means a process used by professional health personnel through a formal program involving multiple organizational components and committees to:

- Assess the degree to which services provided conform to desired medical standards and practices; and
- Quality improvement or maintenance of care and services.

“Quality Improvement” means a process designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time, in the areas of clinical care and non-clinical care and is expected to have a favorable effect on health outcomes and member satisfaction. Quality Improvement includes focusing organizational efforts on improving performance and utilizing data to develop intervention strategies to improve performance and outcomes.

“Utilization management/review” means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided. Utilization management applies to a contractor’s process to evaluate and approve or deny the medical necessity, appropriateness, efficacy and efficiency of health care services, procedures, or settings. Utilization review includes processes for prior authorization, concurrent review, retrospective review, and case management.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-501 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-501 repealed, former Section R9-22-502 renumbered and adopted without change as Section R9-22-501 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-501 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-502. Pre-existing Conditions**

- A. A contractor shall not impose a pre-existing condition exclusion with respect to covered services.
- B. A contractor or subcontractor shall not adopt or use any procedure to identify a person who has an existing or anticipated medical or psychiatric condition in order to discourage or exclude the person from enrolling in the contractor’s health plan or encourage the person to enroll in another health plan.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-502 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-502 renumbered without change as Section R9-22-501, former Section R9-22-503 renumbered and amended as Section R9-22-502 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-502 repealed, new Section R9-22-502 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

**R9-22-503. Provider Requirements Regarding Records**

The provider shall maintain records that meet uniform accounting standards and generally accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date. A provider shall maintain and upon request, make available to a contractor and to the Administration, financial and medical records relating to payment for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. Providers shall provide one copy of a medical record at no cost if requested by the member.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-503 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-503 renumbered and amended as Section R9-22-502, new Section R9-22-503 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective May 30, 1986 (Supp. 86-3). Amended subsection (D) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsections (F) and (G) effective December 22, 1987 (Supp. 87-4). Amended subsection (I) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). New Section made by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions**

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- A.** A contractor or the contractor's marketing representative shall not offer or give any form of compensation or reward, or engage in any behavior or activity that may be reasonably construed as coercive, to induce or procure AHCCCS enrollment with the contractor. Any marketing solicitation offering a benefit, good, or service in excess of the covered services in Article 2 is deemed an inducement.
- B.** A marketing representative shall not misrepresent itself, the contracting health plan represented, or the AHCCCS program, through false advertising, false statements, or in any other manner to induce a member of another contractor to enroll in the represented health plan. Violations of this subsection include, but are not limited to, false or misleading claims, inferences, or representations such as:
1. A member will lose benefits under the AHCCCS program or lose any other health or welfare benefits to which a member is legally entitled, if the member does not enroll in the represented contracting health plan;
  2. Marketing representatives are employees of the state or representatives of the Administration, a county, or any health plan other than the health plan by which they are employed, or by which they are reimbursed; and
  3. The represented health plan is recommended or endorsed as superior to its competition by any state or county agency, or any organization, unless the organization has certified its endorsement in writing to the health plan and the Administration.
- C.** A marketing representative shall not engage in any marketing or pre-enrollment practice that discriminates against a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.
- D.** The Administration shall hold a contractor responsible for a violation of this Section resulting from the performance of any marketing representative, subcontractor, agent, program, or process under the contractor's employ or direction and shall impose contract sanctions on the contractor as specified in contract.
- E.** A contractor shall produce and distribute informational materials that are approved by the Administration to each enrolled member or designated representative after the contractor receives notification of enrollment from the Administration. The contractor shall ensure that the informational materials include, at a minimum:
1. A description of all covered services as specified in contract;
  2. An explanation of service limitations and exclusions;
  3. An explanation of the procedure for obtaining services;
  4. An explanation of the procedure for obtaining emergency services;
  5. An explanation of the procedure for filing a grievance and appeal; and
  6. An explanation of when plan changes may occur as specified in contract.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-504 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-504 repealed, former Section R9-22-505 renumbered and adopted without change as Section R9-22-504 effective October 1, 1983 (Supp. 83-5). Former Section R9-22-504 repealed, former Section R9-22-528 renumbered and

amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services**

A provider shall not provide hospital or medical services to a member unless the provider is licensed by the Arizona Department of Health Services and meets the requirements in 42 CFR 441 and 482, as of October 1, 2007, and 42 CFR 456 Subpart C, as of October 1, 2007, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation contains no future editions or amendments. An Indian Health Service (IHS) hospital and a Veterans Administration hospital shall not provide services to a member unless accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-505 adopted as an emergency expired, former Section R9-22-506 adopted as an emergency now adopted, amended and renumbered as Section R9-22-505 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-505 renumbered without change as Section R9-22-504, new Section R9-22-505 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-505 renumbered and amended as Section R9-22-509, former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5). Editorial correction, spelling of "paraphernalia" in subsection (A) (Supp. 87-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). New Section made by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-506. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-506 adopted as an emergency adopted, amended and renumbered as Section R9-22-505, former Section R9-22-507 adopted as an emergency now adopted, amended and renumbered as Section R9-22-506 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-506 repealed, new Section R9-22-506 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (D) effective December 22, 1987 (Supp. 87-4). Repealed effective April 13, 1990 (Supp. 90-2). New Section adopted effective December 13, 1993 (Supp. 93-4). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-507. Repealed****Historical Note**

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Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-507 adopted as an emergency adopted, amended and renumbered as Section R9-22-506, former Section R9-22-508 adopted as an emergency now adopted, amended and renumbered as Section R9-22-507 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-507 repealed, new Section R9-22-507 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-508. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-508 adopted as an emergency adopted, amended and renumbered as Section R9-22-507, former Section R9-22-509 adopted as an emergency now adopted, amended and renumbered as Section R9-22-508 as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-509. Transition and Coordination of Member Care****A.** A contractor shall assist in the transition of members to and from other AHCCCS contractors.

1. Both the receiving and relinquishing contractor shall:
  - a. Coordinate with the other contractor to facilitate and schedule appointments for medically necessary services for the transitioned member within the Administration's timelines specified in the contract. If requested by the Administration, a contractor shall submit the policies and procedures regarding transition of members to the Administration for review and approval;
  - b. Assist in the referral of transitioned members to other community health agencies or county medical assistance programs for medically necessary services not covered by the Administration, as appropriate; and
  - c. Develop policies and procedures to be followed when transitioning members who have significant medical conditions; are receiving ongoing services; or have, at the time of the transition, received prior authorization or approval for undelivered, specific services.
2. The relinquishing contractor shall notify the receiving contractor of relevant information about the member's medical condition and current treatment regimens within the timelines defined in contract;
3. The relinquishing contractor shall forward medical records and other relevant materials to the receiving contractor. The relinquishing contractor shall bear the cost of reproducing and forwarding medical records and other relevant materials;
4. Within the timelines specified in contract, the receiving contractor shall ensure that the member selects or is assigned to a primary care provider, and provide the member with:
  - a. Information regarding the contractor's providers,
  - b. Emergency numbers, and
  - c. Instructions about how to obtain services.

- B.** A contractor shall not use a county or noncontracting provider health resource alternative to diminish the contractor's contractual responsibility or accountability for providing the full scope of covered services. The Administration may impose sanctions as described in contract if a contractor makes referrals to other agencies or programs to reduce expenses incurred by the contractor on behalf of its members.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-509 adopted as an emergency adopted, amended and renumbered as Section R9-22-508, former Section R9-22-510 adopted as an emergency now adopted and renumbered as Section R9-22-509 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-509 repealed, former Section R9-22-505 renumbered and amended as Section R9-22-509 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-510. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-510 adopted as an emergency adopted and renumbered as Section R9-22-509, former Section R9-22-511 adopted as an emergency now adopted, amended and renumbered as Section R9-22-510 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-510 repealed, new Section R9-22-510 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-511. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-511 adopted as an emergency adopted, amended and renumbered as Section R9-22-510, former Section R9-22-512 adopted as an emergency now adopted, amended and renumbered as Section R9-22-511 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-511 repealed, new Section R9-22-511 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-512. Release of Safeguarded Information**

- A.** The Administration, contractors, providers, and noncontracting providers shall limit the release of safeguarded information to persons or agencies for the following purposes in accordance with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments:

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1. Official purposes directly related to the administration of the AHCCCS program including:
    - a. Establishing eligibility and post-eligibility treatment of income, as applicable;
    - b. Determining the amount of medical assistance;
    - c. Providing services for members;
    - d. Performing evaluations and analysis of AHCCCS operations;
    - e. Filing liens on property as applicable;
    - f. Filing claims on estates, as applicable; and
    - g. Filing, negotiating, and settling medical liens and claims.
  2. Law enforcement. The Administration may release safeguarded information without the applicant's or member's written or verbal consent, for the purpose of conducting or assisting an investigation, prosecution, or criminal or civil proceeding related to the administration of the AHCCCS program.
  3. The Administration may release safeguarded member information to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.
- B.** Except as provided in subsection (A), the Administration, contractors, providers, and noncontracting providers shall disclose safeguarded information only to:
1. An applicant;
  2. A member;
  3. An unemancipated minor, with written permission of a parent, custodial relative, or designated representative, if:
    - a. An Administration employee, authorized representative, or responsible caseworker is present during the examination of the safeguarded information; or
    - b. After written notification to the provider, and at a reasonable time and place.
  4. Persons authorized by the applicant or member; or
  5. A court order or subpoena compliant with 45 CFR 164.512(e), October 1, 2004, incorporated by reference, on file with the Administration and available from the U.S. Government Printing Office, 732 N. Capitol St., N.W., Washington, D.C. 20401. This incorporation by reference contains no future editions or amendments.
- C.** The Administration, contractors, providers, and noncontracting providers shall safeguard identifiable information, protected health information as specified in 45 CFR 160, and information obtained in the course of application for or re-determination of eligibility concerning an applicant or member, that includes, but is not limited to the following:
1. Name and address;
  2. Social Security number;
  3. Social and economic conditions or circumstances;
  4. Agency evaluation of personal information;
  5. Medical data and information concerning medical services received, including diagnosis and history of disease or disability;
  6. State Data Exchange (SDX) tapes, and other types of information received from outside sources for the purpose of verifying income eligibility and amount of medical assistance payments; and
  7. Any information received in connection with the identification of legally liable third-party resources.
- D.** The restriction upon disclosure of information in this Section does not apply to:

1. De-identified information as described by 45 CFR 164.514, October 1, 2004, incorporated by reference in subsection (A); or
  2. A disclosure, in response to a request for information, that complies with 45 CFR 160 and 45 CFR 164, October 1, 2004, and 42 CFR 431.300 through 431.307, October 1, 2004, incorporated by reference in subsection (A).
- E.** A provider shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-512 adopted as an emergency adopted, amended and renumbered as Section R9-22-511, former Section R9-22-513 adopted as an emergency now adopted and renumbered as Section R9-22-512 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-512 repealed, new Section R9-22-512 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-513. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-513 adopted as an emergency adopted and renumbered as Section R9-22-512, former Section R9-22-514 adopted as an emergency now adopted, amended and renumbered as Section R9-22-513 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-513 repealed, former Section R9-22-526 renumbered and amended as Section R9-22-513 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-514. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-514 adopted as an emergency adopted, amended and renumbered as Section R9-22-513, former Section R9-22-515 adopted as an emergency now adopted, amended and renumbered as Section R9-22-514 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-514 repealed, former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-515. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-515 adopted as an emergency



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adopted, amended and renumbered as Section R9-22-514, former Section R9-22-517 adopted as an emergency now adopted, amended and renumbered as Section R9-22-515 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-515 repealed, former Section R9-22-522 renumbered and amended as Section R9-22-515 effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-516. Renumbered****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-516 adopted as an emergency expired, former Section R9-22-518 adopted as an emergency now adopted, amended and renumbered as Section R9-22-516 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-516 renumbered as Section R9-22-513 effective October 1, 1985 (Supp. 85-5).

**R9-22-517. Renumbered****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-517 adopted as an emergency adopted, amended and renumbered as Section R9-22-515, former Section R9-22-519 adopted as an emergency now adopted and renumbered and amended as Section R9-22-517 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-517 renumbered and amended as Section R9-22-514 effective October 1, 1985 (Supp. 85-5).

**R9-22-518. Information to Enrolled Members**

- A. Each contractor shall produce and distribute printed informational materials to each member or family unit no later than 10 days of receipt of notification of enrollment from the Administration. The contractor shall ensure that the informational materials meet the requirements specified in the contractor's current contract.
- B. A contractor shall provide a member with the name, address, and telephone number of the member's primary care provider no later than 10 days from the date of enrollment. The contractor shall include information on how the member may change primary care providers.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-518 adopted as an emergency adopted, amended and renumbered as Section R9-22-516, former Section R9-22-520 adopted as an emergency now adopted, amended and renumbered as Section R9-22-518 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-518 repealed, new Section R9-22-518 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

**R9-22-519. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-519 adopted as an emergency adopted, amended and renumbered as Section R9-22-517, former Section R9-22-521 adopted as an emergency now adopted, amended and renumbered as Section R9-22-519 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-519 repealed, new Section R9-22-519 adopted effective October 1, 1985 (Supp. 85-5). Repealed effective December 8, 1997 (Supp. 97-4).

**R9-22-520. Expired****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-520 adopted as an emergency adopted, amended and renumbered as Section R9-22-518, former Section R9-22-522 adopted as an emergency now adopted, amended and renumbered as Section R9-22-520 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-520 repealed, new Section R9-22-520 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

**R9-22-521. Program Compliance Audits**

- A. The Administration shall conduct an onsite program compliance audit of a contractor at least once every three years during the term of the Administration's contract with the contractor. The Administration may conduct, without prior notice, inspections of contractor facilities or perform other elements of a program compliance audit.
- B. An audit team may perform any or all of the following procedures:
  1. Conduct private interviews and group conferences with members, physicians, other health professionals, and members of the contractor's administrative staff including, but not limited to, the contractor's principal management persons;
  2. Examine records, books, reports, and papers of the contractor and any management company, and all providers or subcontractors providing health care and other services. The examination may include, but need not be limited to: minutes of medical staff meetings, peer review and quality of care review records, duty rosters of medical personnel, appointment records, written procedures for the internal operation of the health plan, contracts and correspondence with members and with providers of health care services and other services to the plan, and additional documentation deemed necessary by the Administration to review the quality of medical care.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-521 adopted as an emergency adopted, amended and renumbered as Section R9-22-519, former Section R9-22-523 adopted as an emergency now adopted, amended and renumbered as Section R9-22-521 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-521 repealed, new Section R9-22-521 adopted effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4).

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Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

*Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General has not certified this rule. This Section was subsequently amended through the regular rulemaking process.*

#### **R9-22-522. Quality Management/Utilization Management (QM/UM) Requirements**

- A.** A contractor shall comply with Quality Management/Utilization Management (QM/UM) requirements specified in this Section and in contract. The contractor shall ensure compliance with QM/UM requirements that are accomplished through delegation or subcontract with another party.
- B.** In addition to any requirements specified in contract, a contractor shall:
  1. Submit to the Administration a written QM/UM plan that includes a description of the systems, methodologies, protocols, and procedures to be used in:
    - a. Monitoring and evaluating the types of services provided,
    - b. Identifying the numbers and costs of services provided,
    - c. Assessing and improving the quality and appropriateness of care and services,
    - d. Evaluating the outcome of care provided to members, and
    - e. Determining the actions necessary to improve service delivery;
  2. Submit the QM/UM plan to the Administration on an annual basis within timelines specified in contract. If the QM/UM plan is changed during the year, the contractor shall submit the revised plan to the Administration before implementation;
  3. Receive approval from the Administration before implementing the initial or revised QM/UM plan;
  4. Ensure that a QM/UM committee operates under the control of the contractor's medical director and includes representation from medical and executive management personnel. The committee shall:
    - a. Oversee the development, revision, and implementation of the QM/UM plan; and
    - b. Ensure that there are qualified QM/UM personnel and sufficient resources to implement the contractor's QM/UM activities; and
  5. Ensure that the QM/UM activities include at least:
    - a. Prior authorization for non-emergency or scheduled hospital admissions;
    - b. Concurrent review of inpatient hospitalization;
    - c. Retrospective review of hospital claims;
    - d. Program and provider audits designed to detect over- or under-utilization, service delivery effectiveness, and outcome;
    - e. Medical records audits;
    - f. Surveys to determine satisfaction of members;
    - g. Assessment of the adequacy and qualifications of the contractor's provider network;

- h. Review and analysis of QM/UM data;
- i. Measurement of performance using objective quality indicators;
- j. Ensuring individual and systemic quality of care;
- k. Integrating quality throughout the organization;
- l. Process improvement;
- m. Credentialing a provider network;
- n. Resolving quality of care grievances; and
- o. Quality improvement activities focused on improving the quality of care and the efficient, cost-effective delivery and utilization of services.

- C.** A member's primary care provider shall maintain medical records that:
  1. Conform to professional medical standards and practices for documentation of medical diagnostic and treatment data;
  2. Facilitate follow-up treatment; and
  3. Permit professional medical review and medical audit processes.
- D.** Within 30 days following termination of the contract between a subcontractor and a contractor, the subcontractor or the subcontractor's designee shall forward to the primary care provider medical records or copies of medical records of all members assigned to the subcontractor or for whom the subcontractor has provided services.
- E.** The Administration shall monitor each contractor and the contractor's providers to ensure compliance with Administration QM/UM requirements and adherence to the contractor's QM/UM plan.
  1. A contractor and the contractor's providers shall cooperate with the Administration in the performance of the Administration's QM/UM monitoring activities; and
  2. A contractor and the contractor's providers shall develop and implement mechanisms for correcting deficiencies identified through the Administration's QM/UM monitoring.

#### **Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-522 adopted as an emergency adopted, amended and renumbered as Section R9-22-520, former Section R9-22-524 adopted as an emergency now adopted and renumbered as Section R9-22-522 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-522 renumbered and amended as Section R9-22-515, new Section R9-22-522 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 4330, effective January 3, 2009 (Supp. 08-4).

#### **R9-22-523. Expired**

#### **Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-523 adopted as an emergency adopted, amended and renumbered as Section R9-22-521, former Section R9-22-525 adopted as an emergency now adopted, amended and renumbered as Section R9-22-523

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as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1985 (Supp. 85-5). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

**R9-22-524. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-524 adopted as an emergency adopted and renumbered as Section R9-22-522, former Section R9-22-526 adopted as an emergency now adopted, amended and renumbered as Section R9-22-524 as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-524 repealed, new Section R9-22-524 adopted effective October 1, 1985 (Supp. 85-4). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 11 A.A.R. 4277, effective December 5, 2005 (Supp. 05-4).

**R9-22-525. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

**R9-22-526. Renumbered****Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of the permanent rule identical to the emergency (Supp. 83-3). Former Section R9-22-526 repealed, new Section R9-22-526 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-526 renumbered and amended as Section R9-22-501 effective October 1, 1985 (Supp. 85-1).

**R9-22-527. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-527 renumbered and amended as Section R9-22-505 effective October 1, 1985 (Supp. 85-5).

**R9-22-528. Renumbered****Historical Note**

Adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-528 renumbered and amended as Section R9-22-504 effective October 1, 1985 (Supp. 85-5).

**R9-22-529. Renumbered****Historical Note**

Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

**ARTICLE 6. RFP AND CONTRACT PROCESS****R9-22-601. General Provisions**

- A. The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.
- B. This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396u-2(d)(3).
- C. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
- D. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.
- E. The following terms are defined as related to this Article: "Procurement file" means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-601 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Amended effective December 13, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**R9-22-602. RFP**

- A. RFP content. The Administration shall include the following items in any RFP under this Article:
  1. Instructions and information to an offeror concerning the proposal submission including:
    - a. The deadline for submitting a proposal,
    - b. The address of the office at which a proposal is to be received,
    - c. The period during which the RFP remains open, and
    - d. Any special instructions and information;
  2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;
  3. The contract terms and conditions, including bonding or other security requirements, if applicable;
  4. The factors used to evaluate a proposal;
  5. The location and method of obtaining documents that are incorporated by reference in the RFP;
  6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;
  7. The type of contract to be used and a copy of a proposed contract form or provisions;
  8. The length of the contract service;
  9. A requirement for cost or pricing data;

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10. The minimum RFP requirements; and
  11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.
- B. Proposal process.**
1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.
  2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.
  3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror's proposal. The Administration shall provide an offeror fair treatment with respect to discussion and revision of a proposal. The Administration shall not disclose information derived from a proposal submitted by a competing offeror.
  4. The Administration shall allow for the adjustment of covered services by expansion, deletion, segregation, or combination in order to secure the most financially advantageous proposals for the state.
  5. The Administration may conduct an investigation of a person or organization who has ownership or management interests in corporate offerors or affiliated corporate organizations of an offeror.
  6. The Administration may issue a written request for best and final offers. The Administration shall state in the request the date, time, and place for the submission of best and final offers.
  7. The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers. The Administration shall state in the written request for best and final offers that if the offeror does not submit a notice of withdrawal or a best and final offer, the Administration shall take the most recent offer as the offeror's best and final offer.
- C. Proposal rejection.**
1. The Administration may reject an offeror's proposal if the offeror fails to supply the information requested by the Administration.
  2. The offeror shall not disclose information pertaining to its proposal to any other offeror prior to contract award. The offeror may disclose proposal information to a person other than another offeror if the recipient agrees to keep the information confidential until contract award. Disclosure in violation of this subsection may be grounds for rejecting a proposal.
  3. The Administration shall provide written notification to an offeror whose proposal is rejected. The rejection notice shall be part of the contract file and a public record.
  4. If the Administration determines that it is in the best interest of the state, the Administration may reject any and all proposals, in whole or in part, under the RFP. The reasons for rejection shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a proposal is rejected in whole or in part.
- D. Proposal cancellation.** If the Administration determines that it is in the best interest of the state, the Administration may cancel a RFP. The reasons for cancellation shall be part of the contract file. An offeror shall have no right to damages for any claims against the state, the state's employees, or agents if a RFP is cancelled.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-602 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-603. Contract Award**

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-603 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-604. Contract or Proposal Protests; Appeals**

- A.** Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by 9 A.A.C. 34.
- B.** Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.
- C.** Filing of a protest.
1. A person may file a protest with the procurement officer regarding:
    - a. A RFP issued by the Administration,
    - b. A proposed award, or
    - c. An award of a contract.
  2. A protester shall submit a written protest and include the following information:
    - a. The name, address, and telephone number of the protester;
    - b. The signature of the protester or protester's representative;
    - c. Identification of a RFP or contract number;
    - d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
    - e. The relief requested.

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- D.** Time for filing a protest.
1. A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals.
  2. Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.
  3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest no later than 10 days after the procurement officer makes the procurement file available for public inspection.
- E.** Stay of procurement during the protest. If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:
1. A reasonable probability exists that the protest will be sustained, and
  2. The stay of the contract award is in the best interest of the state.
- F.** Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:
1. An appeal is filed before a contract award, and
  2. The procurement officer issues a stay of the contract award under subsection (E), unless
  3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.
- G.** Decision by the procurement officer.
1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
  2. The procurement officer shall furnish a copy of the decision to the protester by:
    - a. Certified mail, return receipt requested; or
    - b. Any other method that provides evidence of receipt.
  3. The Administration may extend, for good cause, the time-limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
  4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protester may proceed as if the procurement officer issued an adverse decision.
- H.** Remedies.
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
  2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
    - a. Seriousness of the procurement deficiency,
    - b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
    - c. Good faith of the parties,
    - d. Extent of performance,
    - e. Costs to the state, and
    - f. Urgency of the procurement.
    - g. Best interest of the state.
3. An appropriate remedy may include one or more of the following:
- a. Terminating the contract;
  - b. Reissuing the RFP;
  - c. Issuing a new RFP;
  - d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
  - e. Any relief determined necessary to ensure compliance with applicable statutes and rules.
- I.** Appeals to the Director.
1. A person may file an appeal of a procurement officer's decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
  2. The appeal shall contain:
    - a. The information required in subsection (C)(2),
    - b. A copy of the procurement officer's decision,
    - c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
    - d. A request for hearing unless the person requests that the Director's decision be based solely upon the procurement file.
- J.** Dismissal. The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
1. The appeal does not state a basis for protest,
  2. The appeal is untimely under subsection (I)(1), or
  3. The appeal is moot.
- K.** Hearing. Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.

**Historical Note**

Adopted effective July 16, 1985 (Supp. 85-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**R9-22-605. Waiver of Contractor's Subcontract with Hospitals**

If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.

**Historical Note**

Adopted effective January 31, 1986 (Supp. 86-1). Amended effective December 13, 1993 (Supp. 93-4). Section repealed by final rulemaking at 5 A.A.R. 607, effective February 5, 1999 (Supp. 99-1). New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**R9-22-606. Contract Compliance Sanction**

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- A. The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
  1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
  2. Imposition of a monetary sanction.
- B. The Director shall consider the nature, severity, and length of the violation when determining a sanction.
- C. The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.
- D. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

**ARTICLE 7. STANDARDS FOR PAYMENTS****R9-22-701. Standards for Payments Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

“Accommodation” means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the GSA.

“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

“CHC” means a Community Health Center, which includes both Federally Qualified Health Centers and Rural Health Clinics.

“CPT” means Current Procedural Terminology, published, and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

“Direct graduate medical education costs” or “direct program costs” means the costs that are incurred for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“Encounter” means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(G)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

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“Freestanding Children’s Hospital” means a separately standing hospital with at least 120 pediatric beds that is dedicated to providing the majority of the hospital’s services to children.

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency or fellowship program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCAC” means a health care acquired condition described under 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

“HCPCS” means the Health Care Procedure Coding System, published, and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies, or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“ICU” means the intensive care unit of a hospital.

“Indirect program costs” means the marginal increase in operating costs that a provider experiences as a result of having an approved graduate medical education program and that is not accounted for by the direct program costs.

“Intern and Resident Information System” means a software program used by teaching providers and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

“OPPC” means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(G).

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(a).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

“Primary care GME program” means a graduate medical education program that prepares a physician for the practice of

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internal medicine, family medicine, pediatrics, obstetrics, geriatrics, or psychiatry.

“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Qualifying health information exchange organization” means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A qualifying health information exchange organization must include representation by the administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

“Rebase” means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician’s eligibility for board certification.

“Revenue code” means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB04 forms.

“Sub-acute services” means inpatient care for a patient with an acute illness, injury, or exacerbation of a disease process when the patient does not require acute inpatient hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

“Specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

“Sponsoring institution” means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

“Trip” means a one-way transport each time a taxi is called. If the taxi waits for the member, then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

### Historical Note

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-701 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-701 repealed, new Section R9-22-701 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 20 A.A.R. 1956, effective September 6, 2014; amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

**R9-22-701.01. Reserved**

**R9-22-701.02. Reserved**

**R9-22-701.03. Reserved**

**R9-22-701.04. Reserved**

**R9-22-701.05. Reserved**

**R9-22-701.06. Reserved**

**R9-22-701.07. Reserved**

**R9-22-701.08. Reserved**

**R9-22-701.09. Reserved**

**R9-22-701.10 Scope of the Administration’s and Contractor’s Liability**

The Administration shall bear no liability for providing covered services for any member beyond the date of termination of the member’s eligibility or during the member’s enrollment with a contractor. A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as



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provided in Articles 2 and 5 of this Chapter and as specified in contract.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

**R9-22-702. Charges to Members**

- A.** For purposes of this subsection, the term “member” includes the member’s financially responsible representative as described under A.R.S. § 36-2903.01.
- B.** Registered providers must accept payment from the Administration or a contractor as payment in full.
- C.** Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.
- D.** An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member:
  1. To collect the copayment described in R9-22-711;
  2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
  3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member’s AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
  4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;
  5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
  6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member’s contractor is not responsible for payment of “out of network” services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member’s contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
  7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or
  8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.
- E.** The signature requirement of subsections (D)(4), (D)(5), and (D)(6) do not apply if:
  1. The member is unable or incompetent to sign such a document, or
  2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member’s health.
- F.** Except as provided for in this Section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for the provider’s failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-702 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text identical to the emergency (Supp. 83-3). Former Section R9-22-702 repealed, new Section R9-22-702 adopted effective October 1, 1983 (Supp. 83-5). Amended by adding subsection (B) effective October 1, 1985 (Supp. 85-5). Amended by adding subsection (C) effective October 1, 1987 (Supp. 87-4). Amended effective April 13, 1990 (Supp. 90-2). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3217, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3).

**R9-22-703. Payments by the Administration**

- A.** General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- B.** Timely submission of claims.
  1. Under A.R.S. § 36-2904, the Administration shall deem a paper claim to be submitted on the date that it is received by the Administration. An electronic claim is deemed received by the Administration when the claim enters the information processing system designated by the Administration for electronic claims in a form that is capable of being processed by the designated information processing system. The Administration shall do one or more of the following for each claim it receives:
    - a. Place a date stamp on the face of the claim,
    - b. Assign a system-generated claim reference number,
 or

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- c. Assign a system-generated date-specific number.
  2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    - b. Six months from the date of eligibility posting.
  3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
    - a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
    - b. Twelve months from the date of eligibility posting.
  4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an HIS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.
- C. Claims processing.
  1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
  2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
    - a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
    - b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
    - c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
  3. A claim is paid on the date indicated on the disbursement check.
  4. A claim is denied as of the date of the remittance advice.
  5. The Administration shall process a hospital claim under this Article.
- D. Prior authorization.
  1. An AHCCCS-registered provider shall:
    - a. Obtain prior authorization from the Administration for non-emergency hospital admissions, covered services as specified in Articles 2 and 12 of this Chapter, and for administrative days as described in R9-22-712.75,
    - b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
    - c. Make records available for review by the Administration upon request.
  2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).
  3. If the Administration issues prior authorization for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the Administration shall adjust the claim payment.
- E. Review of claims and coverage for hospital supplies.
  1. The Administration may conduct prepayment and post-payment review of any claims, including but not limited to hospital claims.
  2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
    - a. Patient care kit,
    - b. Toothbrush,
    - c. Toothpaste,
    - d. Petroleum jelly,
    - e. Deodorant,
    - f. Septi soap,
    - g. Razor or disposable razor,
    - h. Shaving cream,
    - i. Slippers,
    - j. Mouthwash,
    - k. Shampoo,
    - l. Powder,
    - m. Lotion,
    - n. Comb, and
    - o. Patient gown.
  3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
    - a. Arm board,
    - b. Diaper,
    - c. Underpad,
    - d. Special mattress and special bed,
    - e. Gloves,
    - f. Wrist restraint,
    - g. Limb holder,
    - h. Disposable item used instead of a durable item,
    - i. Universal precaution,
    - j. Stat charge, and
    - k. Portable charge.
  4. The Administration shall determine in a hospital claims review whether services rendered were:
    - a. Covered services as defined in Article 2;
    - b. Medically necessary;
    - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
    - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
  5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.
- F. Overpayment for AHCCCS services.
  1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
  2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
  3. The Administration shall document any recoupment of an overpayment on a remittance advice.
  4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.
- G. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article

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2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

- H.** Prior quarter reimbursement. A provider shall:
1. Bill the Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from a member of AHCCCS eligibility.
  2. Reimburse a member when payment has been received from the Administration for covered services during a prior quarter eligibility period. All funds paid by the member shall be reimbursed.
  3. Accept payment received by the Administration as payment in full.
- I.** Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
- J.** Payment for out-of-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an out-of-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- K.** Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. The Administration shall reimburse an in-state or out-of-state provider of inpatient hospital services rendered with a discharge date on or after October 1, 2014, the DRG rate established by the Administration.
- L.** The Administration may enter into contracts for the provisions of transplant services.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R-22-703 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-703 repealed, new Section R9-22-703 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsection (B), paragraph (1) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (A) effective September 16, 1987 (Supp. 87-3). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 17 A.A.R. 1658, effective August 2, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final

rulemaking at 27 A.A.R. 237, effective April 4, 2021 (Supp. 21-1).

**R9-22-704. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-704 adopted as an emergency now adopted and amended as a permanent rule effective August 30 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Amended subsection A., Paragraph 2. effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

**R9-22-705. Payments by Contractors**

- A.** General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.
1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
  2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
    - a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
    - b. The service is emergent under Article 2 of this Chapter.
- B.** Timely submission of claims.
1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
    - a. Place a date stamp on the face of the claim,
    - b. Assign a system-generated claim reference number, or
    - c. Assign a system-generated date-specific number.
  2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
    - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
    - b. Six months from the date of eligibility posting.
  3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:

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- a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
  - b. Twelve months from the date of eligibility posting.
- C. Date of claim.
  - 1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
  - 2. A hospital claim is considered paid on the date indicated on the disbursement check.
  - 3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
  - 4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.
  - 5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.
  - 6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.
- D. Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.
- E. Payment for Inpatient out-of-state hospital payments for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).
- F. Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- G. Payment for in-state outpatient hospital services.
 

A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other Sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- H. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
- I. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45.
- J. Review of claims and coverage for hospital supplies.
  - 1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
  - 2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
  - 3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post-payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the contractor shall adjust the claim payment.
  - 4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
  - 5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
    - a. Patient care kit,
    - b. Toothbrush,
    - c. Toothpaste,
    - d. Petroleum jelly,
    - e. Deodorant,
    - f. Septi soap,
    - g. Razor,
    - h. Shaving cream,
    - i. Slippers,
    - j. Mouthwash,
    - k. Disposable razor,
    - l. Shampoo,
    - m. Powder,
    - n. Lotion,
    - o. Comb, and

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- p. Patient gown.
- 6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
  - a. Arm board,
  - b. Diaper,
  - c. Underpad,
  - d. Special mattress and special bed,
  - e. Gloves,
  - f. Wrist restraint,
  - g. Limb holder,
  - h. Disposable item used instead of a durable item,
  - i. Universal precaution,
  - j. Stat charge, and
  - k. Portable charge.
- 7. The contractor shall determine in a hospital claims review whether services rendered were:
  - a. Covered services as defined in R9-22-201;
  - b. Medically necessary;
  - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
  - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
- 8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.
- K.** Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.
- L.** Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
  - 1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
  - 2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
  - 3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.
- M.** Interest payment. In addition to the requirements in subsection (L), a contractor shall pay interest for late claims as defined by contract.
- N.** For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the amended rule identical to emergency (Supp. 83-3). For-

mer Section R9-22-705 repealed, new Section R9-22-705 adopted effective October 1, 1983 (Supp. 83-5).

Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5). Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1).

Amended effective October 1, 1985 (Supp. 85-5).

Amended subsection (C) effective October 1, 1986 (Supp. 86-5). Amended subsection (C) effective October 1, 1987; amended subsection (C) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 867, effective March 4, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-706. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-706 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-706 repealed, new Section R9-22-706 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Amended as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Amended as an emergency effective October 25, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-5).

Emergency expired. Permanent amendment adopted effective February 1, 1985 (Supp. 85-1). Amended effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended subsections (A), (D), (E), (F), and (G) effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (F) effective December 22, 1987 (Supp. 87-4). Amended subsections (A) and (F) effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4).

**R9-22-707. Repealed****Historical Note**

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Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-707 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Repealed as a permanent action effective May 16, 1983 (Supp. 83-3). New Section R9-22-707 adopted effective October 1, 1983 (Supp. 83-5). Adopted as an emergency effective May 18, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-3). Adopted as an emergency effective August 16, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 84-4). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1985 (Supp. 85-5). Former Section R9-22-707 repealed, new Section R9-22-707 adopted effective October 1, 1986 (Supp. 86-5). Amended subsection (A) effective October 1, 1987 (Supp. 87-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Section repealed by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

#### **R9-22-708. Payments for Services Provided to Eligible American Indians**

- A. For purposes of this Article "IHS enrolled" or "enrolled with IHS" means an American Indian who has elected to receive covered services through IHS instead of a contractor.
- B. For an American Indian who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (HHS) in the *Federal Register*, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in A.A.C. Chapter 29, Article 3 of this Title.
- C. When IHS refers an American Indian enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.
- D. For an American Indian enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.
- E. Once an American Indian enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

#### **Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-708 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-708 repealed, new Section R9-22-708 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-708 renumbered and amended as Section R9-22-709, new Section R9-22-708 adopted effective October 1, 1985 (Supp. 85-5). Amended effective October 1, 1986 (Supp. 86-5). Amended by final rulemaking at 10 A.A.R. 4656, effective January 1, 2005 (Supp. 04-4). Amended by final

rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

#### **R9-22-709. Contractor's Liability to Hospitals for the Provision of Emergency and Post-stabilization Care**

A contractor is liable for emergency hospitalization and post-stabilization care as described in R9-22-210 and R9-22-210.01.

#### **Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-709 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-709 repealed, new Section R9-22-709 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-709 renumbered and amended as Section R9-22-713, former Section R9-22-708 renumbered and amended as Section R9-22-709 effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

*Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.*

#### **R9-22-710. Payments for Non-hospital Services**

- A. Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
  1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration's capped-fee-for-service schedule.
  2. Procedure codes. The Administration shall maintain a current copy of the National Standard Code Sets mandated under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004), incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
    - a. A person shall submit an electronic claim consistent with 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).
    - b. A person shall submit a paper claim using the National Standard Code Sets as described under 45

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CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).

- c. The Administration may deny a claim for failure to comply with subsection (A) (2) (a) or (b).
3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (A)(3)(d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.
  - a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.
  - b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.
  - c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours. For dates of service beginning:
    - i. October 1, 2012 through September 30, 2013, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2012.
    - ii. October 1, 2013 through September 30, 2014, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2013.
    - iii. October 1, 2014 through September 30, 2015, the Administration and its contractors shall reimburse ambulance services at 74.74 percent of the ADHS rates that are in effect as of August 2, 2014.
  - d. Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.
- B. Pharmacy services. The Administration shall not reimburse pharmacy services unless the services are provided by a pharmacy having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. Except as specified in subsection (C), the Administration shall reimburse pharmacy services according to the terms of the contract.
- C. FQHC Pharmacy reimbursement.
  1. For purposes of this Section the following terms are defined:
    - a. "340B Drug Pricing Program" means the discount drug purchasing program described in 42 U.S.C. 256b.
    - b. "340B Ceiling Price" means the maximum price that drug manufacturers can charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to HRSA.
    - c. "340B entity" means a covered entity, eligible to participate in the 340B Drug Pricing Program, as defined by the Health Resources and Human Services Administration.
    - d. "Actual Acquisition Cost (AAC)" means the purchase price of a drug paid by a pharmacy net of discounts, rebates, chargebacks and other adjustments to the price of the drug. The AAC excludes dispensing fees.
    - e. "Contracted Pharmacy" means an arrangement through which a 340B entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications subject to 340B pricing.
    - f. "Dispensing Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Dispensing Fee does not include any payment for the drugs being dispensed.
    - g. "Federally Qualified Health Center" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the criteria under sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receives funds under section 330 of the Public Health Service Act.
    - h. "Federally Qualified Health Center Look-Alike" means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the definition of "health center" under section 330 of the Public Health Service Act, but does not receive grant funding under section 330.
    - i. "FQHC or FQHC Look-Alike pharmacy" means a pharmacy that dispenses drugs to FQHC or FQHC-LA patients and that is owned and/or operated by an FQHC/FQHC-LA or by an entity that reports the costs of an FQHC/FQHC-LA on its Medicare Cost Report, whether or not collocated with an FQHC or an FQHC Look-Alike.
2. Effective the later of February 1, 2012, or CMS approval of a State Plan Amendment, an FQHC or FQHC Look-Alike shall:
  - a. Notify the AHCCCS provider registration unit of its status as a 340B covered entity no later than:
    - i. 30 days after the effective date of this Section;
    - ii. 30 days after registration with the Health Resources and Services Administration (HRSA) for participation in the 340B program, or
    - iii. The time of application to become an AHCCCS provider.
  - b. Provide the 340B pricing file to the AHCCCS Administration upon request. The 340B pricing file shall be provided in the file format as defined by AHCCCS.
  - c. Identify 340B drug claims submitted to the AHCCCS FFS PBM or the Managed Care Contractors' PBMs for reimbursement. The 340B drug claim identification and claims processing for a drug claim submission shall be consistent with claim instructions.

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tions issued and required by AHCCCS to identify such claims.

3. The FQHC and the FQHC Look-Alike pharmacies shall submit claims for AHCCCS members for drugs that are identified in the 340B pricing file, whether or not purchased under the 340B pricing file, with the lesser of:
  - a. The actual acquisition cost, or
  - b. The 340B ceiling price.
4. The AHCCCS Fee-for-Service and Managed Care Contractors' PBMs shall reimburse claims for drugs which are identified in the 340B pricing file dispensed by FQHC and FQHC Look -Alike pharmacies, whether or not purchased under the 340B pricing file, at the amount submitted under subsection (C)(3) plus a dispensing fee listed in the AHCCCS Capped Fee-For-Service Schedule unless a contract between the 340B entity and a Managed Care Contractor's PBM specifies a different dispensing fee.
5. Contracted pharmacies shall not submit claims for drugs dispensed under an agreement with the 340B entity as part of the 340B drug pricing program, and the AHCCCS Administration and Managed Care Contractors shall not reimburse such claims.
6. The AHCCCS Administration and Managed Care Contractors shall reimburse contracted pharmacies for drugs not dispensed under an agreement with the 340B entity as part of the 340B program at the price and dispensing fee set forth in the contract between the contracted pharmacy and the AHCCCS or its Managed Care Contractors' PBMs. Neither the Administration nor its Managed Care Contractors will reimburse a contracted pharmacy that does not have a contract with the Administration or MCO's PBM.
7. The AHCCCS Administration and its Managed Care Contractors shall reimburse FQHC and FQHC Look-Alike pharmacies for drugs that are not eligible under the 340B Drug Pricing Program at the price and dispensing fee set forth in their contract with the AHCCCS or its Managed Care Contractors' PBMs.
8. AHCCCS may periodically conduct audits to ensure compliance with this Section.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5). Amended subsections (B) through (D) effective October 1, 1986 (Supp. 86-5). Amended subsection (B) effective July 1, 1988 (Supp. 88-3). Amended subsection (B) effective April 27, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective December 13, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3830, effective

November 12, 2005 (Supp. 05-3). Amended by exempt rulemaking at 18 A.A.R. 212, effective February 1, 2012 (Supp. 12-1). Amended by exempt rulemaking at 18 A.A.R. 1971, effective August 1, 2012 (Supp. 12-3).

Amended by exempt rulemaking at 18 A.A.R. 2630, effective October 1, 2012 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 1681, effective August 9, 2013 (Supp. 13-2). Amended by exempt rulemaking at 19 A.A.R. 3525, effective October 18, 2013 (Supp. 13-4)

**R9-22-711. Copayments****A. For purposes of this Article:**

1. A copayment is a monetary amount that a member pays directly to a provider at the time a covered service is rendered.
2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
3. No refunds shall be made for a retroactive period if there is a change in an individual's status that alters the amount of a copayment.

**B. The following services are exempt from AHCCCS copayments for all members:**

1. Family planning services and supplies,
2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman,
3. Emergency services as described in 42 CFR 447.56(2)(i),
4. All services paid on a fee-for-service basis,
5. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms,
6. Provider preventable services.

**C. The following individuals are exempt from AHCCCS copayments:**

1. An individual under age 19, including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. An individual eligible for the Arizona Long-Term Care Program in A.R.S. § 36-2931;
4. An individual eligible for QMB under Chapter 29;
5. An individual eligible for the Children's Rehabilitative Services program under A.R.S. § 36-2906(E);
6. An individual receiving nursing facility or HCBS services under R9-22-216;
7. An individual receiving hospice care as defined in 42 U.S.C. 1396d(o);
8. An American Indian individual enrolled in a health plan and has received services through an IHS facility, tribal 638 facility or urban Indian health program;
9. An individual eligible in the Breast and Cervical Cancer program as described under Article 20;
10. An individual who is pregnant including the postpartum period which is the last day of the month in which the 60th day following the date the pregnancy ends;
11. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age;
12. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age; and
13. An adult eligible under R9-22-1427(E), with income at or below 106% of the FPL.



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- D. Non-mandatory copayments.** Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through (6) are subject to the copayments listed in this subsection. A provider shall not deny a service when a member states to the provider an inability to pay a copayment.
1. A caretaker relative eligible under R9-22-1427(A);
  2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6)(a)(iii);
  3. An individual eligible for State Adoption Assistance in R9-22-1433;
  4. An individual eligible for Supplemental Security Income (SSI);
  5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in Article 15; and
  6. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6)(g).
  7. Copayment amount per service:
    - a. \$2.30 per prescription drug.
    - b. \$3.40 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services or non-emergent surgical procedures according to the National Standard Code Sets. An outpatient visit includes any setting where these services are performed such as a physician's office, an Ambulatory Surgical Center (ASC), or a clinic.
    - c. \$2.30 per visit, if a copayment is not being imposed under subsection (D)(7)(b) and any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
- E. Mandatory copayments.**
1. Copayments for individuals eligible for Transitional Medical Assistance (TMA) under R9-22-1427(B)(1)(c)(i). Unless otherwise listed in subsection (C), an individual is required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
    - a. \$2.30 per prescription drug.
    - b. \$4.00 per outpatient visit, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
    - c. If a copayment is not being imposed under subsection (E)(1)(b), \$3.00 per visit if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
    - d. If a copayment is not being imposed under subsection (E)(1)(b) or (c), \$3.00 per visit, if any of the services rendered during the visit are coded as non-emergent surgical procedures according to the National Standard Code Sets.
  2. Copayments for persons eligible under R9-22-1427(E) with income above 106% of the FPL and for persons eligible under A.R.S. §§ 36-2907.10 and 36-2907.11. Subject to CMS approval, unless otherwise listed in subsection (C), these individuals are required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician's provider's office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
    - a. \$4.00 per prescription drug.
    - b. \$5.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate from \$50 to less than \$100, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
    - c. \$10.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate of \$100 or greater, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
    - d. If a copayment is not being imposed under subsection (E)(2)(b) or (E)(2)(c), for services coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
      - i. \$2.00 if the rate on the fee schedule is \$20 to \$39.99,
      - ii. \$4.00 if the rate on the fee schedule is \$40 to \$49.99, or
      - iii. \$5.00 if the rate on the fee schedule is \$50 and above per visit.
    - e. If a copayment is not being imposed under subsection (E)(2)(b) –(E)(2)(d), for services coded as non-emergent surgical procedures according to the National Standard Code Sets,
      - i. \$30.00 if the rate on the fee schedule is \$300 to \$499.99, or
      - ii. \$50.00 if the rate on the fee schedule is \$500 and above per visit.
    - f. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$2.00 per trip for non-emergency transportation in an urban area.
    - g. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$8.00 for non-emergency use of the emergency room.
    - h. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay \$75 for an Inpatient stay.
  3. The provider may deny a service if the member does not pay the copayment required by subsection (E), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.
- F.** A provider is responsible for collecting any copayment imposed under this Section.
- G.** The total aggregate amount of copayments under subsections (D) or (E) may not exceed 5% of the family's income as applied on a quarterly basis. The member may establish that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. In addition, the Administration shall also use claims and encounters information available to the Administration to establish when a member's copayment obligation has reached 5% of the family's income.

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- H.** Reduction in payments to providers. The Administration and its contractors shall reduce the payment it makes to any provider by the amount of a member's copayment obligation under subsection (E), regardless of whether the provider successfully collects the copayments described in this Section.

**Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Sections R9-22-711 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-711 repealed, new Section R9-22-711 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by exempt rulemaking at 9 A.A.R. 4557, effective October 1, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 2194, effective May 3, 2004 (Supp. 04-2). Amended by exempt rulemaking at 10 A.A.R. 4266, effective October 1, 2004 (Supp. 04-3). Amended by final rulemaking at 16 A.A.R. 1449, effective October 1, 2010 (Supp. 10-3). Section amended by exempt rulemaking at 18 A.A.R. 461, effective April 1, 2012 (Supp. 12-1). Section amended by final rulemaking at 19 A.A.R. 2954, effective November 11, 2013 (Supp. 13-3). Amended by exempt rulemaking at 20 A.A.R. 128, effective December 30, 2013 (Supp. 13-4). Amended by exempt rulemaking at 20 A.A.R. 2755, effective January 1, 2015 (Supp. 14-3). Amended by final rulemaking at 29 A.A.R. 1866 (August 25, 2023), with an immediate effective date of August 1, 2023 (Supp. 23-3).

**Editor's Note:** The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

**R9-22-712. Reimbursement: General**

- A.** Inpatient and outpatient discounts and penalties. If a claim is pending for additional documentation required under A.R.S. § 36-2903.01(G)(4), the period during which the claim is pending is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(G)(5).
- B.** Inpatient and outpatient in-state or out-of-state hospital payments.
1. Payment for inpatient out-of-state hospital services for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d).
  2. Payment for inpatient in-state hospital services for claims with discharge dates on or before September 30, 2014. AHCCCS shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.
  3. Payment for inpatient in-state or out-of-state hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in the absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
  4. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
  5. Outpatient in-state hospital payments. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other Sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.
- C.** Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.
- D.** Prior authorization. The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.
- E.** Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims.
- F.** Claim receipt.
1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
  2. Hospital claims are considered paid on the date indicated on disbursement checks.
  3. A denied claim is considered adjudicated on the date the claim is denied.
  4. Claims that are denied and are resubmitted are assigned new receipt dates.

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5. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
  6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.
- G. Outpatient hospital reimbursement.** The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.
1. **Computation of outpatient hospital reimbursement.** The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
    - a. **Cost-to-charge ratios.** The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
    - b. **Cost-to-charge limit.** To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
  2. **New hospitals.** The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
  3. **Specialty outpatient services.** The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
  4. **Reimbursement requirements.** To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
  5. **Rebasing.** The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
  6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) by applying the following formula:  

$$CCR * [1.047 / (1 + \% \text{ increase})]$$
 Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.  
 "Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

**Historical Note**

Adopted as an emergency effective February 23, 1983 pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to emergency (Supp. 83-3). Former Section R9-22-712 repealed, new Section R9-22-712 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). New Section R9-22-712 adopted under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended effective January 14, 1997 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 3831, effective August 25, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 17 A.A.R.

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1658, effective August 2, 2011 (Supp. 11-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.01. Inpatient Hospital Reimbursement for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014**

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHCCCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for the fiscal year ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital's 1996 fiscal year end.
  - a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.
  - b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:
    - i. Those missing information necessary for the rate calculation,
    - ii. Medicare crossovers,
    - iii. Those submitted by freestanding psychiatric hospitals, and
    - iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.
2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.
  - a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:
    - i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.
    - ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).
    - iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further

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- assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital's certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).
- iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.
  - b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.
  - c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.
  - d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.
3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.
    - a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment through September 30, 2014 in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.
    - b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
    - c. Seven tiers. The seven tiers are:
      - i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.
      - ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.
      - iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meets the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.
      - iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split

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- a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.
- v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.
  - vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.
  - vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.
4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.
  5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates through September 30, 2011.
  6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.
    - a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.
    - b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For inpatient hospital admissions with begin dates of service on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.
    - c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three-year phase-in does not apply to out-of-state or new hospitals.
      - i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.
      - ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.
      - iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare

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Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.

- d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.
  - i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.
  - ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b).
  - iii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.
  - iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.
7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. If the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.
8. Ownership change. The Administration shall not change any of the components of a hospital's tiered per diem rates upon an ownership change.
9. Psychiatric hospitals. The Administration shall pay free-standing psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.
10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.
11. Outliers for new hospitals. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.
12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be

reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by exempt rulemaking at 17 A.A.R. 1337, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.02. Reserved**

**R9-22-712.03. Reserved**

**R9-22-712.04. Reserved**

**R9-22-712.05. Graduate Medical Education Fund Allocation**

- A. Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(G)(9)(a).
- B. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(b). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (B)(3).
  1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:
    - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
    - b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
    - c. It is not administered by or does not receive its primary funding from an agency of the federal government.
  2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (B)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
    - a. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(G)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
    - b. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(G)(9)(a) that were established before July 1, 2006.
  3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under

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subsection (B) shall provide the applicable information listed in this subsection to the Administration:

- a. A GME program shall provide all of the following:
    - i. The program name and number assigned by the accrediting organization;
    - ii. The original date of accreditation;
    - iii. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
    - iv. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
    - v. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not already provided this information to the Administration;
  - b. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
    - i. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital's two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
    - ii. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital's two most recently completed Medicare cost reporting years;
    - iii. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part of the report for the most recently completed cost reporting year.
4. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:
- a. Information provided by hospitals under subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (B)(3)(b)(i) and (ii).
  - b. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined as follows:
    - i. Total the number of days determined for each participating institution under subsection (B)(4)(a) and divide each total by 365.
    - ii. Proportionally adjust the result of subsection (B)(4)(b)(i) for each participating institution within each program according to the number of residents determined to be eligible under subsection (B)(2).
  - c. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (B)(3) and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (B)(3). The Medicaid-adjusted eligible residents shall be determined as follows:
    - i. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
    - ii. The number of allocated eligible residents determined for each participating hospital under subsection (B)(4)(b)(ii) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for that hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (B)(1)(c) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for the program's sponsoring institution or, if the sponsoring institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is made ineligible under subsection (B)(1)(c) shall be multiplied by zero percent.
  - d. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (B)(4)(c)(ii) by the per-resident conversion factor determined below and totaling the resulting dollar amounts for all participating institutions in the program. The per-resident conversion factor shall be determined as follows:
    - i. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.
    - ii. Calculate the total allocated residents determined under subsection (B)(4)(b)(i) for those hospitals described under subsection (B)(4)(d)(i).
    - iii. Divide the total GME costs calculated under subsection (B)(4)(d)(i) by the total allocated residents calculated under subsection (B)(4)(d)(ii).
5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (B)(4) in the following manner:
- a. The allocated amounts shall be distributed in the following order of priority:
    - i. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-



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- 2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;
- ii. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;
  - b. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each hospital within that program under subsection (B)(4)(c)(ii).
  - c. If funds are insufficient to cover all distributions within any priority group described under subsection (B)(5)(a), the Administration shall adjust the distributions proportionally within that priority group.
- C. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(i). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (C)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (C) if it meets all the conditions of subsections (B)(1)(a) through (c).
  2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (C)(4), the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
    - a. All filled resident positions in approved programs established on or after July 1, 2006; and
    - b. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (C)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
  3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (C) shall provide to the Administration:
    - a. A GME program shall provide all of the following:
      - i. The requirements of subsections (B)(3)(a)(i) through (iv);
      - ii. The academic year rotation schedule on file with the program current as of the date of reporting; and
      - iii. For programs described under subsection (C)(2)(b), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
    - b. A hospital seeking a distribution under subsection (C) shall provide the requirements of subsection (B)(3)(b).
  4. Allocation of expansion funds. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
    - a. Information provided by hospitals in accordance with subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided in accordance with subsections (B)(3)(b)(i) and (ii).
    - b. For approved programs whose resident activity is not represented in the information provided in accordance with subsection (B)(3)(b), information provided by GME programs under subsection (C)(3)(a) shall be used to determine the number of days that each eligible resident is expected to work at each participating institution.
    - c. The number of eligible residents allocated to each participating institution for each approved GME program shall be determined by totaling the number of days determined under subsections (C)(4)(a) and (b) and dividing the totals by 365.
    - d. The number of allocated residents determined under subsection (C)(4)(c) shall be adjusted for Arizona Medicaid utilization in accordance with subsection (B)(4)(c).
    - e. The total allocation for each approved program shall be determined in accordance with subsection (B)(4)(d).
  5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (C)(4) to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each within that program under subsection (C)(4)(d).
- D. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for GME programs approved by the Administration to hospitals for indirect program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(ii). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D)(3).
1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (D) if all of the following apply:
    - a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona or is the base hospital for one or more of the GME programs in Arizona whose sponsoring institutions are not hospitals;
    - b. It incurs indirect program costs for the training of residents in the GME programs, which are or will be calculated on the hospital's Medicare Cost Report or are reimbursable under the Children's Hospitals Graduate Medical Education Payment Program administered by HRSA;
    - c. It is not administered by or does not receive its primary funding from an agency of the federal government.

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2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (D)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (D)(1)(c):
    - a. Any filled resident position in an approved program that includes a rotation of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule;
    - b. For approved programs that have been established for less than one year as of the date of reporting under subsection (D)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match who will perform rotations of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule.
  3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (D) shall provide to the Administration:
    - a. A GME program shall provide all of the following:
      - i. The requirements of subsections (B)(3)(a)(i) through (iv);
      - ii. The academic year rotation schedule on file with the program current as of the date of reporting;
      - iii. For programs described under subsection (D)(2)(c), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
    - b. A hospital seeking a distribution under subsection (D) shall provide the requirements of subsection (B)(3)(b)(iii).
  4. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds to approved GME programs in the following manner:
    - a. Using the information provided by programs under subsection (D)(3), the Administration shall determine for each program the number of residents in the program who are eligible under subsection (D)(2) and the number of months per year that each eligible resident will perform rotations in counties described by subsection (D)(2), multiply the number of eligible residents by the number of months and multiply the result by the per resident per month conversion factor determined under subsection (D)(4)(b).
    - b. Using the most recent Medicare Cost Reports on file with the Administration for all hospitals that have calculated a Medicare indirect medical education payment, the Administration shall determine a per resident per month conversion factor as follows:
      - i. Calculate each hospital's Medicare share by dividing the Medicare inpatient discharges on the Medicare Cost Report by the total inpatient hospital discharges on the Medicare Cost Report.
      - ii. Calculate the ratio of residents to beds by dividing the total allocated residents described in subsection (B)(4)(d)(ii) by the number of bed days available from the Medicare Cost Report and dividing the result by the number of days in the cost reporting period.
      - iii. Calculate the indirect medical education adjustment factor by adding 1 to the value calculated in (D)(4)(b)(ii), multiplying the result by the exponential value 0.405, subtracting 1 from the result, and multiplying that result by 1.35.
      - iv. Calculate each hospital's total indirect medical education cost by adding the DRG amounts other than outlier payments from the Medicare cost report and the managed care simulated payments from the Medicare Cost Report, multiplying the total by the indirect medical education adjustment factor determined in (D)(4)(b)(iii) and dividing the result by the Medicare share determined in (D)(4)(b)(i).
      - v. Calculate each hospital's Medicaid indirect medical education cost by multiplying the amount determined in (D)(4)(b)(iv) by the value determined in subsection (B)(4)(c)(i).
      - vi. Total the amounts determined in (D)(4)(b)(v) for all hospitals, divide the result by the total allocated residents described in subsection (B)(4)(d)(ii) for all hospitals, and divide that result by 12.
  5. Distribution of funds for indirect program costs. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the amount calculated for the hospital at subsection (D)(4)(a).
- E.** Reallocation of funds. If funds appropriated for subsection (B) are not allocated by the Administration and funds appropriated for subsections (C) and (D) are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the funds not allocated under subsection (B) shall be allocated under subsections (C) and (D) to the extent of the calculated distributions. If funds are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the Administration shall adjust the distributions proportionally. If funds appropriated for subsections (C) and (D) are not allocated by the Administration and funds appropriated for subsection (B) are insufficient to cover all distributions under subsection (B)(5), the funds not allocated under subsections (C) and (D) shall be allocated under subsection (B) to the extent of the calculated distributions.
- F.** The Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals that are eligible under subsection (D)(1) and specified by the local, county, or tribal government for indirect program costs other than those reimbursed under subsection (D). The Administration shall allocate available funds in accordance with subsection (D) except that reimbursement with such funds is not limited to resident positions or rotations in counties with populations of less than 500,000 persons. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the greatest among the following amounts, less any amounts distributed under subsection (D)(5):

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1. The amount that results from multiplying the total number of eligible residents allocated to the hospital under subsection (B)(4)(d)(ii) by 12 by the per resident per month conversion factor determined under subsection (D)(4)(b);
2. The amount calculated for the hospital at subsection (D)(4)(b)(v);
3. The median of all amounts calculated at subsection (D)(4)(b)(v) if the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a new training hospital; or
4. If the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a children's hospital, the median Medicaid indirect medical education payment costs shall be calculated as follows:
  - a. For each hospital with indirect medical education costs on the Medicare Cost Report, determine a per resident total indirect medical education cost by dividing the total indirect medical education costs determined under subsection (D)(4)(b) by the number of filled resident positions under subsection (B)(2).
  - b. Determine the median per resident amount under subsection (F)(4)(a).
  - c. For each hospital without an indirect medical education component on the Medicare cost report, multiply the median per resident amount under subsection (F)(4)(b) by the number of filled resident positions under subsection (B)(2) for that hospital and by the Medicaid utilization percent for that hospital determined in subsection (B)(4)(c)(i).
5. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
6. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
7. It is not administered by or does not receive its primary funding from an agency of the federal government;
8. It has established a new GME program or expanded the number of residents or fellows in an existing GME program on or after July 1, 2020.
3. Eligible positions. For purposes of determining distributions under this Section the following resident and fellowship positions qualify to the extent that the training takes place in Arizona at an eligible health care facility:
  - a. Filled resident or fellow positions in approved programs which began on or after July 1, 2020;
  - b. Eligible positions do not include residents or fellows that receive payments for services under the Access to Professional Services Initiative (APSI) program established in the Contractors' prepaid capitation contracts with the Administration.
4. Annual Reporting
  - a. By December 15 of each year, a GME program shall provide all of the following information for GME programs and positions which are expected to be eligible for funding under this Section as of the upcoming academic year (i.e., July 1 to June 30 of each year):
    - i. The program name and number assigned by the accrediting organization if available;
    - ii. The original date of accreditation if available;
    - iii. The names of the sponsoring institution and all participating institutions expected as of the date of reporting;
    - iv. The number of anticipated resident and fellowship positions eligible for funding as of the upcoming academic year;
    - v. The number of months or partial months during the upcoming academic year that each resident or fellow is expected to work in each hospital or in a non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
    - vi. The academic year of anticipated resident and fellowship positions;
    - vii. The length of the program; and
    - viii. The names and other information requested by AHCCCS to ensure the total GME distributions for each eligible position are not greater than the costs for each eligible position in the Intern and Resident Information System (IRIS) file.
  - b. By December 15 of each year, a GME program located in a county with a population of less than 500,000 persons shall provide the estimated one-time and ongoing costs for each program which it expects to be eligible for funding.
  - c. By September 1 of each year, a GME program shall provide the actual name of residents and fellows hired in the current academic year and other information requested by AHCCCS to ensure that total GME distributions for the eligible position are not

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 1782, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 13 A.A.R. 4032, effective November 1, 2007 (Supp. 07-4). Amended by final rulemaking at 21 A.A.R. 3469, effective January 30, 2016 (Supp. 15-4). Amended by final rulemaking at 24 A.A.R. 185, effective January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 24 A.A.R. 3321, effective January 5, 2019 (Supp. 18-4).

**R9-22-712.06. Supplemental Graduate Medical Education Fund Allocation**

- A.** Gradual Medical Education (GME) reimbursement as of July 1, 2020.
1. In addition to distributions according to Section R9-22-712.05, and subject to the availability of funds and approval by CMS, the Administration shall annually distribute monies appropriated for the GME programs approved by the Administration to hospitals for direct and indirect costs for graduate medical education programs which were established or expanded on or after July 1, 2020. The Administration shall estimate the distributions using information possessed by the Administration as of December 15 of each calendar year. The actual distributions will be made using information possessed by the Administration as of September first of the year in which the new residency or fellowship begins.
  2. Eligible Hospitals. A hospital is eligible for distributions under this Section if all of the following apply:

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greater than the costs for each eligible position in the IRIS file.

- B.** Preliminary allocation of funds for urban hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for hospitals in counties with a population of 500,000 persons or more based on the number of new residents and fellows in graduate medical education programs in the following manner:
1. Each eligible resident and fellow is placed into tiers with the following priority:
    - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
    - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
    - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
    - d. All other residents and fellows.
  2. The amount of the distribution for each GME program for direct costs is calculated as the product of:
    - a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
    - b. The Arizona Medicaid utilization as determined by R9-22-712.05(B)(4)(c)(i) in the previous calendar year; and,
    - c. The average direct cost per resident determined under R9-22-712.05(B)(4)(d) in the previous calendar year.
  3. If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier and sub-tier. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
    - a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
    - b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
    - c. Twelve months.
    - d. Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a tier or sub-tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher tier or sub-tier. If funding is insufficient to fully fund a tier or sub-tier, the remainder of funds will be prorated for eligible positions in that tier or sub-tier.
4. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.
- C.** Preliminary allocation of funds for rural hospitals. Annually by January 15, the Administration shall estimate the annual GME distributions under this Section using the funds appropriated for rural hospitals based on the number of eligible resident and fellow positions in graduate medical education programs located in a county with a population of less than 500,000 persons in the following manner:
1. Each resident and fellow will then be placed into a tier with the following priority:
    - a. Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this Section for the previous academic year and who is continuing in the same GME program.
    - b. Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, General Surgery, and any other program determined as high needs by the AHCCCS Administration.
    - c. Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this Section in a prior year.
    - d. All other residents and fellows.
  2. Residents and fellows in each tier are further divided into four sub-tiers with the following priority based on the location of the sponsoring or participating hospital:
    - a. Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85 percent primary care shortage.
    - b. Hospitals in a county designated as a HPSA with a greater than 50 percent to 85 percent primary care shortage.
    - c. Hospitals in a county designated as a HPSA with a 25-50 percent primary care shortage.
    - d. Hospitals in a county designated as a HPSA with a less than 25 percent primary care shortage.
  3. Funds shall first be allocated for direct and indirect costs based in order of priority of each tier. If not enough funding is available to fully fund a tier or sub-tier, the remainder of funds will be prorated in a tier or sub-tier.
  4. The amount of the distribution for each GME program for direct costs is calculated as the product of:
    - a. The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals;
    - b. The Arizona Medicaid utilization determined under R9-22-712.05(B)(4)(c)(i); and,
    - c. The actual direct cost per resident per year.
  5. The amount of the distribution for each GME program for indirect costs is calculated as the product of:
    - a. The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;

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- b. The indirect cost per resident per month calculated in R9-22-712.05(D)(4)(b)(vi) in the previous calendar year; and
    - c. Twelve months.
  - 6. Payments are made to participating hospitals based on the FTEs who worked at their hospitals per year.
  - D.** Final allocation of funds. Annually no sooner than September 1 following the start of the academic year, the Administration will recalculate the allocation for urban and rural hospitals using the same methodology used to estimate distributions, but using the actual residents and fellows as reported in R9-22-712.06(A)(4)(c).
  - F.** Exclusions. To ensure that residents and fellows are not double counted residents/fellows which receive funding through R9-22-712.06 shall not receive funding through R9-22-712.05.
- Historical Note**
- New Section made by final rulemaking at 27 A.A.R. 2496 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4). Amended by final rulemaking at 29 A.A.R. 923 (April 21, 2023), with an immediate effective date of March 31, 2023 (Supp. 23-1).
- R9-22-712.07. Rural Hospital Inpatient Fund Allocation**
- A.** For purposes of this Section, the following words and phrases have the following meanings unless the context specifically requires another meaning:
    - 1. "Calculated inpatient costs" means the sum of inpatient covered charges multiplied by the Milliman study's implied cost-to-charge ratio of .8959.
    - 2. "Claims paid amount" means the sum of all claims paid by the Administration and contractors, as reported by the contractor to the Administration, to a rural hospital for covered inpatient services rendered for dates of service during the previous state fiscal year.
    - 3. "Fund" means any state funds appropriated by the Legislature for the purposes set forth in A.R.S. § 36-2905.02 and any federal funds that are available for matching the state funds.
    - 4. "Inpatient covered charges" means the sum of all covered charges billed by a hospital to the Administration or contractors, as reported by the contractors to the Administration, for inpatient services rendered during the previous state fiscal year.
    - 5. "Milliman study" means the report issued by Milliman USA on March 11, 2004, to the Arizona Hospital and Healthcare Association that updated a portion of a cost study entitled "Evaluation of the AHCCCS Inpatient Hospital Reimbursement System" prepared by Milliman USA for AHCCCS on November 15, 2002. A copy of each report is on file with the Administration.
    - 6. "Rural hospital" means a health care institution that is licensed as an acute care hospital by the Arizona Department of Health Services for the previous state fiscal year and is not an IHS hospital or a tribally owned or operated facility and:
      - a. Has 100 or fewer PPS beds, not including beds reported as sub provider beds on the hospital's Medicare Cost Report, and is located in a county with a population of less than 500,000 persons, or
      - b. Is designated as a critical access hospital for the majority of the previous state fiscal year.
  - B.** Each February, the Administration shall allocate the Fund to the following three pools for the fiscal year:
    - 1. Rural hospitals with 25 or fewer PPS beds not including sub provider beds and all Critical Access Hospitals, regardless of the number of beds in the Critical Access Hospital;
    - 2. Rural hospitals other than Critical Access Hospitals with 26 to 75 PPS beds not including sub provider beds; and
    - 3. Rural hospitals other than Critical Access Hospitals with 76 to 100 PPS beds not including sub provider beds.
  - C.** The Administration shall allocate the Fund to each pool according to the ratio of claims paid amount for all hospitals assigned to the pool to total claims paid amount for all rural hospitals.
  - D.** The Administration shall determine each hospital's claims paid amount and allocate the funds in each pool to each hospital in the pool based on the ratio of each hospital's claims paid amount to the sum of the claims paid amount for all hospitals assigned to the pool.
  - E.** The Administration shall not make a Fund payment to a hospital that will result in the hospital's claims paid amount plus that hospital's Fund payment being greater than that hospital's calculated inpatient costs.
    - 1. If a hospital's claims paid amount plus the hospital's Fund payment would be greater than the hospital's calculated inpatient costs, the Administration shall make a Fund payment to the hospital equal to the difference between the hospital's calculated inpatient costs and the hospital's claims paid amount.
    - 2. The Administration shall reallocate any portion of a hospital's Fund allocation that is not paid to the hospital due to the reason in subsection (E)(1) to the other eligible hospitals in the pool based upon the ratio of the claims paid amount for each hospital remaining in the pool to the sum of the claims paid amount for each hospital remaining in the pool.
  - F.** If funds remain in a pool after allocations to each hospital in the pool under subsections (D) and (E), the Administration shall reallocate the remaining funds to the other pools based upon the ratio of each pool's original allocation of the Fund as determined under subsection (C) to the sum of the remaining pools' original Fund allocations under subsection (C). The Administration shall allocate remaining funds to the hospitals in the remaining pools under subsection (D) and (E). See Exhibit 1 for an example.
  - G.** Subject to CMS approval of the method and distribution of the Fund, the administration or its contractors will distribute the Fund as a lump sum allocation to the rural hospitals in either one or two installments by the end of each state fiscal year.
- Historical Note**
- New Section made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 22 A.A.R. 3476, effective January 30, 2016 (Supp. 15-4).

**Exhibit 1. Pool Example**

Pool A receives \$2,000,000. Pool B receives \$7,000,000. Pool C receives \$3,000,000.

If all of the funds in Pool B are paid to eligible hospitals and there is \$1,000,000 remaining, the remaining funds would be allocated to Pool A and Pool C based on the ratio of each pool's original allocation (original allocations of \$2,000,000 and \$3,000,000) to the total of their original allocation ( $\$2,000,000 + \$3,000,000 = \$5,000,000$ ).

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Pool A would receive 2/5 of the remaining funds (\$400,000) and Pool C would receive 3/5 of the remaining funds (\$600,000).

**Historical Note**

Exhibit 1 made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2).

**R9-22-712.08. Federally Qualified Health Center and Rural Health Clinic Graduate Medical Education Program**

- A.** Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for primary care GME programs approved by the Administration to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for direct and indirect program costs eligible for funding under A.R.S. § 36-2907.06(I).
1. A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D).
  2. For purposes of this subsection, the term "FQHC" includes Federally Qualified Health Center Look-Alikes.
- B.** Eligible health care facilities. A health care facility is eligible for a distribution under subsection (G) if all of the following apply:
1. It is an FQHC or RHC in Arizona that is the sponsoring institution of, or a full member of a consortium that is the sponsoring institution of, or a participating institution in, one or more approved primary care GME programs in Arizona;
  2. It incurs direct or indirect costs for the training of residents in Arizona in approved primary care GME programs;
  3. The GME program is not eligible for funding under R9-22-712.05; and
  4. The GME program is not fully funded by the federal government.
- C.** Eligible residents and resident positions. For purposes of determining program allocation amounts under subsections (E) and (F) the following residents and resident positions are eligible for consideration, to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B):
1. All filled resident positions in approved primary care GME programs; or
  2. For approved primary care GME programs established for less than one year as of the date of annual reporting under subsection (D) and that have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.
- D.** Annual reporting. By April 1st of each year, an FQHC or RHC seeking a distribution under this subsection shall:
1. Provide to the Administration the following information about each approved primary care GME program:
    - a. The program name and number assigned by the accrediting organization;
    - b. The original date of accreditation of the program;
    - c. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
    - d. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
    - e. The academic year rotation schedule on file with the program current as of the date of reporting; and
  - f. For programs described under subsection (C)(2), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.
2. Provide to the Administration the most recent Medicare Cost Report for the FQHC or RHC seeking the distribution, and
  3. For an FQHC or RHC that is a full member of a consortium that is the sponsoring institution of an approved primary care GME program, provide to the Administration a signed letter attesting to the responsibility of the full member FQHC or RHC for direct or indirect costs of training residents in the program.
- E.** Allocation of funds for direct graduate medical education costs. Annually the Administration shall allocate available funds for direct graduate medical education costs to each eligible FQHC or RHC in the following manner:
1. A Medicaid utilization percent for each FQHC or RHC seeking a distribution shall be calculated using the Medicare Cost Report submitted under subsection (D)(2), dividing the Title XIX visit count by the whole number of visits reported and rounding the result up to the nearest multiple of 5 percent.
  2. A total number of residents eligible for funding in each program shall be calculated using the information submitted under subsection (D)(1), dividing the number of resident rotations in the year that take place in Arizona and not at a health care facility made ineligible under subsection (B) by the total number of resident rotations in the program for that year, multiplying the result by the total number of filled resident positions in the program and rounding to two digits after the decimal.
  3. The allocation for direct graduate medical education costs for each eligible FQHC or RHC shall be calculated by multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is \$170,090. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.
- F.** Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds for indirect program costs to each eligible FQHC or RHC in the following manner:
1. By multiplying the number of residents determined under subsection (E)(2) by the statewide average per-resident amount determined under this subsection and multiplying the result by the Medicaid utilization percent calculated for the FQHC or RHC under subsection (E)(1). The statewide average per-resident amount for the academic year ending June 30, 2022 is \$167,330;
  2. Annually thereafter, a statewide average per-resident amount shall be calculated by applying the Federally Qualified Health Center PPS Market Basket Update less

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Productivity Adjustment published by CMS for the calendar year in which the GME academic year begins.

- G.** Distribution of funds. On an annual basis subject to available funds, the Administration shall distribute to each eligible FQHC and RHC the sum of all amounts calculated for the FQHC or RHC under subsections (E)(3) and (F).
- H.** The Administration may enter into intergovernmental agreements with local, county, and tribal governments and any university under the jurisdiction of the Arizona Board of Regents wherein such entities may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will contribute to the state funding to qualify for federal matching funds. Those funds will be used for the purposes of reimbursing FQHCs and RHCs that are eligible under this rule and designated by the local, county, or tribal governments for receipt of the contributed funds. The Administration shall allocate available funds in accordance with subsections (E) and (F).

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 837 (April 29, 2022), with an immediate effective date of April 5, 2022 (Supp. 22-2).

**R9-22-712.09. Hierarchy for Tier Assignment through September 30, 2014**

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND primary Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 3231, effective October 1, 2005 (Supp. 05-3). Amended by exempt rulemaking at 17 A.A.R. 1707, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3).

Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.10. Outpatient Hospital Reimbursement: General**

- A.** Effective rule. The outpatient hospital reimbursement rules apply to dates of service beginning July 1, 2005, subject to Laws 2004, Ch. 279, § 19.
- B.** Basis For Payment. Except as provided under R9-22-712.30, AHCCCS shall pay for designated outpatient procedures provided to AHCCCS members according to the AHCCCS Outpatient Capped Fee-For-Service Schedule as defined in R9-22-712.20.
- C.** Data. AHCCCS shall use Medicare Cost Report and adjudicated claim and encounter data from non-IHS acute care hospitals located in the state of Arizona to develop fees for the AHCCCS Outpatient Capped Fee-For-Service Schedule.
- D.** Hospital Services Subject To Fees. AHCCCS shall reimburse services, in the following outpatient hospital categories under the AHCCCS Outpatient Capped Fee-For-Service Schedule:
1. Surgery,
  2. Emergency Department,
  3. Laboratory,
  4. Radiology,
  5. Clinic, and
  6. Other services.
- E.** Reimbursement. AHCCCS shall reimburse outpatient hospital services by procedure codes, in proper combination with revenue codes, as prescribed by AHCCCS.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

**R9-22-712.11. Reserved****R9-22-712.12. Reserved****R9-22-712.13. Reserved****R9-22-712.14. Reserved****R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals**

Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

**R9-22-712.16. Reserved****R9-22-712.17. Reserved****R9-22-712.18. Reserved****R9-22-712.19. Reserved****R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule**

- A.** To establish the AHCCCS Outpatient Capped Fee-for-service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:
1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-for-service Schedule.
  2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services to be paid

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under the AHCCCS Outpatient Capped Fee-for-service Schedule.

3. Match the revenue code on each detail of each claim and encounter to the ancillary line item CCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
  4. Multiply the line item CCR from subsection (A)(3) by the covered billed charge for that revenue code to establish the cost for the service.
  5. Inflate the cost for the service from subsection (A)(4) using Global Insight Health-care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
  6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
  7. Combine data from all Arizona hospitals identified in subsection (A)(3) for each procedure code to establish the statewide median cost for each procedure.
  8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
  9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
    - a. The AHCCCS Non-hospital Capped Fee-for-service Fee Schedule,
    - b. 116 percent of the procedure-specific median cost AHCCCS-based fee, or
    - c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
  10. Compare the AHCCCS-based fee established in subsections (A)(8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.
  11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-for-service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.
- B.** For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually.
1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration's Capped Fee-for-service Schedule under R9-22-710.
  2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-service Schedule. This

hourly rate includes reimbursement for associated services.

- C.** The AHCCCS Outpatient Capped Fee-for-service Schedule including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

**R9-22-712.21. Reserved**

**R9-22-712.22. Reserved**

**R9-22-712.23. Reserved**

**R9-22-712.24. Reserved**

**R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs**

- A.** AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.
- B.** Payment made under subsection (A) or R9-22-712.20(B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.
- C.** A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services including the effective date of any changes to the listing are on file and posted on AHCCCS' web site.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3).

**R9-22-712.26. Reserved**

**R9-22-712.27. Reserved**

**R9-22-712.28. Reserved**

**R9-22-712.29. Reserved**

**R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule**

- A.** AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.
- B.** For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the method specified in R9-22-712.20(A)(3).
- C.** For all claims with a begin date of service on or after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban Cost-to-charge Ratio or the CMS Medicare Outpatient Rural Cost-to-charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals



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located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural CCRs to the CCRs as published by CMS in the *Federal Register* on or before August 1st of that year.

- D. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied by the covered charges.
- E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this Section.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4).

**R9-22-712.31. Reserved**

**R9-22-712.32. Reserved**

**R9-22-712.33. Reserved**

**R9-22-712.34. Reserved**

**R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees**

- A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
  1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
  2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
  5. By 113 percent for a Freestanding Children's Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
  6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
- B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-

of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:

1. By 73 percent for public hospitals;
  2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
  3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
  4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
  5. By 78 percent for a Freestanding Children's Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
  6. By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.
- C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
  - D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).
  - E. For outpatient services with dates of service from October 1, 2023 through September 30, 2024 (CYE 2024), the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2023. If a hospital receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
    1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c) or (d):
      - a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface

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- that delivers patient data into the hospital's EHR system.
- ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
  - iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
  - iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
  - v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements, which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
- b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
      - (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
    - ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
      - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
  - c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
      - (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
    - ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
      - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
  - d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSdap@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must

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contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

- i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
  - ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in subsection (2)(a), (b), (c) or (d). No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
- a. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
    - i. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - ii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
    - iii. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
    - iv. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements, which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
  - b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
      - (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
    - ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
      - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
  - c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
      - (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by

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- facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
- ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
    - (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
    - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
  - d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
    - ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.
  3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in subsection (3)(a), (b), (c), (d), (e), or (f):
    - a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
      - ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
    - iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
    - v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements, which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
    - b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
      - i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
        - (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
        - (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for

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- documents within the Registry.
- ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
    - (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
    - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
  - c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
      - (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
    - ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
      - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
  - d. On March 15, 2023 a hospital that is identified as a Medicare Annual Payment Update (APU) recipient on the QualityNet.org website will qualify for the DAP increase. APU recipients are those hospitals that satisfactorily meet the requirements for the Inpatient Psychiatric Facility Quality Reporting Program, which includes multiple clinical quality measures.
  - e. On March 15, 2023, long-term care hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for the DAP increase. The national average will be downloaded from the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury for long-term care hospitals. Facility results will be compared to the national average results for the measure.
  - f. On March 15, 2023, rehabilitation hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for the DAP increase. The national average will be downloaded from the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury rehabilitation hospitals. Facility results will be compared to the national average results for the measure.
4. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets these criteria specified in subsection (4)(a) or (b);
    - a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
      - ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      - iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
      - iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID)

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- created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
- v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements, which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
  - b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. No later than November 1, 2023, complete the AzHDR Participant Agreement.
    - ii. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
  - c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required.
    - ii. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
  - d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
    - ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.
- F. For outpatient services with dates of service from October 1, 2024 through September 30, 2025 (CYE 2025), the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2024. If a hospital receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.
1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d) (e) or (f):
    - a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
      - iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      - iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
      - v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE Platform.

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- vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
- vii. No later than September 1, 2024, hospitals must launch the integration implementation project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
- viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
  - (1) HIE Participation Agreement for ONE Platform.
  - (2) Statement of Work (SOW) to access the ONE Platform Portal.
  - (3) Statement of Work (SOW) to send data to ONE Platform.
- x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
- xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform HIE portal.
- b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
  - iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
  - iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
    - (3) Statement of Work (SOW) to send data to ONE Platform.
  - v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
  - vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
  - viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
  - ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during

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- the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
    - ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.
    - iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.
    - iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.
  - d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
    - iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
    - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
    - e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
      - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings/referrals within CommunityCares per facility location.
      - iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
      - iv. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - v. No later than November 30, 2024, the hospital must develop and submit a current facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
      - vi. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
    - f. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
      - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will



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- participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
- ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP.
  - iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
  - iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSdap@azahcccs.gov.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c), (d), (e), (f), (g) or (h):
    - a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's (EHR) system.
      - iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      - iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
    - b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
      - v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE platform.
      - vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
      - vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
      - viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
      - ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
        - (1) HIE Participation Agreement for ONE Platform.
        - (2) Statement of Work (SOW) to access the ONE Platform Portal.
        - (3) Statement of Work (SOW) to send data to ONE Platform.
      - x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
      - xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

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- i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
- ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
- iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
- iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
  - (1) HIE Participation Agreement for ONE Platform.
  - (2) Statement of Work (SOW) to access the ONE Platform Portal.
  - (3) Statement of Work (SOW) to send data to ONE Platform.
- v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
- vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
- vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
- viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
- ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- c. Hospitals who participated in the DAP AzHDR program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCS ID.
- d. Hospitals who have not participated in the DAP AzHDR program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than November 1, 2024, the hospital must submit the AzHDR Subscription Agreement to the HIE organization.
  - iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.
  - iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per AHCCCS ID.
- e. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the

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- HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
- ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
  - iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
  - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
  - f. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
    - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
    - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
    - iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist hospitals in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
  - g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
    - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
    - iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
  - h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
    - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
    - iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
    - iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
  3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in (3)(a), (b), (c), (d) or (e):
    - a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more

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- HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
- iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
  - iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable), laboratory, and radiology information (if applicable), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
  - v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to the ONE platform.
  - vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
  - vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
  - viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
  - ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
    - (3) Statement of Work (SOW) to send data to ONE Platform.
  - x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
  - b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
    - iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
    - iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
      - (1) HIE Participation Agreement for ONE Platform.
      - (2) Statement of Work (SOW) to access the ONE Platform Portal.
      - (3) Statement of Work (SOW) to send data to ONE Platform.
    - v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.

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- vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
- vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
- viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
- ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI).
  - ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.
  - iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.
  - iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.
- d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
  - iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screenings/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater.
  - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
- e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
  - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.

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- iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
  - iv. Hospitals that meet or fall below the national average for the pressure ulcer performance measure will qualify for a 2.0% DAP increase. On March 15, 2024, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
  - v. Hospitals that meet or fall below the national average for the pressure ulcer performance measure will qualify for a 2.0% DAP increase. On March 15, 2024, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
4. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets these criteria specified in (4)(a), (b), (c), (d), (e), (f), (g) or (h):
- a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
    - iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
  - iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following patient identifiable information to the production environment of the HIE: registration, encounter summary, and data elements defined by the HIE specific to individuals with a serious mental illness. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
  - v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to the ONE Platform.
  - vi. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
  - vii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following patient identifiable information to the production environment of the HIE: registration, encounter summary, and data elements defined by the HIE specific to individuals with a serious mental illness.

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- viii. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
  - (1) HIE Participation Agreement for ONE Platform.
  - (2) Statement of Work (SOW) to access the ONE Platform Portal.
  - (3) Statement of Work (SOW) to send data to ONE Platform.
- ix. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
- x. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
- b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
  - iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
  - iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
  - v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
- c. Hospitals who participated in the DAP AzHDR program in CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCS ID.
- d. Hospitals who have not participated in the DAP AzHDR program CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than November 1, 2024, the hospital must complete the AzHDR Subscription Agreement.
  - iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.
  - iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per registered AHCCCS ID.
- e. Hospitals who participated in the DAP SDOH program in CYE 2024.
  - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening

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- tool, and to define the CYE 2025 in-network screening/referral monthly goal.
- iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screenings/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/ referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
  - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
  - f. Hospitals that have not participated in the DAP SDOH program in CYE 2024.
    - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
    - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
    - iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
  - g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
    - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
    - iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
    - h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
      - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
      - iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
      - iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp. 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 3394 (October 27, 2023), with an immediate effective date of October 4, 2023 (Supp. 23-4). Amended by final rulemaking at 30 A.A.R. 3103 (October 25, 2024), with an immediate effective date of October 1, 2024 (Supp. 24-4).



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**R9-22-712.36. Reserved****R9-22-712.37. Reserved****R9-22-712.38. Reserved****R9-22-712.39. Reserved****R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update**

- A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.
- B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.
- C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:
  1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
  2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.
- D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this Section.
- E. Rebase. AHCCCS shall rebase the outpatient fees every five years.
- F. Statewide CCR:
  1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
  2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30(C).
- G. Other Updates. In addition to the other updates provided for in this Section, the Administration may adjust the Outpatient Capped Fee-For-Service Fee Schedule and the Statewide CCR to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by exempt rulemaking at 18 A.A.R. 1914, effective July 18, 2012 (Supp. 12-3). Amended by final rulemaking at 19 A.A.R. 3315, effective November 30, 2013 (Supp. 13-4). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.41. Reserved****R9-22-712.42. Reserved****R9-22-712.43. Reserved****R9-22-712.44. Reserved****R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions**

- A. AHCCCS shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department.
- B. AHCCCS shall include payment for the emergency room, observation, and other outpatient hospital services provided to the member before the hospital admission in the AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule under Article 7 of this Chapter.
- C. Same day admit and discharge.
  1. For discharges before September 30, 2014. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
  2. For discharge dates on and after October 1, 2014. Same day admit and discharge claims are paid for through the outpatient fee schedule.

**Historical Note**

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.46. Reserved****R9-22-712.47. Reserved****R9-22-712.48. Reserved****R9-22-712.49. Reserved****R9-22-712.50. Outpatient Hospital Reimbursement: Billing**

To receive appropriate reimbursement, hospitals shall:

1. Bill outpatient hospital services on the CMS approved Uniform Billing Form or in electronic format using the appropriate HIPAA transaction.
2. Follow the UB Manual Guidelines, as published by the National Uniform Billing Committee, and use the appropriate revenue code and procedure code combination as prescribed by AHCCCS and on file and online with AHCCCS.

**Historical Note**

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New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

- R9-22-712.51. Reserved**
- R9-22-712.52. Reserved**
- R9-22-712.53. Reserved**
- R9-22-712.54. Reserved**
- R9-22-712.55. Reserved**
- R9-22-712.56. Reserved**
- R9-22-712.57. Reserved**
- R9-22-712.58. Reserved**
- R9-22-712.59. Reserved**

**R9-22-712.60. Diagnosis Related Group Payments**

- A.** Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this Section and R9-22-712.61 through R9-22-712.81.
- B.** Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.
- C.** Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. The applicable version of the APR-DRG classification system shall be available on the agency's website.
- D.** Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.
- E.** Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.
- F.** For purposes of this Section and Sections R9-22-712.61 through R9-22-712.81:
  - 1. "DRG National Average length of stay" means the national arithmetic mean length of stay published in the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.
  - 2. "Length of stay" means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.
  - 3. "Medicare" means Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.
  - 4. "Medicare labor share" means a hospital's labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016

(Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.61. DRG Payments: Exceptions**

- A.** Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 801 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).
  - 1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;
  - 2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
  - 3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;
- B.** Notwithstanding Section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.
- C.** Notwithstanding Section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.
- D.** Notwithstanding Section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the Federal Register.
- E.** For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.
- F.** For inpatient services with a date of admission from October 1, 2023 through September 30, 2024 (CYE 2024), provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration's public website as part of its fee schedule,

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subsequent to a public notice published no later than September 1, 2023. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype. If a hospital receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (G), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c) or (d):
  - a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
    - ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
    - iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
  - b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
      - (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
    - ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
      - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
  - c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
      - (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community
  - v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements, which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.

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- Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
- ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
    - (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
    - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
  - d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSdap@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
    - ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in subsection (2)(a), (b), (c) or (d):
    - a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.
      - ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
    - iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
    - v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements, which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
  - b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
      - (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is

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- defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
- ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
    - (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
    - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
  - c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
      - (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
    - ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
      - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
  - d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSdap@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
    - ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
- G.** For outpatient services with dates of service from October 1, 2024 through September 30, 2025 (CYE 2025), the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2024. If a hospital receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.
1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d), (e) or (f):
    - a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. Hospitals must meet the following milestones in maintaining existing connections to the current HIE platform:
        - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.
      - iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immuni-

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- zation data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
- v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE Platform.
  - vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
  - vii. No later than September 1, 2024, hospitals must launch the integration implementation project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
  - viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
  - ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
    - (3) Statement of Work (SOW) to send data to ONE Platform.
  - x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform HIE portal.
  - b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
    - iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
    - iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
      - (1) HIE Participation Agreement for ONE Platform.
      - (2) Statement of Work (SOW) to access the ONE Platform Portal.
      - (3) Statement of Work (SOW) to send data to ONE Platform.
    - v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
    - vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
    - vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and

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- focus on improving data integrity in the test environment.
- ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
  - c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
    - ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.
    - iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.
    - iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.
  - d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
    - iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
    - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
    - e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
      - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings/referrals within CommunityCares per facility location.
      - iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
      - iv. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s)

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- (NPI), that the hospital requests to participate in the DAP.
- v. No later than November 30, 2024, the hospital must develop and submit a current facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
  - vi. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
- f. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
    - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP.
    - iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
    - iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
  2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c), (d), (e), (f), (g) or (h):
    - a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's (EHR) system.
      - iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
    - v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE platform.
    - vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
    - vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
    - viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
    - ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
      - (1) HIE Participation Agreement for ONE



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- Platform.
- (2) Statement of Work (SOW) to access the ONE Platform Portal.
- (3) Statement of Work (SOW) to send data to ONE Platform.
- x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
- xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
- b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
  - iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
  - iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
    - (3) Statement of Work (SOW) to send data to ONE Platform.
  - v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
  - vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
  - viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
  - ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- c. Hospitals who participated in the DAP AzHDR program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCS ID.
- d. Hospitals who have not participated in the DAP AzHDR program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

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- ii. No later than November 1, 2024, the hospital must submit the AzHDR Subscription Agreement to the HIE organization.
- iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.
- iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per AHCCCS ID.
- e. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
  - iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
  - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
- f. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
  - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
  - iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist hospitals in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
- g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
  - iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
- h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
  - iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
  - iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.

**Historical Note**

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New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3111 and at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp. 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 3394 (October 27, 2023), with an immediate effective date of October 4, 2023 (Supp. 23-4). Amended by final rulemaking at 30 A.A.R. 3103 (October 25, 2024), with an immediate effective date of October 1, 2024 (Supp. 24-4).

**R9-22-712.62. DRG Base Payment**

- A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjusters.
- B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital's labor-related share of that amount is adjusted by the hospital's wage index. The hospital's labor share is determined based on the labor share for the Medicare inpatient prospective payment system published in 85 Fed. Reg. 59060 through 59061 (September 18, 2020). The hospital's wage index is determined based on the wage index tables reference in 85 Fed. Reg. 59059 (September 18, 2020). The statewide standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
- C. Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the "pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the "post-HCAC" DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 27 A.A.R. 2512 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4).

**R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount**

- A. Notwithstanding Section R9-22-712.62, a select specialty hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:

1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
  2. Hospitals designated as type: hospital, subtype: short term that has a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.
- B. The select specialty hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
  - C. Notwithstanding Section R9-22-712.62, a rural hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:
    1. A health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds, and that is located in a county with a population of less than five hundred thousand persons; or
    2. A health care institution that is licensed as a critical access hospital.
  - D. The rural hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
  - E. Notwithstanding Sections R9-22-712.62 and R9-22-712.63(B), a hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) or R9-22-712.63(B) to calculate the DRG base rate for a health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has greater than twenty percent of Medicaid inpatient reimbursement with a primary diagnosis of behavioral health in the prior federal fiscal year as of April 30th.
  - F. The hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.
  - G. Notwithstanding Section R9-22-712.62 and R9-22-712.63(B), a hospital standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) or R9-22-712.63(B) to calculate the DRG base rate for a health care institution with two separate ADHS acute care hospital licenses, with one facility that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has one single AHCCCS registration for both licenses.
  - H. The hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency's website.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 29 A.A.R. 19 (January 6, 2023), with an immediate effective date of December 16, 2022 (Supp. 22-4).

**R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals**

- A. DRG Base payment:
  1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.

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2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be included in the AHCCCS capped fee schedule available on the agency's website.
- B. Outlier CCR:**
1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
  2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.
- C.** A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2015.
- D.** Other than as required by this Section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.65. DRG Provider Policy Adjustor**

- A.** After calculating the DRG base payment as required in R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor that is included in the AHCCCS capped fee schedule available on the agency's website.
- B.** A hospital is a high-utilization hospital if the hospital had:
1. Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals;
  2. A Medicaid inpatient utilization rate greater than 30 percent calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital's Medicare Cost Report for the fiscal year ending 2016; and,
  3. Received less than \$2 million in add-on payment for outliers under R9-22-712.68, based on adjudicated claims and encounters for fiscal year beginning October 1, 2015.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.66. DRG Service Policy Adjustor**

In addition to Section R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the service policy

adjustor listed in the AHCCCS capped fee schedule, available on the agency's website, corresponding to the following DRG codes:

1. Normal newborn DRG codes,
2. Neonates DRG codes,
3. Obstetrics DRG codes,
4. Psychiatric DRG codes,
5. Rehabilitation DRG codes,
6. Burn DRG codes.
7. Claims for members under age 19 assigned DRG codes other than listed above:
  - a. For dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
  - b. For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
  - c. For dates of discharge on or after January 1, 2016 and before January 1, 2017, for severity of illness levels 3 and 4.
  - d. For dates of discharge on or after January 1, 2017, and before January 1, 2018 for severity of illness levels 3 and 4.
  - e. For dates of discharge on or after January 1, 2018, for severity of illness levels 3 and 4.
8. Claims for members assigned DRG codes other than listed above.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.67. DRG Reimbursement: Transfers**

- A.** For purposes of this Section a "transfer" means the transfer of a member from a hospital to a short-term general hospital for inpatient care, a designated cancer center, children's hospital, or a critical access hospital except when a member is moved for the purpose of receiving sub-acute services.
- B.** Designated cancer center or children's hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.
- C.** The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.
- D.** The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustors, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.
- E.** The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.
- F.** Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustors, or the transfer DRG base payment, whichever is less.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

**R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment**

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- A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.
- B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:
  - 1. For hospitals designated as type: hospital, subtype: children's in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1 of that year.
  - 2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
  - 3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.
- C. AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be used for claims with dates of discharge on or after October 1 of that year.
- D. The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount for critical access hospitals and for all other hospitals are included in the AHCCCS capped fee schedule available on the agency's website.
- E. For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage for claims assigned DRG codes associated with the treatment of burns and for all other claims are included in the AHCCCS capped fee schedule available on the agency's website.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment**

Adjustments to the payments are made to account for days not covered by AHCCCS as follows:

- 1. A covered day reduction factor unadjusted is determined if the member is not eligible on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay. In this case, a covered day reduction factor unadjusted is calculated by dividing the number of AHCCCS covered days by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.
- 2. A covered day reduction factor unadjusted is also determined if the member is eligible on the first day of the inpatient stay but is determined ineligible for one or more

days prior to the date of discharge. In this case, a covered day reduction factor unadjusted is calculated by adding one to the number of AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.

- 3. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
- 4. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
- 5. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members**

In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.

- 1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.
- 2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
- 3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
- 4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.71. Final DRG Payment**

- A. The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.
- B. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem pay-

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ment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

- C. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
- D. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration's website and is on file for public inspection at the AHCCCS administration located at 801 E. Jefferson Street, Phoenix, Arizona.
- E. For inpatient services with a date of discharge from October 1, 2023 through September 30, 2024 (CYE 2024), the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2023. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype. If a hospital receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time.
  - 1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), or (d):
    - a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's system.
      - ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      - iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
    - iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
    - v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. Which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
  - b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
      - (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
    - ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
      - (2) No later than April 1, 2024, have onboard-

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- ing completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
- c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
      - (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
    - ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
      - (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
      - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
  - d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
    - ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in subsection (2)(a), (b), (c) or (d):
    - a. No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - i. No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's system.
      - ii. No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
      - iii. No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
      - iv. No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and Health Level Seven (HL7). The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant.
      - v. No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. Which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.
    - b. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding

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NPI(s), that the hospital requests to participate in the DAP.

- i. For hospitals that have participated in DAP HIE requirements in CYE 2023:
  - (1) No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization.
  - (2) After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.
- ii. For hospitals that have not participated in DAP HIE requirements in CYE 2023:
  - (1) No later than November 1, 2023, complete the AzHDR Participant Agreement, and
  - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.
- c. No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the Community Cares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
  - i. For hospitals that have participated in DAP SDOH requirements in CYE 2023:
    - (1) No later than September 30, 2023, initiate use of the Community Cares referral system operated by the HIE organization.
    - (2) No later than May 1, 2024: After all the onboarding requirements have been met and the provider has access to the system and through September 30, 2024, the hospital must regularly utilize the Community Cares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in Community Cares. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024.
  - ii. For hospitals that have not participated in DAP SDOH requirements in CYE 2023:
    - (1) No later than November 1, 2023, complete the Community Cares Access Agreement and the HIE Participant Agreement, as required, and
    - (2) No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.
- d. No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
  - i. No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
  - ii. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facility's policy.
- F. For outpatient services with dates of service from October 1, 2024 through September 30, 2025 (CYE 2025), the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration's public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2024. If a hospital receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (F), the hospital shall be disqualified from participating in a DAP for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time. A hospital can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital subtypes.
  1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children's will qualify for an increase if it meets the criteria in subsection (1)(a), (b), (c), (d), (e) or (f):
    - a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
      - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
      - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the hospital's Electronic Health Record (EHR) system.



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- iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
- iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
- v. No later than May 1, 2024, hospitals must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE Platform.
- vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
- vii. No later than September 1, 2024, hospitals must launch the integration implementation project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
- viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
  - (1) HIE Participation Agreement for ONE Platform.
  - (2) Statement of Work (SOW) to access the ONE Platform Portal.
  - (3) Statement of Work (SOW) to send data to ONE Platform.
- x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
- xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform HIE portal.
- b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
  - iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
  - iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
    - (3) Statement of Work (SOW) to send data to ONE Platform.
  - v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.

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- vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
- viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
- ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- c. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI) that the hospital requests to participate in the DAP.
  - ii. Within 30 days of sending data into the test environment but no later than December 1, 2024, the hospital must review the results of up to 217 parameters from the HIE Data Quality Report with the HIE organization, identifying the high-risk (red) and moderate risk (orange) scores for each parameter.
  - iii. Within 60 days of sending data into the test environment, but no later than December 1, 2024, the hospital must achieve an HIE Data Quality Report with 0 high-risk (red) test parameters prior to sending data into the HIE production environment.
  - iv. No later than December 1, 2024, the hospital must submit a written resolution plan to Contexture along with an expected timeline and detailed action plan for resolution to correct the moderate risk (orange) parameters on the HIE Data Quality Report.
- d. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
  - iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
  - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
- e. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings/referrals within CommunityCares per facility location.
  - iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to

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- review progress. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
- iv. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - v. No later than November 30, 2024, the hospital must develop and submit a current facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
  - vi. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
- f. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
- i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP.
  - iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
  - iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in (2)(a),(b), (c), (d), (e), (f), (g) or (h):
- a. Hospitals who participated in the DAP HIE program in CYE 2023 and/or CYE 2024.
    - i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - ii. No later than May 1, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, standard Admission, Discharge, Transfer (ADT) Alerts, standard Clinical Notifications, or an interface that delivers patient data into the facility's (EHR) system.
    - iii. No later than May 31, 2024, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
    - iv. No later than May 31, 2024, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If a hospital is in the process of integrating a new EHR system, the hospital must notify the HIE organization and get the implementation timeline approved to continue meeting DAP requirements.
    - v. No later than May 1, 2024, the hospital must complete their HIE Integration workbook in its entirety to connect data sender interfaces to ONE platform.
    - vi. No later than May 1, 2024, the hospital must submit a signed Picture Archiving and Communication System (PACS) Statement of Work (SOW) to participate in sharing images via the HIE.
    - vii. No later than September 1, 2024, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
    - viii. No later than December 30, 2024, the hospital must have a connection in place with the HIE and electronically submit the following patient information to the ONE Platform production environment: ADT information, including data from the hospital emergency department (if applicable); laboratory and radiology information (if applicable); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active

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- medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- ix. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
    - (3) Statement of Work (SOW) to send data to ONE Platform.
  - x. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - xi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
- b. Hospitals who have not participated in the DAP HIE program in CYE 2023 or CYE 2024.
- i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than October 1, 2024, the hospital must launch the implementation project to access patient health information via the HIE and complete the HIE portal training prior to access being granted.
  - iii. No later than December 30, 2024, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the HIE Portal.
  - iv. No later than February 28, 2025, the hospital must have in place the following new agreements with the HIE organization as a result of the affiliation of Health Current and Colorado Regional Health Information Organization (CORHIO).
    - (1) HIE Participation Agreement for ONE Platform.
    - (2) Statement of Work (SOW) to access the ONE Platform Portal.
    - (3) Statement of Work (SOW) to send data to ONE Platform.
  - v. No later than May 1, 2025, the hospital must launch the implementation project to access patient health information via the HIE and complete the ONE Platform portal training prior to access being granted.
  - vi. No later than July 30, 2025, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing the ONE Platform portal.
  - vii. No later than August 1, 2025, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the HIE on their behalf.
  - viii. No later than August 1, 2025, the hospital must launch the integration implementations project, have a VPN connection in place with the HIE, and electronically submit test patient information to the ONE Platform test environment. The hospital is required to engage in interface testing as required by the HIE and focus on improving data integrity in the test environment.
  - ix. No later than September 30, 2025, the hospital must electronically submit the following patient identifiable information to the production environment of the HIE organization: ADT information, including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. The hospital is required to engage in interface testing as required by the HIE.
- c. Hospitals who participated in the DAP AzHDR program in CYE 2023 and/or CYE 2024.
- i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 patient document uploads of advanced directives and 15 searches of advance directives per month per registered AHCCCSID.
- d. Hospitals who have not participated in the DAP AzHDR program in CYE 2023 or CYE 2024.

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- i. No later than April 1, 2024, the hospital must have in place an active Health Information Exchange (HIE) Participation Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization indicating Arizona Health Directives Registry (AzHDR) participation. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
- ii. No later than November 1, 2024, the hospital must submit the AzHDR Subscription Agreement to the HIE organization.
- iii. No later than April 1, 2025, the hospital must have onboarding completed by working with AzHDR to submit user information to gain credentials to access AzHDR and complete training.
- iv. No later than May 1, 2025, the hospital must participate in the utilization of the AzHDR platform by facilitating at least 5 searches/uploads of advance directives per month per AHCCCS ID.
- e. Hospitals who participated in the DAP SDOH program in CYE 2023 and/or CYE 2024.
  - i. No later than April 1, 2024, the hospital must have an active CommunityCares Agreement and submit a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than September 30, 2024, the hospital must participate in a post-live meeting with their assigned SDOH Advisor to discuss training needs, SDOH Screening and Referral workflows, implementation of the SDOH screening tool, and to define the CYE 2025 in-network screening/referral monthly goal.
  - iii. From October 1, 2024 through September 30, 2025, the hospital must participate in the utilization of CommunityCares by facilitating screenings/referrals. All screening/referrals entered into CommunityCares by the hospital will be counted towards the utilization requirements and tracked monthly. Based on the SDOH CYE 2024 monthly screenings/referrals average, the hospital's goal for CYE 2025 is to improve the submission of the monthly screenings/referrals average by 5%, and no less than a combination of 10 screenings or referrals per month per facility location, whichever is greater. This goal will be defined and discussed in the post-live meeting with the hospital's assigned SDOH Advisor.
  - iv. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to review progress on goals. If the goal is not being met, the SDOH Advisor will assist the hospital in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
- f. Hospitals who have not participated in the DAP SDOH program in CYE 2023 or CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a CommunityCares Access Agreement and a signed Differential Adjusted Payment Statement of Work (DAP SOW) to the HIE organization. The participant list attached to the DAP SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP, and the total number of patient visits per year.
  - ii. No later than January 1, 2025, the hospital must have onboarding completed by working with the CommunityCares team to submit all requirements prior to gaining access to the system. The hospital must utilize CommunityCares by facilitating in-network screenings and referrals within CommunityCares per facility location.
  - iii. From October 1, 2024, through September 30, 2025, the hospital must meet with their SDOH Advisor quarterly to set a utilization goal and to review progress. If the goal is not being met, the SDOH Advisor will assist hospitals in completing a written document that identifies barriers to achieving goals and outlines steps to overcome these barriers (improvement plan).
- g. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
  - ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
  - iii. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov.
- h. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
  - i. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCS-DAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.

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- ii. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
- iii. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
- iv. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCCSdap@azahcccs.gov.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 31, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp. 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4). Amended by final rulemaking at 28 A.A.R. 3283 (October 14, 2022), with an immediate effective date of September 23, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 3394 (October 27, 2023), with an immediate effective date of October 4, 2023 (Supp. 23-4). Amended by final rulemaking at 30 A.A.R. 3103 (October 25, 2024), with an immediate effective date of October 1, 2024 (Supp. 24-4).

**R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay**

- A. If a member's enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in Sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in Sections R9-22-712.60 through R9-22-712.81.
- B. When a member's enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer responsible on the date of discharge as the "from" date of service on the claim regardless of the date of admission.
- C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the same manner as other interim claims as described in R9-22-712.76.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final

rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare**

If the hospital receives less than the full Medicare payment for a member eligible for benefits under Part A of Medicare because the member has exceeded the maximum benefit permitted under Part A of Medicare, the hospital shall submit a separate claim for services performed after the date the maximum Medicare Part A benefit is exceeded. The claim may include all diagnosis codes for the entire inpatient stay, but the hospital is only required to include revenue codes, surgical procedure codes, service units, and charges for services performed after the date the Medicare Part A benefit is exceeded. A claim so submitted shall be reimbursed using the DRG payment methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.74. DRG Reimbursement: Third Party Liability**

DRG payments are subject to reduction based on cost avoidance under Section R9-22-1003 and other rules regarding first-and third-party liability under Article 10 of this Chapter including cost avoidance for claims for ancillary services covered under Part B of Medicare.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.75. DRG Reimbursement: Payment for Administrative Days**

- A. Categories of Administrative Days. Administrative days fall into one of two categories, either subsection (A)(1) or (A)(2).
  - 1. Administrative days due to lack of appropriate placement options and not meeting inpatient medical criteria. Administrative days are days in which a member is admitted as an inpatient to an acute care hospital, does not meet the criteria for an acute inpatient stay, but is admitted or not discharged because; (1) an appropriate placement outside the hospital is not available, (2) the member cannot be safely discharged or transferred, or (3) the Administration or the contractor failed to provide for the appropriate placement outside the hospital in a timely manner.
    - a. Administrative days may occur prior to an acute care episode, for example, when a woman with a high-risk pregnancy is admitted to a hospital while awaiting delivery.
    - b. Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a nursing facility or other sub-acute or post-acute setting.
    - c. Administrative days may also include days in a receiving hospital when the member has been discharged from one acute care hospital for the purpose of receiving sub-acute services at the receiving hospital.
    - d. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays.

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- e. Administrative days include inpatient claims covered by a RBHA or TRBHA that otherwise meet the criteria in subsection (A)(1).
- 2. Administrative days for claims with the principal diagnosis of behavioral health meeting inpatient medical criteria. Administrative days are days with dates of discharge on or after October 1, 2018, in which a member is admitted as an inpatient to an acute care hospital, meets the criteria for an acute inpatient stay, and the principal diagnosis on the hospital claim is a behavioral health diagnosis. Inpatient claims covered by a RBHA or TRBHA are not considered administrative days under subsection (A)(2) regardless of the principal diagnosis on the hospital claim.
- B. Reimbursement of Administrative Days.
  - 1. Administrative days under subsection (A)(1) are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care such as the rate paid for stays at a nursing facility.
  - 2. Administrative days under subsection (A)(2) are reimbursed at the daily rate found on the Inpatient Behavioral Health Capped Fee-For-Service Schedule meeting the criteria of "Service Description – Psychiatric Stay," regardless of revenue code.
- C. Prior authorization is required for administrative days.
- D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 25 A.A.R. 3111, effective October 1, 2019 (Supp. 19-4).

**R9-22-712.76. DRG Reimbursement: Interim Claims**

- A. For inpatient stays with a length of stay greater than 29 days, a hospital may submit interim claims for each 30 day period during the inpatient stay.
- B. Hospitals shall be reimbursed for interim claims at a per diem rate of \$500 per day.
- C. Following discharge, the hospital shall void all interim claims. In such circumstances, the hospital shall submit a claim to the payer with whom the member is enrolled on the date of discharge, whether the Administration or a contractor, for the entire inpatient stay for which the final claim shall be reimbursed under the DRG payment methodology. Interim claims will be recouped.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day**

- A. Except as provided for in subsection (B), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the contractor or the Administration shall process the claim as an outpatient claim and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50.
- B. Claims with an admission date and discharge date that are the same calendar date that also indicate that the member expired

on the date of discharge shall be reimbursed under the DRG methodology.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.78. DRG Reimbursement: Readmissions**

If a member is readmitted without prior authorization to the same hospital that the member was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed only if the readmission could have been prevented by the hospital.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.79. DRG Reimbursement: Change of Ownership**

The administration shall not change any of the components of the calculation of reimbursement for inpatient services using the DRG methodology based upon a change in the hospital's ownership except to the extent those components would change under the methodology had the hospital not changed ownership (e.g., updating the hospital's cost-to-charge ratio as of September 1 of each year under R9-22-712.68).

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

**R9-22-712.80. DRG Reimbursement: New Hospitals**

- A. DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in subsection R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in subsection R9-22-712.62(B) shall be calculated as the statewide standardized amount after adjusting that amount for the labor-related share and the wage index published by CMS as described in subsection R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in subsection R9-22-712.62(B).
- B. Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in subsection R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in subsection R9-22-712.68(C).
- C. In addition to the requirement of this Section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.81. DRG Reimbursement: Updates**

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In addition to the other updates provided for in Sections R9-22-712.60 through R9-22-712.80, the Administration may update the version of the APR-DRG classification system established by 3M Health Information Systems, adjust the statewide standardized amount in Section R9-22-712.62, the base payments in R9-22-712.63 and R9-22-712.64, the provider policy adjustor in R9-22-712.65, service policy adjustors in R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration shall publish any proposed classification system on the agency's website at least 30 days prior to the effective date, to ensure a sufficient period for public comment, as required by 42 C.F.R. § 447.205. In addition, the public notice shall be available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. The requirements of 42 CFR § 447.205 as of November 2, 2015 are incorporated by reference and do not include any later amendments.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 23 A.A.R. 2896, effective January 1, 2018 (Supp. 17-4).

**R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments**

- A.** "Hospital-based freestanding emergency department" (hospital-based FSED) means an outpatient treatment center, as defined in R9-10-101, that: (1) provides emergency room services under R9-10-1019, (2) is subject to the requirements of 42 C.F.R. 489.24, and (3) shares an ownership interest with a hospital, regardless of whether the outpatient treatment center operates under a hospital's single group license as described in A.R.S. § 36-422.
- B.** A hospital-based FSED shall register with the Administration separately from the hospital with which an ownership interest is shared and shall obtain a separate provider identification number. The Administration shall not charge a separate provider enrollment fee for registration of a hospital-based FSED. The Administration shall accept a hospital's compliance with the provider screening and enrollment requirements of 42 CFR Part 455 as compliance by the hospital-based FSED.
- C.** For dates of service on and after March 1, 2017, and except as provided in subsection (D), services provided by a hospital-based FSED for evaluation and management CPT codes 99281 through 99285 shall be reimbursed at the following percentages of the amounts otherwise reimbursable under R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with R9-22-712.20 through R9-22-712.30 without a percentage reduction.
  1. 60 percent for a level 1 emergency department visit as indicated by CPT 99281.
  2. 80 percent for a level 2 emergency department visit as indicated by CPT 99282.
  3. 90 percent for a level 3 emergency department visit as indicated by CPT 99283.
  4. 100 percent for a level 4 or 5 emergency department visit as indicated by CPT codes 99284 and 99285.
- D.** A hospital-based FSED located in a city or town in a county with less than 500,000 residents, where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under R9-22-712.20 through R9-22-712.35 using the adjustment in R9-22-712.35 associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.
- E.** Services provided by an outpatient treatment center that provides emergency room services under R9-10-1019 but does not otherwise meet the criteria in subsection A, shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule under R9-22-710.
- F.** The Administration shall not reimburse a hospital for services provided at a hospital-based FSED if the member is admitted directly from a hospital-based FSED to a hospital with an ownership interest in the hospital-based FSED. As provided in R9-22-712.60(B), payments made for the inpatient stay using the DRG methodology shall be the sole reimbursement.
- G.** For dates of service from October 1, 2023 through September 30, 2024 (CYE 2024), the payment otherwise required for hospital-based FSED services provided by qualifying hospital-based FSEDs shall be increased by a percentage established by the Administration and shall be applied to the payment methodology as described in subsection (C). The percentage is published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2023. A hospital-based FSED will qualify for an increase if it meets the criteria specified below. If a hospital-based FSED receives a DAP for CYE 2024 but fails to meet all of the requirements in subsection (G), the hospital-based FSED shall be disqualified from participating in a DAP for dates of service October 1, 2024 through September 30, 2025 (CYE 2025), if a DAP would be available at that time.
- H.** An outpatient treatment center designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital-based freestanding emergency department will qualify for an increase if it meets the criteria in subsection (H)(1):
  1. No later than April 30, 2023, the hospital-based FSED must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP).
  2. The LOI must contain each hospital-based FSED, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.
    - a. No later than November 30, 2023, develop and submit a hospital-based FSED policy that meets AHCCCS/ADHS standards for a NDP.
    - b. No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the hospital-based FSEDs' policy.
- I.** For dates of service from October 1, 2024 through September 30, 2025 (CYE 2025), the payment otherwise required for hospital-based FSED services provided by qualifying hospital-based FSEDs shall be increased by a percentage established by the Administration and shall be applied to the payment methodology as described in subsection (C). The percentage is published on the Administration's public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2024. A hospital-based FSED can and will qualify for an increase if it meets the criteria specified below for any of the applicable hospital-based FSED subtypes. If a hospital-based FSED receives a DAP for CYE 2025 but fails to meet all of the requirements in subsection (G), the hospital-based FSED shall be disqualified from participating in a DAP



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for dates of service October 1, 2025 through September 30, 2026 (CYE 2026), if a DAP would be available at that time.

- J.** A outpatient treatment center designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital-based freestanding emergency department will qualify for an increase if it meets the criteria in subsection (1)(a) or (b):
1. Hospitals with an Emergency Department that participated in the NDP DAP in CYE 2024.
    - a. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - b. No later than November 30, 2024, the hospital must develop and submit a facility policy that ensures hospitals are purchasing Naloxone through standard routine pharmacy ordering.
    - c. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCSDAP@azahcccs.gov.
  2. Hospitals with an Emergency Department that have not participated in the NDP DAP in CYE 2024.
    - a. No later than April 1, 2024, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP.
    - b. No later than November 30, 2024, the hospital must develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.
    - c. No later than January 1, 2025, the hospital must begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.
    - d. No later than February 28, 2025, the hospital must submit a Naloxone Distribution Program Attestation to AHCCCS to the following email address: AHCCSDAP@azahcccs.gov.

**Historical Note**

New Section made by final rulemaking at 23 A.A.R. 22, February 11, 2017 (Supp. 16-4). Amended by final rulemaking at 29 A.A.R. 3394 (October 27, 2023), with an immediate effective date of October 4, 2023 (Supp. 23-4). Amended by final rulemaking at 30 A.A.R. 3103 (October 25, 2024), with an immediate effective date of October 1, 2024 (Supp. 24-4).

**R9-22-713. Overpayment and Recovery of Indebtedness**

- A.** If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.

- B.** If the funds described in subsection (A) are not remitted, the Administration may recover the funds paid by the Administration to a contractor or subcontracting provider through:
1. A repayment agreement executed with the Administration;
  2. Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or
  3. Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Former Section R9-22-713 repealed, new Section R9-22-713 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714, former Section R9-22-709 renumbered and amended as Section R9-22-713 effective October 1, 1985 (Supp. 85-5). Amended by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

**R9-22-714. Payments to Providers**

- A.** Provider agreement. The Administration or a contractor shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.
- B.** Provider reimbursement. The Administration or a contractor shall reimburse a provider for a service furnished to a member only if:
1. The provider personally furnishes the service to a specific member. For purposes of this Section, services personally furnished by a provider include:
    - a. Services provided by medical residents or dental students in a teaching environment; or
    - b. Services provided by a licensed or certified assistant under the general supervision of a licensed practitioner in accordance with 4 A.A.C. 24, 9 A.A.C. 16, 4 A.A.C. 43, or 4 A.A.C. 45;
  2. The provider verifies that individuals who have provided services described in subsection (B)(1) have not been placed on the List of Excluded Individuals/Entities (LEIE) maintained by the United States Department of Health and Human Services Office of the Inspector General (OIG), located at OIG's web site;
  3. The service contributes directly to the diagnosis or treatment of the member; and
  4. The service ordinarily requires performance by the type of provider seeking reimbursement.
- C.** The Administration or a contractor may make a payment for covered services only:
1. To the provider;
  2. To anyone specified in a reassignment from the provider to a government agency or reassignment by a court order;
  3. To a business agent, if the agent's compensation for the service is:
    - a. Related to the cost of processing the billing;
    - b. Not related on a percentage or other basis to the amount that is billed or collected; and

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- c. Not dependent upon collection of the payment;
- 4. To the employer of the provider, if the provider is required as a condition of employment to turn over the provider's fees to the employer;
- 5. To the inpatient facility in which the service is provided, if the provider has a contract under which the inpatient facility submits the claim; or
- 6. To a foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the foundation, plan or similar organization submits the claim.
- D. The Administration or a contractor shall not make a payment to or through a factor, either directly or by power of attorney, for a covered service furnished to a member by a provider.
- E. Reimbursement for a pathology service. Unless otherwise specified in a contract, the Administration or a contractor shall reimburse a pathologist for a pathology service furnished to a member only if the other requirements in this Section are met and the service is:
  - 1. A surgical pathology service;
  - 2. A specific cytopathology, hematology, or blood banking pathology service that requires performance by a physician and is listed in the capped fee-for-service schedule;
  - 3. A clinical consultation service that:
    - a. Is requested by the member's attending physician or primary care physician,
    - b. Is related to a test result that is outside the clinically significant normal or expected range in view of the condition of the member,
    - c. Results in a written narrative report included in the member's medical record,
    - d. Requires the exercise of medical judgment by the consultant pathologist, and
    - e. Is listed in the capped fee-for-service schedule; or
  - 4. A clinical laboratory interpretative service that:
    - a. Is requested by the member's attending physician or primary care physician,
    - b. Results in a written narrative report included in the member's medical record,
    - c. Requires the exercise of medical judgment by the consultant pathologist, and
    - d. Is listed in the capped fee-for-service schedule.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule is similar to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). Former Section R9-22-713 renumbered and amended as Section R9-22-714 effective October 1, 1985 (Supp. 85-5). Section repealed; new Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 9 A.A.R. 3800, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

*Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney*

*General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.*

**R9-22-715. Hospital Rate Negotiations**

- A. A contractor that negotiates with hospitals for inpatient or out-patient services shall reimburse hospitals for services rendered on or after March 1, 1993, as described in A.R.S. § 36-2903.01 and this Article, or at the negotiated rate that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, and this Article. This subsection does not apply to urban hospitals described under R9-22-718. Contractors may engage in rate negotiations with a hospital at any time during the contract period.
- B. The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

**Historical Note**

Adopted as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Adopted as a permanent rule effective May 16, 1983; text of adopted rule identical to the emergency (Supp. 83-3). Repealed effective October 1, 1983 (Supp. 83-5). New Section R9-22-715 adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

*Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.*

**R9-22-716. Repealed****Historical Note**

Adopted effective October 1, 1985 (Supp. 85-5). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Section repealed by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

**R9-22-717. Repealed****Historical Note**

Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3).

*Editor's Note: The following Section was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor's Regulatory Review Council. The agency was required*

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*to submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and was required to hold a public hearing. It has since been amended under the regular rulemaking process.*

**R9-22-718. Urban Hospital Inpatient Reimbursement Program**

**A. Definitions.** The following definitions apply to this Section:

1. "Contractor" has the same meaning as set forth in A.R.S. § 36-2901, and includes all contractors regardless of whether the GSA's served by the contractor includes urban or rural counties.
2. "Noncontracted Hospital" means an urban hospital, including psychiatric hospitals, which does not have a contract under this Section with a contractor.
3. "Urban Hospital" means a hospital that is not a rural hospital, as defined in R9-22-712.07, and that is physically located in Maricopa or Pima County.

**B. General Provisions.**

1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.
2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2905.01 and this Section.
3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
4. A contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the contractor.
5. A noncontracted urban hospital shall be reimbursed for inpatient services by a contractor at 95 percent of the amount calculated as defined in A.R.S. § 36-2903.01 and this Article, unless otherwise negotiated by both parties.

**C. Contract Begin Date.** A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.

**D. Outpatient urban hospital services.** Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01. Outpatient services in an urban hospital that result in an admission shall be paid as inpatient services in accordance with this Section.

**E. Urban Hospital Contract.**

1. Provisions of an urban hospital contracts. The urban hospital contract shall contain but is not limited to the following provisions:
  - a. Required provisions as described in the Request for Proposals (RFP);
  - b. Dispute settlement procedures. If the AHCCCS Grievance System prescribed in A.R.S. § 36-2903.01(B) and rule is not used, then arbitration shall be used;
  - c. Arbitration procedure. If arbitration is used, the urban hospital contract shall identify:
    - i. The parties' agreement on arbitrating claims arising from the contract,
    - ii. Whether arbitration is nonbinding or binding,
    - iii. Timeliness of arbitration,
    - iv. What contract provisions may be appealed,
    - v. What rules will govern arbitrations,

- vi. The number of arbitrators that shall be used,
- vii. How arbitrators shall be selected, and
- viii. How arbitrators shall be compensated.
- d. Timeliness of claims submission and payment;
- e. Prior authorization;
- f. Concurrent review;
- g. Electronic submission of claims;
- h. Claims review criteria;
- i. Payment of discounts or penalties such as quick-pay and slow-pay provisions;
- j. Payment of outliers;
- k. Claim documentation specifications under A.R.S. § 36-2904.
- l. Treatment and payment of emergency room services; and
- m. Provisions for rate changes and adjustments.
2. AHCCCS review and approval of urban hospital contracts:
  - a. AHCCCS may review, approve, or disapprove the hospital contract rates, terms, conditions, and amendments to the contract;
  - b. The AHCCCS evaluation of each urban hospital contract shall include but not be limited to the following areas:
    - i. Availability and accessibility of services to members,
    - ii. Related party interests,
    - iii. Inclusion of required terms pursuant to this Section, and
    - iv. Reasonableness of the rates.
- F. Quick-Pay/Slow-Pay. A payment made by a contractor to a noncontracted hospital shall be subject to quick-pay discounts and slow-pay penalties under A.R.S. § 36-2904.

**Historical Note**

Adopted under an exemption from the provisions of the Administrative Procedure Act, effective January 29, 1997; pursuant to Laws 1996, Ch. 288, § 24 (Supp. 97-1). Amended by exempt rulemaking at 10 A.A.R. 500, effective February 1, 2004 (Supp. 04-1). Amended by exempt rulemaking at 13 A.A.R. 3190, effective October 1, 2007 (Supp. 07-3). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 24 A.A.R. 1515, effective June 30, 2018 (Supp. 18-2).

**R9-22-719. Contractor Performance Measure Outcomes**

The Administration may retain a specified percentage of capitation reimbursement to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

**R9-22-720. Reinsurance**

**A.** Reinsurance is a stop-loss program provided by the Administration to a contractor for partial reimbursement of the cost of covered services for a member with an acute medical condition when the cost of covered services exceeds a pre-determined deductible level amount within a contract year. The Administration self-insures the reinsurance program through a reduction to capitation rates. The reinsurance program also

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includes a catastrophic reinsurance program for members diagnosed with specific medical conditions.

- B. The Administration shall specify in contract guidelines for claims submission, processing, payment, and the types of care and services that are provided to a member whose care is covered by reinsurance.
- C. When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could have been provided at a lower cost according to the guidelines, the Administration shall reimburse the contractor as if the care or services had been provided as specified in the guidelines.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

**R9-22-721. Behavioral Health Inpatient Facilities**

“Behavioral health inpatient facility” means a health care institution, other than Arizona State Hospital, that meets the following requirements:

1. Provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
  - a. Have a limited or reduced ability to meet the individual’s basic physical needs;
  - b. Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;
  - c. Be a danger to self;
  - d. Be a danger to others;
  - e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
  - f. Be gravely disabled; and
2. Is one of the following facility types:
  - a. Psychiatric hospitals;
  - b. Mental health residential treatment centers;
  - c. Secure residential treatment centers with 17 or more beds;
  - d. Non-secure residential treatment centers with 1-16 beds;
  - e. Non-secure residential treatment centers with 17 or more beds;
  - f. Sub-acute facilities with 1-16 beds;
  - g. Sub-acute facilities with 17 or more beds.

**Historical Note**

New Section made by final rulemaking at 25 A.A.R. 3120, effective October 1, 2019 (Supp. 19-4).

**R9-22-722. Reserved**

**R9-22-723. Reserved**

**R9-22-724. Reserved**

**R9-22-725. Reserved**

**R9-22-726. Reserved**

**R9-22-727. Reserved**

**R9-22-728. Reserved**

**R9-22-729. Reserved**

*Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st*

*Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 1041 (Supp. 15-3).*

*Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 491 (Supp. 15-2).*

**R9-22-730. Hospital Assessment Fund - Hospital Assessment**

A. For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:

1. “2022 Medicare Cost Report” means: The Medicare Cost Report for the hospital fiscal year ending in calendar year 2022 as reported in the CMS Healthcare Provider Cost Reporting Information System (HCRIS) release dated October 7, 2023.
2. “2022 Uniform Accounting Report” means the Uniform Accounting Report submitted to the Arizona Department of Health Services as of January 8, 2024 for the hospital’s fiscal year ending in calendar year 2022.
3. “Quarter” means the three month period beginning January 1, April 1, July 1, and October 1 of each year.
4. A “new hospital” means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 2, 2024.
5. “Outpatient Net Patient Revenues” means an amount, calculated using data in the hospital’s 2022 Uniform Accounting Report or other data sources specified by subsection (N), that is equal to the hospital’s 2022 total net patient revenue multiplied by the ratio of the hospital’s 2022 gross outpatient revenue to the hospital’s 2022 total gross patient revenue.

B. Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2024, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital’s 2022 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as “Other Long Term Care Discharges,” multiplied by the following rates appropriate to the hospital’s peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital’s peer group:

1. \$993.50 per discharge and 1.4871% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
2. \$993.50 per discharge and 0.6196% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
3. \$248.50 per discharge and 0.6196% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
4. \$248.50 per discharge and 0.6196% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2022 Medicare Cost Report.

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5. \$794.75 per discharge and 1.6110% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2022 Uniform Accounting Report.
  6. \$894.00 per discharge and 1.8588% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2022 Uniform Accounting Report.
  7. \$198.75 per discharge and 0.4957% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
  8. \$993.50 per discharge and 2.4785% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C.** Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January 2, 2024.
- D.** Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2022 Medicare Cost Report, are assessed a rate of \$248.50 for each discharge from the psychiatric sub-provider as reported in the 2022 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).
- E.** Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2022 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2022 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).
- F.** Notwithstanding subsection (B), for any hospital that reported more than 22,800 discharges on the hospital's 2022 Medicare Cost Report, discharges in excess of 22,800 are assessed a rate of \$99.50 for each discharge in excess of 22,800. The initial 22,800 discharges are assessed at the rate required by subsection (B).
- G.** Assessment notice. On or before the 15th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the Hospital Assessment Fund assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.
- H.** Assessment due date. The Hospital Assessment Fund assessment must be received by the Administration no later than:
1. The 15th day of the second month of the quarter, or
  2. In the event CMS approves the assessment after the 15th day of the first month of the quarter, 30 days after notification by the Administration that the assessment invoice is available.
- I.** Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2022 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2024:
1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
  2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
  3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2022 Medicare Cost Report.
  4. Hospitals designated as type: hospital, subtype; rehabilitation.
  5. Hospitals designated as type: med-hospital, subtype: special hospitals.
  6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2022 Medicare Cost Report are reimbursed by Medicare.
  7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2022 Medicare Cost Report.
  8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.
- J.** New hospitals. For hospitals that did not file a 2022 Medicare Cost Report because of the date the hospital began operations:
1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.
  2. If the hospital began operating between January 3 and September 30, the assessment will begin on October 1 of the following calendar year.
  3. A hospital is not considered a new hospital based on a change in ownership.
  4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply;
    - a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
    - b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
  5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.

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6. For hospitals providing self-reported data, described in subpart 4 and 5:
  - a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
  - b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.
- K. Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this Section is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.
- L. Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.
- M. Required information for the inpatient assessment. For any hospital that has not filed a 2022 Medicare Cost report, or if the 2022 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2022 Uniform Accounting Report filed by the hospital in place of the 2022 Medicare Cost report to calculate the assessment. If the 2022 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2022 Medicare Cost report to calculate the assessment.
- N. Required information for the outpatient assessment. For any hospital that has not filed a 2022 Uniform Accounting Report, if the 2022 Uniform Accounting Report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, or if the 2022 Uniform Accounting Report does not reconcile to 2022 Audited Financial Statements, the Administration shall use the data reported on 2022 Audited Financial Statements to calculate the outpatient assessment. If the 2022 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration shall use data reported on the 2022 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2022 Medicare Cost report to calculate the outpatient assessment.
- O. The Administration will review and update as necessary rates and peer groups periodically to ensure the assessment is sufficient to fund the state match obligation to cover the cost of the populations as specified in A.R.S. § 36-2901.08.
- P. Enforcement. If a hospital does not comply with this Section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.

New Section R9-22-730 made by exempt rulemaking at 20 A.A.R. 281, effective January 15, 2014 (Supp. 14-1).

Amended by exempt rulemaking at 20 A.A.R. 1833, effective July 1, 2014 (Supp. 14-2). Amended by final exempt rulemaking at 21 A.A.R. 637, effective April 15, 2015 (Supp. 15-2). Amended by final exempt rulemaking at 21 A.A.R. 1486, effective July 16, 2015 (Supp. 15-3). Amended by final exempt rulemaking at 22 A.A.R. 2050, effective July 14, 2016 (Supp. 16-4). Amended by final exempt rulemaking at 23 A.A.R. 1945, effective July 1, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 24 A.A.R. 2229, effective July 10, 2018 (Supp. 18-3). Amended by final exempt rulemaking at 25 A.A.R. 1938, effective July 1, 2019 (Supp. 19-3). Amended by final exempt rulemaking at 26 A.A.R. 1702, effective July 1, 2020 (Supp. 20-3). Amended by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4). Amended by final exempt rulemaking at 27 A.A.R. 2370, effective October 1, 2021 (Supp. 21-3). Amended by final exempt rulemaking 28 A.A.R. 2213 (September 2, 2022), effective October 1, 2022 (Supp. 22-3). Amended by final exempt rulemaking at 29 A.A.R. 2204 (September 22, 2023), effective October 1, 2023 (Supp. 23-3). Amended by final exempt rulemaking at 30 A.A.R. 3057 (October 18, 2024), effective October 1, 2024 (Supp. 24-3).

#### **R9-22-731. Health Care Investment Fund - Hospital Assessment**

- A. For purposes of this Section, terms are the same as defined in A.A.C. R9-22-730 unless the context specifically requires another meaning.
- B. Beginning October 1, 2024, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2024, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital's 2022 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as "Other Long Term Care Discharges," multiplied by the following rates appropriate to the hospital's peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital's peer group:
  1. \$510.25 per discharge and 4.1707% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.
  2. \$510.25 per discharge and 1.7378% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.
  3. \$127.75 per discharge and 1.7378% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.
  4. \$127.75 per discharge and 1.7378% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2022 Medicare Cost Report.
  5. \$408.25 per discharge and 4.5182% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal.

#### **Historical Note**

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- tal intensive care as reported in the hospital's 2022 Uniform Accounting Report.
6. \$459.25 per discharge and 5.2133% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital's 2022 Uniform Accounting Report.
  7. \$102.25 per discharge and 1.3902% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children's.
  8. \$510.25 per discharge and 6.9511% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.
- C. Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January 2, 2024.
  - D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital's 2022 Medicare Cost Report, are assessed a rate of \$127.75 for each discharge from the psychiatric sub-provider as reported in the 2022 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).
  - E. Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital's 2022 Medicare Cost Report, are assessed a rate of \$0 for each discharge from the rehabilitative sub-provider as reported in the 2022 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).
  - F. Notwithstanding subsection (B), for any hospital that reported more than 22,800 discharges on the hospital's 2022 Medicare Cost Report, discharges in excess of 22,800 are assessed a rate of \$51.25 for each discharge in excess of 22,800. The initial 22,800 discharges are assessed at the rate required by subsection (B).
  - G. Assessment notice. On or before the 10th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital's peer group assignment and the assessment due for the quarter.
  - H. Assessment due date. The assessment must be received by the Administration no later than the 10th day of the second month of the quarter.
  - I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital's 2022 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2024:
    1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
    2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH".
    3. Hospitals designated as type: hospital, subtype: psychiatric that reported fewer than 2,500 discharges on the 2022 Medicare Cost Report.
    4. Hospitals designated as type: hospital, subtype; rehabilitation.
    5. Hospitals designated as type: med-hospital, subtype: special hospitals.
    6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2022 Medicare Cost Report are reimbursed by Medicare.
    7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2022 Medicare Cost Report.
    8. Hospitals designated as type: hospital, subtype: short-term that are an urban public acute care hospital.
  - J. New hospitals. For hospitals that did not file a 2022 Medicare Cost Report because of the date the hospital began operations:
    1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.
    2. If the hospital began operating between January 3 and September 30, the assessment will begin on October 1 of the following calendar year.
    3. A hospital is not considered a new hospital based on a change in ownership.
    4. The assessment will be based on the discharges reported in the hospital's first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply:
      - a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. "Annualized" means divided by a ratio equal to the number of months of data divided by 12 months.
      - b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
    5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.
    6. For hospitals providing self-reported data, described in subpart 4 and 5:
      - a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
      - b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.

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- K. Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this Section is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.
- L. Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.
- M. Required information for the inpatient assessment. For any hospital that has not filed a 2022 Medicare Cost report, or if the 2022 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2022 Uniform Accounting Report filed by the hospital in place of the 2022 Medicare Cost report to calculate the assessment. If the 2022 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2022 Medicare Cost report to calculate the assessment.
- N. Required information for the outpatient assessment. For any hospital that has not filed a 2022 Uniform Accounting Report, if the 2022 Uniform Accounting Report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, or if the 2022 Uniform Accounting Report does not reconcile to 2022 Audited Financial Statements, the Administration shall use the data reported on 2022 Audited Financial Statements to calculate the outpatient assessment. If the 2022 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration shall use data reported on the 2022 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2022 Medicare Cost report to calculate the outpatient assessment.
- O. Enforcement. If a hospital does not comply with this Section, the director may suspend or revoke the hospital's provider agreement. If the hospital does not comply within 180 days after the hospital's provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital's license.

**Historical Note**

New Section made by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4). Amended by final rulemaking at 27 A.A.R. 2514 (October 29, 2021), with an immediate effective date of October 6, 2021 (Supp. 21-4). Amended by final exempt rulemaking at 28 A.A.R. 3351 (October 21, 2022), effective October 1, 2022 (Supp. 22-3). Amended by final rulemaking at 29 A.A.R. 3419 (October 27, 2023) with an immediate effective date of October 4, 2023 (Supp. 23-4). Amended by final exempt rulemaking at 30 A.A.R. 3061

(October 18, 2024), effective October 1, 2024 (Supp. 24-3).

**ARTICLE 8. REPEALED**

*Article 8, consisting of R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-22-801. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended subsections (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-802. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-802 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 29, 1985 (Supp. 85-5). Amended subsections (A), (B), (C) and (D) effective October 14, 1988 (Supp. 88-4). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-802 repealed, new Section R9-22-802 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-803. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-803 adopted as an emergency now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-803 repealed, new Section R9-22-803 adopted effective October 1, 1983 (Supp. 83-5). Former Section R9-22-803 renumbered and amended as Section R9-22-804. Adopted effective January 31, 1986 (Supp. 86-1). Amended effective



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September 29, 1992 (Supp. 92-3). Former Section R9-22-803 repealed, new Section R9-22-803 adopted January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-804. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-804 adopted as an emergency adoption now adopted as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended effective October 1, 1983 (Supp. 83-5). Former Section R9-22-804 repealed, former Section R9-22-803 renumbered and amended as Section R9-22-804 effective October 29, 1985 (Supp. 85-5). Amended effective October 14, 1988 (Supp. 88-4). Amended subsections (B) and (C) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-804 repealed, new Section R9-22-804 adopted effective January 14, 1997 (Supp. 97-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**Exhibit A. Repealed****Historical Note**

New Exhibit adopted by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Exhibit repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-805. Repealed****Historical Note**

Former Section R9-22-805 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective January 31, 1986 (Supp. 86-1).

**ARTICLE 9. REPEALED****R9-22-901. Repealed****Historical Note**

Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-901 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1983 (Supp. 83-5). Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-902. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-902 renumbered and amended as Section R9-22-904, former Section R9-22-903 renumbered and amended as Section R9-22-902 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-902 repealed, new Section R9-22-902 adopted effective May 30, 1989 (Supp. 89-2). Amended effective April 13, 1990 (Supp. 90-2). Amended effective September 29, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-903. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-903 renumbered and amended as Section R9-22-902, former Section R9-22-904 renumbered and amended as Section R9-22-903 effective October 1, 1986 (Supp. 86-5). Former Section R9-22-903 repealed, new Section R9-22-903 adopted effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-904. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-904 renumbered and amended as Section R9-22-903, former Section R9-22-902 renumbered and amended as Section R9-22-904 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-905. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-905 renumbered without change as Section R9-22-908, former Section R9-22-907 renumbered and amended as Section R9-22-905 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

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4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-906. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Amended effective October 1, 1986 (Supp. 86-5). Amended effective October 1, 1987 (Supp. 87-4). Amended effective May 30, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-907. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-907 renumbered and amended as Section R9-22-905, former Section R9-22-908 renumbered and amended as Section R9-22-907 effective October 1, 1986 (Supp. 86-5). Amended effective May 30, 1989 (Supp. 89-2). Section repealed by final rulemaking at 5 A.A.R. 4061, effective October 8, 1999 (Supp. 99-4). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-908. Repealed****Historical Note**

Adopted effective August 29, 1985 (Supp. 85-4). Former Section R9-22-908 renumbered and amended as Section R9-22-907, former Section R9-22-905 renumbered without change as Section R9-22-908 effective October 1, 1986 (Supp. 86-5). Former R9-22-908 repealed effective May 30, 1989 (Supp. 89-2). New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**R9-22-909. Repealed****Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed by final rulemaking at 12 A.A.R. 4484, effective January 6, 2007 (Supp. 06-4).

**ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES****R9-22-1001. Definitions**

In addition to the definitions in A.R.S. §§ 36-2901, 36-2923 and 9 A.A.C. 22, Article 1, the following definitions apply to this Article:

“Absent parent” means an individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child.

“Cost avoid” means to deny a claim and return the claim to the provider for a determination of the amount of first- or third-party liability.

“First-party liability” means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

“Third-party” means a person, entity, or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

“Third-party liability” means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

**Historical Note**

Former Section R9-22-712 renumbered and amended as Section R9-22-1001 effective October 1, 1985 (Supp. 85-5). Amended subsections (E) through (H) effective October 1, 1986 (Supp. 86-5). Amended subsections (B), (C), (E), and (F) effective December 22, 1987 (Supp. 87-4). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

**R9-22-1002. General Provisions**

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law. AHCCCS is not the payor of last resort when the following entities are the third-party:

1. Indian Health Services (IHS/638), contract health,
2. Title IV-E,
3. Arizona Early Intervention Program (AZEIP),
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300,
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et seq., and
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart (G).

**Historical Note**

Section R9-22-529 adopted effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5). Amended subsections (C) and (D) effective October 1, 1986 (Supp. 86-5). Amended effective December 22, 1987 (Supp. 87-4). Amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

**R9-22-1003. Cost Avoidance**

A. The Administration’s reimbursement responsibility.

1. The Administration shall pay no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability, unless Medicare is the third-party.

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2. If Medicare is the third-party that is liable, the Administration shall pay the Medicare copayment, coinsurance, and deductible regardless of the Capped Fee-For-Service Schedule, as described under 9 A.A.C. 29, Article 3.
- B.** The Contractor's reimbursement responsibility.
  1. If the contract between the contractor and the provider does not state otherwise, a contractor shall pay no more than the difference between the contracted rate and the amount of the third-party liability.
  2. If the provider does not have a contract with the contractor, a contractor shall pay no more than the difference between the Capped Fee-For-Service rate and the amount of the third-party liability.
- C.** The following parties shall take reasonable measures to identify potentially legally liable first- or third-party sources:
  1. AHCCCS, the Administration, or a contractor;
  2. A provider;
  3. A noncontracting provider; and
  4. A member.
- D.** Except as specified under subsection (E), the Administration or a contractor shall cost avoid a claim for AHCCCS covered services under Article 2 if the Administration or a contractor has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Administration or the contractor receives confirmation that another party is legally responsible for payment of a health care service under Article 2.
- E.** The Administration or contractor shall pay the full amount of the claim according to the Capped-Fee-For-Service Schedule or the contracted rate as described under subsection (B), and then seek reimbursement from any liable parties if the claim is for:
  1. Prenatal care for pregnant women,
  2. Preventive pediatric services, including E.P.S.D.T. and administration of vaccines to children under the Vaccines for Children (VFC) program; or
  3. Services covered by third-party liability that is derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 10 A.A.R. 3012, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 21 A.A.R. 1237, effective July 7, 2015 (Supp. 15-3).

**R9-22-1004. Member Participation**

A member shall cooperate in identifying potentially legally liable first- or third-parties and timely assist the Administration and a contractor, provider, or noncontracting provider in pursuing any first- or third-party who may be liable to pay for covered services.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

**R9-22-1005. Collections**

- A.** Parties that notify AHCCCS. A provider or noncontracting provider shall cooperate with AHCCCS by identifying all

potential sources of first- or third-party liability and notify AHCCCS of these sources.

- B.** Parties that pursue collection or reimbursement. AHCCCS, a provider, or noncontracting provider shall pursue collection or reimbursement from all potential sources of first- or third-party liability.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1006. AHCCCS Monitoring Responsibilities**

AHCCCS shall monitor first- or third-party liability payments to a provider or noncontracting provider, which include but are not limited to payments by or for:

1. Private health insurance;
2. Employment-related disability and health insurance;
3. Long-term care insurance;
4. Other federal programs not excluded by statute from recovery;
5. Court ordered or non-court ordered medical support from an absent parent;
6. State worker's compensation;
7. Automobile insurance, including underinsured and uninsured motorists insurance;
8. Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
9. First-party probate estate recovery;
10. Adoption-related payment; or
11. A tortfeasor.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**R9-22-1007. Notification for Perfection, Recording, and Assignment of AHCCCS Liens**

- A.** Hospital requirements. A hospital providing medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall within 30 days after a member's discharge:
  1. Notify AHCCCS via facsimile or mail under R9-22-1008, or
  2. Mail AHCCCS a copy of the lien the hospital proposes to record or has recorded under A.R.S. § 33-932.
- B.** Provider and noncontracting provider requirements. A provider or noncontracting provider, other than a hospital, rendering medical services to a member for an injury or condition resulting from circumstances reflecting the probable liability of a first- or third-party shall notify AHCCCS via facsimile or mail under R9-22-1008 within 30 days after providing the service.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

**R9-22-1008. Notification Information for Liens**

- A.** Except as provided in subsection (B), a hospital, provider, and noncontracting provider identified in R9-22-1007 shall provide the following information to AHCCCS in writing:
  1. Name of the hospital, provider or noncontracting provider;
  2. Address of the hospital, provider or noncontracting provider;

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3. Name of member;
  4. Member's Social Security Number or AHCCCS identification number;
  5. Address of member;
  6. Date of member's admission or date service is provided;
  7. Amount estimated to be due for care of member;
  8. Date of discharge, if member has been discharged;
  9. Name of county in which injuries were sustained; and
  10. Name and address of all persons, firms, and corporations and their insurance carriers identified by the member or legal representative as being liable for damages.
- B.** If the date of discharge is not known at the time the information in subsection (A) is provided, a party identified in subsection (A) shall notify AHCCCS of the date of discharge within 30 days after the member has been discharged.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1). Amended by final rulemaking at 15 A.A.R. 179, effective March 7, 2009 (Supp. 09-1).

**R9-22-1009. Notification of Health Insurance Information**

A provider or noncontracting provider shall notify AHCCCS, in writing, of the following health insurance information within 10 days of receipt of the health insurance information:

1. Name of member,
2. Member's Social Security Number or AHCCCS identification number,
3. Insurance carrier name,
4. Insurance carrier address,
5. Policy number or insurance holder's Social Security Number,
6. Policy begin and end dates, and
7. Insurance holder's name.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 1146, effective May 1, 2004 (Supp. 04-1).

**ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS****R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims; Definitions**

- A.** Scope. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).
- B.** Purpose. This Article describes the circumstances AHCCCS considers and the process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and time-frames used by a person to request a State Fair Hearing.
- C.** Definitions. The following definitions apply to this Article:
1. "Assessment" means a monetary amount that does not exceed twice the dollar amount claimed by the person for each service.
  2. "Claim" means a request for payment submitted by a person for payment for a service or line item of service, including a submission of an encounter.
  3. "Day" means calendar day unless otherwise specified.
  4. "File" means the date that AHCCCS receives a written acceptance, request for compromise, request for a counter

proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.

5. "Penalty" means a monetary amount, based on the number of items of service claimed or reported, that does not exceed \$2,000 times the number of line items of service.
6. "Person" means an individual or entity as described under A.R.S. § 1-215.
7. "Reason to know" or "had reason to know" means that a person, acts in deliberate ignorance of the truth or falsity of, or with reckless disregard of the truth or falsity of information. No proof of specific intent to defraud is required.

**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Amended subsection A. effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Amended effective June 9, 1998 (Supp. 98-2). Amended by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1102. Determining the Amount of a Penalty and an Assessment**

- A.** AHCCCS shall determine the amount of a penalty and assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.
- B.** AHCCCS shall include in the amount of the penalty and assessment the cost incurred by AHCCCS for conducting the following:
1. An investigation,
  2. Audit, or
  3. Inquiry.

**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1103. Repealed****Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5). Amended effective December 13, 1993 (Supp. 93-4). Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3). Section repealed by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1104. Mitigating Circumstances**

AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of penalties and assessments.

1. The following are mitigating circumstances:
  - a. All the services are of the same type,
  - b. All the dates of services occurred within six months or less,
  - c. The number of claims submitted is less than 25,
  - d. The nature and circumstances do not indicate a pattern of inappropriate claims for the services, and

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- e. The total amount claimed for the services is less than \$1,000.
2. The degree of culpability of a person who presents or causes to present a claim is a mitigating circumstance, including but not limited to, if:
  - a. Each service is the result of an unintentional and unrecognized error in the process that the person followed in presenting or in causing to present the service,
  - b. Corrective steps were taken promptly by the person after the error was discovered, and
  - c. The person had a fraud and abuse control plan that was operating effectively at the time each claim was presented or caused to be presented.
3. The financial condition of a person who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction will render the provider incapable to continue providing services. AHCCCS shall consider the resources available to the person when determining the amount of the penalty, assessment, or penalty and assessment.
4. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.
- e. The person knows or had reason to know that the payment would violate the terms of an agreement between the person and AHCCCS system.
- d. The person knows or had reason to know that the payment would violate state or federal law.
3. The prior offenses of a person who presents or causes to present each claim are an aggravating circumstance if:
  - a. At any time before the submittal of the claim the person was held criminally or civilly liable for any act, or
  - b. The person had received an administrative sanction in connection with:
    - i. A Medicaid program,
    - ii. A Medicare program, or
    - iii. Any other public or private program of reimbursement for medical services.
4. The adverse effect on patient care that resulted, or could have resulted, from the failure to provide medically necessary care by a person in connection with a claim.
5. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

**Historical Note**

Adopted effective October 1, 1986 (Supp. 86-5).  
 Amended effective June 9, 1998 (Supp. 98-2). Section repealed; new Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
 Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4). Amended by final rulemaking at 30 A.A.R. 925 (May 10, 2024), with an immediate effective date of April 25, 2024 (Supp. 24-2).

**R9-22-1105. Aggravating Circumstances**

AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented are aggravating circumstances if:
  - a. A person has forged, altered, recreated, destroyed, or failed to maintain records;
  - b. The person refuses to provide pertinent documentation to AHCCCS for a claim or refuses to cooperate with investigators;
  - c. The services are of several billing code types;
  - d. All the dates of services occurred within six months or greater;
  - e. The number of claims submitted is greater than 25;
  - f. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
  - g. The total amount claimed for the services is \$5,000 or greater.
2. The degree of culpability of a person who presents or causes to present each claim is an aggravating circumstance, including but not limited to, if:
  - a. The person knows or had reason to know that each service was not provided as claimed,
  - b. The person knows or had reason to know that no payment could be made because the person had been excluded from reimbursement by AHCCCS, or

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
 Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4). Amended by final rulemaking at 30 A.A.R. 925 (May 10, 2024), with an immediate effective date of April 25, 2024 (Supp. 24-2).

**R9-22-1106. Notice of Intent**

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by certified mail return receipt requested or Federal Express to the person, a written Notice of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. The statutory basis for the penalty, assessment, or the penalty and assessment;
2. Identification of the state or federal regulation and state or federal law that AHCCCS alleges has been violated;
3. The factual basis for AHCCCS' determination that the penalty, assessment, or the penalty and assessment should be imposed;
4. The amount of the penalty, assessment, or penalty and assessment;
5. The process for the person to accept or request a compromise of the penalty, assessment, or penalty and assessment; and
6. The process for requesting a State Fair Hearing.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
 Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1107. Reserved****R9-22-1108. Request for a Compromise**

- A. To request a compromise, the person shall file a written request with AHCCCS within 30 days from the date of receipt of the Notice of Intent. The written request for compromise shall contain the person's reasons for the reduction or modification of the penalty, assessment, or penalty and assessment.

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- B.** Within 30 days from the date of receipt of the request for compromise from the person, AHCCCS shall send a Notice of Compromise Decision that accepts, denies, or offers a counter proposal to the person's request for compromise. If AHCCCS offers a counter proposal the amount of the counter proposal shall represent the penalty, assessment, or penalty and assessment.
1. If AHCCCS does not withdraw the Notice of Intent under R9-22-1112 or denies the request for compromise the original penalty, assessment, or penalty and assessment is upheld.
  2. To dispute the Compromise Decision, the person shall file a request for a State Fair Hearing under R9-22-1110 within 30 days from the date of receipt of the Notice of Compromise Decision. A failure to respond to the Notice of Compromise Decision will lead to the decision being upheld.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4). Amended by final rulemaking at 30 A.A.R. 925 (May 10, 2024), with an immediate effective date of April 25, 2024 (Supp. 24-2).

**R9-22-1109. Failure to Respond to the Notice of Intent**

If a person fails to respond timely to the Notice of Intent, AHCCCS shall uphold the original penalty, assessment, or penalty and assessment.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1110. Request for State Fair Hearing**

- A.** To request a State Fair Hearing regarding a dispute concerning a penalty, assessment, or penalty and assessment, the person shall file a written request for a State Fair Hearing with AHCCCS within 60 days from the date of the receipt of the Notice of Intent under R9-22-1106 or within 30 days from the date of receipt of the Notice of Compromise Decision under R9-22-1108, if applicable.
- B.** AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the person.
- C.** AHCCCS shall mail a Director's Decision to the person no later than 30 days after the date the Administrative Law Judge sends the decision of the Office of Administrative Hearings (OAH) to AHCCCS.
- D.** AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a person may withdraw the hearing request only by sending a written request for withdrawal to OAH.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1111. Issues and Burden of Proof**

- A.** Preponderance of evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a person presented or caused to be presented each claim in violation of this Article and any aggravating circumstances under R9-22-1105. A person shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.
- B.** Statistical sampling.
1. In meeting the burden of proof described in subsection (A), AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims that were presented or caused to be presented by the person. A statistical sampling study constitutes prima facie evidence of the number and amount of claims if computed by valid statistical methods.
  2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a prima facie case as described in subsection (B)(1). AHCCCS shall be given the opportunity to rebut this evidence.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).  
Amended by final rulemaking at 17 A.A.R. 2615, effective February 4, 2012 (Supp. 11-4).

**R9-22-1112. Withdrawal and Continuances**

AHCCCS may withdraw the Notice of Intent at any time. Prior to referring a matter to the Office of Administrative Hearings the parties may mutually agree to a continuance.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 3056, effective September 11, 2004 (Supp. 04-3).

**ARTICLE 12. BEHAVIORAL HEALTH SERVICES****R9-22-1201. Definitions**

Definitions. The following definitions apply to this Article:

"Adult behavioral health therapeutic home" as defined in 9 A.A.C. 10, Article 1.

"Agency" for the purposes of this Article means a behavioral health facility, a classification of a health care institution, including a mental health treatment agency defined in A.R.S. § 36-501, that is licensed to provide behavioral health services according to A.R.S. Title 36, Chapter 4.

"Assessment" means an analysis of a patient's need for physical health services or behavioral health services to determine which services a health care institution will provide to the patient.

"Behavior management services" means services that assist the member in carrying out daily living tasks and other activities essential for living in the community, including personal care services.

"Behavioral health therapeutic home care services" means interactions that teach the client living, social, and communication skills to maximize the client's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the client's treatment plan, as appropriate.

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“Behavioral health services” means medical services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s behavioral health issue.

“Behavioral health technician” means an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:

If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

Are provided with clinical oversight by a behavioral health professional.

“Case management” for the purposes of this Article, means services and activities that enhance treatment, compliance, and effectiveness of treatment.

“Certified psychiatric nurse practitioner” means a registered nurse practitioner who meets the psychiatric specialty area requirements under A.A.C. R4-19-505(C).

“Clinical oversight” means as described under 9 A.A.C. 10.

“Cost avoid” means to avoid payment of a third-party liability claim when the probable existence of third-party liability has been established under 42 CFR 433.139(b).

“Court-ordered evaluation” has the same meaning as “evaluation” in A.R.S. § 36-501.

“Court-ordered pre-petition screening” has the same meaning as “pre-petition screening” in A.R.S. § 36-501.

“Court-ordered treatment” means treatment provided according to A.R.S. Title 36, Chapter 5.

“Crisis services” means immediate and unscheduled behavioral health services provided to a patient to address an acute behavioral health issue affecting the patient.

“Direct supervision” has the same meaning as “supervision” in A.R.S. § 36-401.

“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.

“Health care institution” has the same meaning as defined in A.R.S. § 36-401.

“Health care practitioner” means a:

Physician;

Physician assistant;

Nurse practitioner; or

Other individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901.

“Licensee” means the same as in 9 A.A.C. 10, Article 1.

“Medical practitioner” means a physician, physician assistant, or nurse practitioner.

“Partial care” means a day program of services provided to individual members or groups that is designed to improve the ability of a person to function in a community, and includes basic, therapeutic, and medical day programs.

“Physician assistant” means the same as in A.R.S. § 32-2501 except that when providing a behavioral health service, the physician assistant shall be supervised by an AHCCCS-registered psychiatrist.

“Psychiatrist” means a physician who meets the licensing requirements under A.R.S. § 32-1401 or a doctor of osteopathy who meets the licensing requirements under A.R.S. § 32-1800, and meets the additional requirements of a psychiatrist under A.R.S. § 36-501.

“Psychologist” means a person who meets the licensing requirements under A.R.S. §§ 32-2061 and 36-501.

“Qualified behavioral health service provider” means a behavioral health service provider that meets the requirements of R9-22-1206.

“Respite” means a period of care and supervision of a member to provide rest or relief to a family member or other person caring for the member. Respite provides activities and services to meet the social, emotional, and physical needs of the member during respite.

“TRBHA” or “Tribal Regional Behavioral Health Authority” means a Native American tribe under contract with ADHS/DBHS to coordinate the delivery of behavioral health services to eligible and enrolled members of the federally-recognized tribal nation.

#### Historical Note

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

#### R9-22-1202. ADHS, Contractor, Administration and CRS Responsibilities

- A. ADHS responsibilities. ADHS is responsible for payment of behavioral health services provided to members, except as specified under subsection (D). ADHS’ responsibility for payment of behavioral health services includes claims for inpatient hospital services, which may include physical health services, when the principal diagnosis on the hospital claim is a behavioral health diagnosis. Behavioral health diagnoses are identified as “mental disorders” in the latest International Classification of Diseases (ICD) code set as required by AHCCCS claims and encounters.
- B. ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for American Indian members. American Indian members may receive covered behavioral health services:
  1. From an IHS or tribally operated 638 facility,
  2. From a TRBHA, or
  3. From a RBHA.

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- C. Contractor responsibilities. A contractor shall:
1. Refer a member to a RBHA under the contract terms;
  2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213;
  3. Coordinate a member's transition of care and medical records; and
  4. Be responsible for providing covered inpatient hospital services, which may include behavioral health inpatient hospital services, when the principal diagnosis on the hospital claim is not a behavioral health diagnosis.
- D. Administration and CRS responsibilities.
1. The Administration shall be responsible for payment of behavioral health services provided to an ALTCS FFS or an FES member and for behavioral health services provided by IHS and tribally operated 638 facilities. The Administration is also responsible for payment of behavioral health services provided to these members during prior quarter coverage.
  2. CRS shall be responsible for payment of behavioral health services provided to members enrolled with CRS.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct typographical errors, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4). Amended by final rulemaking at 21 A.A.R. 1225, effective July 7, 2015 (Supp. 15-3).

**R9-22-1203. Eligibility for Covered Services**

Title XIX members. A member determined eligible under A.R.S. § 36-2901(6)(a) or (g) except for the failure to meet U.S. citizenship or qualified alien status requirements, shall receive medically necessary covered services under Article 12 and Article 2.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007

(Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1204. General Service Requirements**

- A. Services. Behavioral health services include mental health, substance abuse, and physical services. Medically necessary services shall be covered and service requirements met as described under Article 2 and Article 5.
- B. Notification to Administration for American Indians enrolled with a tribal contractor. A provider shall notify the Administration no later than 72 hours after an American Indian member enrolled with a tribal contractor presents to a behavioral health hospital for inpatient emergency behavioral health services.
- C. Restrictions and limitations. Room and board is not a covered service unless provided in a behavioral health inpatient facility under R9-22-1205.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1205. Scope and Coverage of Behavioral Health Services**

- A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article and Article 2.
1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
    - a. General acute care hospital,
    - b. Inpatient psychiatric unit in a general acute care hospital, or
    - c. Behavioral health hospital.
  2. Inpatient service limitations:
    - a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorization is obtained.
    - b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      - i. A licensed psychiatrist,
      - ii. A certified psychiatric nurse practitioner,



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- iii. A licensed physician assistant,
  - iv. A licensed psychologist,
  - v. A licensed clinical social worker,
  - vi. A licensed marriage and family therapist,
  - vii. A licensed professional counselor,
  - viii. A licensed independent substance abuse counselor, and
  - ix. A medical practitioner.
- B. Behavioral Health Inpatient facility for children.** Services provided in a Behavioral Health Inpatient facility for children as defined in 9 A.A.C. 10, Article 3 are covered subject to the limitations and exclusions under this Article.
1. Behavioral Health Inpatient facility for children services are not covered unless provided under the direction of a licensed physician in a licensed Behavioral Health Inpatient facility for children accredited by an AHCCCS-approved accrediting body as specified in contract.
  2. Covered Behavioral Health Inpatient facility for children services include room and board and treatment services for behavioral health and substance abuse conditions.
  3. Inpatient Behavioral Health Inpatient facility for children service limitations.
    - a. Services are not covered unless prior authorized, except for emergency services as specified in this Section.
    - b. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
      - i. A licensed psychiatrist,
      - ii. A certified psychiatric nurse practitioner,
      - iii. A licensed physician assistant,
      - iv. A licensed psychologist,
      - v. A licensed clinical social worker,
      - vi. A licensed marriage and family therapist,
      - vii. A licensed professional counselor,
      - viii. A licensed independent substance abuse counselor, and
      - ix. A medical practitioner.
  4. The following may be billed independently if prescribed by a provider as specified in this Section who is operating within the scope of practice:
    - a. Laboratory services, and
    - b. Radiology services.
- C. Covered Inpatient sub-acute agency services.** Services provided in a inpatient sub-acute facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
1. Inpatient sub-acute facility services are not covered unless provided under the direction of a licensed physician in a licensed inpatient sub-acute facility that is accredited by an AHCCCS-approved accrediting body.
  2. Covered Inpatient sub-acute facility services include room and board and treatment services for behavioral health and substance abuse conditions.
  3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
    - a. A licensed psychiatrist,
    - b. A certified psychiatric nurse practitioner,
    - c. A licensed physician assistant,
    - d. A licensed psychologist,
    - e. A licensed clinical social worker,
    - f. A licensed marriage and family therapist,
    - g. A licensed professional counselor,
    - h. A licensed independent substance abuse counselor, and
    - i. A medical practitioner.
  4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
    - a. Laboratory services, and
    - b. Radiology services.
- D. Behavioral health residential facility services.** Services provided in a licensed behavioral health residential facility as defined in 9 A.A.C. 10, Article 1 are covered subject to the limitations and exclusions under this Article.
1. Behavioral health residential facility services are not covered unless provided by a licensed behavioral health residential facility.
  2. Covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical oversight or direct supervision of the behavioral health residential facility staff, whichever is applicable. Room and board are not covered services.
  3. The following licensed and certified providers may bill independently for services:
    - a. A licensed psychiatrist,
    - b. A certified psychiatric nurse practitioner,
    - c. A licensed physician assistant,
    - d. A licensed psychologist,
    - e. A licensed clinical social worker,
    - f. A licensed marriage and family therapist,
    - g. A licensed professional counselor,
    - h. A licensed independent substance abuse counselor, and
- E. Partial care.** Partial care services are covered subject to the limitations and exclusions in this Article.
1. Partial care services are not covered unless provided by a licensed and AHCCCS-registered behavioral health agency that provides a regularly scheduled day program of individual member, group, or family activities that are designed to improve the ability of the member to function in the community. Partial care services include basic, therapeutic, and medical day programs.
  2. Partial care services. Educational services that are therapeutic and are included in the member's behavioral health treatment plan are included in per diem reimbursement for partial care services.
- F. Outpatient services.** Outpatient services are covered subject to the limitations and exclusions in this Article and Article 2.
1. Outpatient services include the following:
    - a. Screening provided by a behavioral health professional or a behavioral health technician as defined in R9-22-1201;
    - b. A behavioral health assessment provided by a behavioral health professional or a behavioral health technician;
    - c. Counseling including individual therapy, group therapy, and family therapy provided by a behavioral health professional or a behavioral health technician;
    - d. Behavior management services as defined in R9-22-1201; and
    - e. Psychosocial rehabilitation services as defined in R9-22-201.
  2. Outpatient service limitations.

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- a. The following licensed or certified providers may bill independently for outpatient services:
  - i. A licensed psychiatrist;
  - ii. A certified psychiatric nurse practitioner;
  - iii. A licensed physician assistant as defined in R9-22-1201;
  - iv. A licensed psychologist;
  - v. A licensed clinical social worker;
  - vi. A licensed professional counselor;
  - vii. A licensed marriage and family therapist;
  - viii. A licensed independent substance abuse counselor;
  - ix. A medical practitioner; and
  - x. An outpatient treatment center or substance abuse transitional facility licensed under 9 A.A.C. 10, Article 14, that is an AHCCCS-registered provider.
- b. A behavioral health practitioner not specified in subsections (F)(2)(a)(i) through (x), who is contracted with or employed by an AHCCCS-registered behavioral health agency shall not bill independently.
- G. Emergency behavioral health services are covered subject to the limitations and exclusions under this Article. In order to be covered, behavioral health services shall be provided by qualified service providers under R9-22-1206. ADHS/DBHS shall ensure that emergency behavioral health services are available 24 hours per day, seven days per week in each GSA for an emergency behavioral health condition for a non-FES member as defined in R9-22-201.
- H. Other covered behavioral health services. Other covered behavioral health services include:
  - 1. Case management as defined in 9 A.A.C. 10, Article 1;
  - 2. Laboratory and radiology services for behavioral health diagnosis and medication management;
  - 3. Medication;
  - 4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
  - 5. Respite care as described within subsection (J);
  - 6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in an adult behavioral health therapeutic home as defined in 9 A.A.C. 10, Article 1;
  - 7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.
- I. Transportation services. Transportation services are covered under R9-22-211.
- J. Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

**Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final

rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1).

Amended by exempt rulemaking at 17 A.A.R. 1870, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 19 A.A.R. 2747, effective October 8, 2013 (Supp. 13-3). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1206. Repealed****Historical Note**

Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed, new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Repealed by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1207. General Provisions for Payment**

- A. Claims submissions.
  - 1. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member to the appropriate RBHA.
  - 2. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member to the appropriate RBHA.
  - 3. A provider of behavioral health services shall submit a claim for non-inpatient emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
  - 4. A provider of behavioral health services shall submit a claim for non-emergency behavioral health services provided to a member enrolled in a TRBHA to the Administration.
  - 5. A provider of emergency behavioral health services, that are the responsibility of ADHS/DBHS or a contractor, shall submit a claim to the entity responsible for emergency behavioral health services under R9-22-210.01(A).
  - 6. A provider shall comply with the time-frames and other payment procedures in Article 7 of this Chapter, if applicable, and A.R.S. § 36-2904.
  - 7. ADHS/DBHS or a contractor, whichever entity is responsible for covering behavioral health services, shall cost avoid any behavioral health service claims if it establishes the existence or probable existence of first-party liability or third-party liability.
- B. Prior authorization. Payment to a provider for behavioral health services or items requiring prior authorization may be denied if a provider does not obtain prior authorization from a RBHA, ADHS/DBHS, a TRBHA, the Administration or a contractor.

**Historical Note**

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Adopted under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Ch. 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 13 A.A.R. 836, effective May 5, 2007 (Supp. 07-1). Amended by final rulemaking at 20 A.A.R. 3098, effective January 4, 2015 (Supp. 14-4).

**R9-22-1208. Repealed****Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 179, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 11 A.A.R. 5480, effective December 6, 2005 (Supp. 05-4).

**ARTICLE 13. CHILDREN'S REHABILITATIVE SERVICES (CRS)**

*Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-1306, made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Exemption to promulgate rules repealed under Laws 2012, Chapter 299, Section 7 (Supp. 13-3).*

*Article 13, consisting of Sections R9-22-1301 through R9-22-1309, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 13 is now in 9 A.A.C. 34 (Supp. 04-1).*

**R9-22-1301. Children's Rehabilitative Services (CRS) related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

"Active treatment" means there is a current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition.

"CRS application" means a submitted form with any additional documentation required by the Administration to determine whether an individual is medically eligible for CRS.

"CRS condition" means a list of medical condition(s) in R9-22-1303 and which are referred to as covered conditions in A.R.S. § 36-2912.

"Functionally limiting" means a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a provider.

"Medically eligible" means meeting the medical eligibility requirements of R9-22-1303.

"Redetermination" means a decision made by the Administration regarding whether a member continues to meet the requirements in R9-22-1302.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

**R9-22-1302. Children's Rehabilitative Services (CRS) Eligibility Requirements**

Beginning October 1, 2013, an AHCCCS member who needs active treatment for one or more of the qualifying medical condition(s) in R9-22-1303 shall be given a CRS Designation. An American Indian member can choose to receive CRS services through an American Indian Health Plan or a contractor. A member enrolled in CMDP shall obtain CRS services through CMDP. The contractor shall provide covered services necessary to treat the condition(s) and other services described within the contract. The effective date of the CRS Designation shall be as specified in contract.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1303. Medical Eligibility**

The following lists identify those medical condition(s) that do qualify for CRS services as well as those that do not qualify for CRS services. The list of condition(s) that qualify for a CRS Designation is all inclusive. The list of condition(s) that do not qualify for a CRS Designation is not an all-inclusive list.

1. Cardiovascular System
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Arrhythmia,
    - ii. Arteriovenous fistula,
    - iii. Cardiomyopathy,
    - iv. Conduction defect,
    - v. Congenital heart defect other than isolated small Ventricular Septal Defects (VSD), Patent Ductus Arteriosus (PDA), Atrial Septal Defects (ASD),
    - vi. Coronary artery and aortic aneurysm,
    - vii. Renal vascular hypertension,
    - viii. Rheumatic heart disease, and
    - ix. Valvular disorder.
  - b. Condition(s) not medically eligible for CRS:

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- i. Arteriovenous fistula that is not expected to cause cardiac failure or threaten loss of function;
- ii. Benign heart murmur;
- iii. Branch artery pulmonary stenosis;
- iv. Essential hypertension;
- v. Patent foramen ovale (PFO);
- vi. Peripheral pulmonary stenosis;
- vii. Postural orthopedic tachycardia; and
- viii. Premature atrial, nodal or ventricular contractions that are of no hemodynamic significance.
2. Endocrine system:
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Addison's disease,
    - ii. Adrenogenital syndrome,
    - iii. Cystic fibrosis (including atypical cystic fibrosis),
    - iv. Diabetes insipidus,
    - v. Hyperparathyroidism,
    - vi. Hyperthyroidism,
    - vii. Hypoparathyroidism, and
    - viii. Panhypopituitarism.
  - b. Condition(s) not medically eligible for CRS
    - i. Diabetes mellitus,
    - ii. Hypopituitarism associated with a malignancy and requiring treatment of less than 90 days,
    - iii. Isolated growth hormone deficiency, and
    - iv. Precocious puberty.
3. Genitourinary system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Ambiguous genitalia,
    - ii. Bladder extrophy,
    - iii. Deformity and dysfunction of the genitourinary system secondary to trauma 90 days or more after the trauma occurred,
    - iv. Ectopic ureter,
    - v. Hydronephrosis, that is not resolved with antibiotics,
    - vi. Polycystic and multicystic kidneys,
    - vii. Pyelonephritis when treatment with drugs or biologicals has failed to cure or ameliorate and surgical intervention is required,
    - viii. Ureteral stricture, and
    - ix. Vesicoureteral reflux, at a grade 3 or higher.
  - b. Condition(s) not medically eligible for CRS:
    - i. Enuresis,
    - ii. Hydrocele,
    - iii. Hypospadias,
    - iv. Meatal stenosis,
    - v. Nephritis, infectious or noninfectious,
    - vi. Nephrosis,
    - vii. Phimosis, and
    - viii. Undescended testicle.
4. Ear, nose, or throat medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Cholesteatoma,
    - ii. Congenital/Craniofacial anomaly that is functionally limiting,
    - iii. Deformity and dysfunction of the ear, nose, or throat secondary to trauma, 90 days or more after the trauma occurred,
    - iv. Mastoiditis that continues 90 days or more after the first diagnosis of the condition,
    - v. Microtia that requires multiple surgical interventions,
    - vi. Neurosensory hearing loss, and
    - vii. Significant conductive hearing loss due to an anomaly in one ear or both ears equal to or greater than a pure tone average of 30 decibels that despite medical treatment, requires a hearing aid.
  - b. Condition(s) not medically eligible for CRS:
    - i. A craniofacial anomaly that is not functionally limiting,
    - ii. Adenoiditis,
    - iii. Cranial or temporal mandibular joint syndrome,
    - iv. Hypertrophic lingual frenum,
    - v. Isolated preauricular tag or pit,
    - vi. Nasal polyp,
    - vii. Obstructive apnea,
    - viii. Perforation of the tympanic membrane,
    - ix. Recurrent otitis media,
    - x. Simple deviated nasal septum,
    - xi. Sinusitis,
    - xii. Tonsillitis, and
    - xiii. Uncontrolled salivation.
5. Musculoskeletal system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Achondroplasia,
    - ii. Arthrogryposis (multiple joint contractures),
    - iii. Bone infection that continues 90 days or more after the initial diagnosis,
    - iv. Chondrodysplasia,
    - v. Chondroectodermal dysplasia,
    - vi. Clubfoot,
    - vii. Collagen vascular disease, including but not limited to, ankylosis spondylitis, polymyositis, dermatomyositis, polyarteritis nodosa, psoriatic arthritis, scleroderma, rheumatoid arthritis and lupus,
    - viii. Congenital or developmental cervical spine abnormality,
    - ix. Congenital spinal deformity,
    - x. Diastrophic dysplasia,
    - xi. Enchondromatosis,
    - xii. Femoral anteversion and tibial torsion,
    - xiii. Fibrous dysplasia,
    - xiv. Hip dysplasia,
    - xv. Hypochondroplasia,
    - xvi. Joint infection that continues 90 days or more after the initial diagnosis,
    - xvii. Juvenile rheumatoid arthritis,
    - xviii. Kyphosis (Scheuermann's Kyphosis) 50 degrees or over,
    - xix. Larsen syndrome,
    - xx. Leg length discrepancy of two centimeters or more,
    - xxi. Legg-Calve-Perthes disease,
    - xxii. Limb amputation or limb malformation,
    - xxiii. Metaphyseal and epiphyseal dysplasia,
    - xxiv. Metatarsus adductus,
    - xxv. Muscular dystrophy,
    - xxvi. Orthopedic complications of hemophilia,

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- xxvii. Osgood Schlatter's disease that requires surgical intervention,
- xxviii. Osteogenesis imperfecta,
- xxix. Rickets,
- xxx. Scoliosis when 25 degrees or greater, or when there is a need for bracing or surgery,
- xxxi. Seronegative spondyloarthropathy such as Reiter's, psoriatic arthritis, and ankylosing spondylitis,
- xxxii. Slipped capital femoral epiphysis,
- xxxiii. Spinal muscle atrophy,
- xxxiv. Spondyloepiphyseal dysplasia, and
- xxxv. Syndactyly.
- b. Condition(s) not medically eligible for CRS:
  - i. Back pain with no structural abnormality,
  - ii. Benign bone tumor,
  - iii. Bunion,
  - iv. Carpal tunnel syndrome,
  - v. Deformity and dysfunction secondary to trauma or injury,
  - vi. Ehlers Danlos,
  - vii. Flat foot,
  - viii. Fracture,
  - ix. Ganglion cyst,
  - x. Ingrown toenail,
  - xi. Kyphosis under 50 degrees,
  - xii. Leg length discrepancy of less than two centimeters at skeletal maturity,
  - xiii. Polydactyly without bone involvement,
  - xiv. Popliteal cyst,
  - xv. Trigger finger, and
  - xvi. Varus and valgus deformities.
- 6. Gastrointestinal system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Anorectal atresia,
    - ii. Biliary atresia,
    - iii. Cleft lip,
    - iv. Cleft palate,
    - v. Congenital atresia, stenosis, fistula, or rotational abnormalities of the gastrointestinal tract,
    - vi. Deformity and dysfunction of the gastrointestinal system secondary to trauma, 90 days or more after the trauma occurred,
    - vii. Diaphragmatic hernia,
    - viii. Gastroschisis,
    - ix. Hirschsprung's disease,
    - x. Omphalocele, and
    - xi. Tracheoesophageal fistula.
  - b. Condition(s) not medically eligible for CRS:
    - i. Celiac disease,
    - ii. Crohn's disease,
    - iii. Hernia other than a diaphragmatic hernia,
    - iv. Intestinal polyp,
    - v. Malabsorption syndrome, also known as short bowel syndrome,
    - vi. Pyloric stenosis,
    - vii. Ulcer disease, and
    - viii. Ulcerative colitis.
- 7. Nervous system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Benign intracranial tumor,
    - ii. Benign intraspinal tumor,
    - iii. Central nervous system degenerative disease,
    - iv. Central nervous system malformation or structural abnormality,
    - v. Cerebral palsy,
    - vi. Craniosynostosis requiring surgery,
    - vii. Deformity and dysfunction secondary to trauma in an individual that continues 90 days or more after the incident,
    - viii. Hydrocephalus,
    - ix. Muscular dystrophy or other myopathy,
    - x. Myelomeningocele, also known as spina bifida,
    - xi. Myoneural disorder, including but not limited to, amyotrophic Lateral Sclerosis or ALS, myasthenia gravis, Eaton-Lambert syndrome, muscular dystrophy, trojer sclerosis, polymyositis, dermatomyositis, progressive bulbar palsy, polio,
    - xii. Neurofibromatosis,
    - xiii. Neuropathy/polyneuropathy, hereditary or idiopathic,
    - xiv. Residual dysfunction that continues 90 days or more after a vascular accident, inflammatory condition, or infection of the central nervous system,
    - xv. Residual dysfunction that continues 90 days or more after near drowning,
    - xvi. Residual dysfunction that continues 90 days or more after the spinal cord injury, and
    - xvii. Uncontrolled seizure disorder, in which there have been more than two seizures with documented compliance of one or more medications.
  - b. Condition(s) not medically eligible for CRS:
    - i. Central apnea secondary to prematurity,
    - ii. Febrile seizures,
    - iii. Headaches,
    - iv. Near sudden infant death syndrome,
    - v. Plagiocephaly, and
    - vi. Spina bifida occulta.
- 8. Ophthalmology:
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Cataracts,
    - ii. Disorder of the iris, ciliary bodies, retina, lens, or cornea,
    - iii. Disorder of the optic nerve,
    - iv. Glaucoma,
    - v. Non-malignant enucleation and post-enucleation reconstruction, and
    - vi. Retinopathy of prematurity.
  - b. Condition(s) not medically eligible for CRS:
    - i. Astigmatism,
    - ii. Ptosis,
    - iii. Simple refraction error, and
    - iv. Strabismus.
- 9. Respiratory system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. Anomaly of the larynx, trachea, or bronchi that requires surgery, and
    - ii. Nonmalignant obstructive lesion of the larynx, trachea, or bronchi.

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- b. Condition(s) not medically eligible for CRS:
  - i. Allergies,
  - ii. Asthma,
  - iii. Bronchopulmonary dysplasia,
  - iv. Chronic obstructive pulmonary disease,
  - v. Emphysema, and
  - vi. Respiratory distress syndrome.
- 10. Dermatological system medical condition(s):
  - a. CRS condition(s) that qualify for CRS medical eligibility:
    - i. A burn scar that is functionally limiting,
    - ii. A hemangioma that is functionally limiting that requires laser or surgery,
    - iii. Complicated nevi requiring multiple procedures,
    - iv. Cystic hygroma such as lymphangioma, and
    - v. Malocclusion that is functionally limiting.
  - b. Condition(s) not medically eligible for CRS:
    - i. A deformity that is not functionally limiting,
    - ii. Ectodermal dysplasia,
    - iii. Isolated malocclusion that is not functionally limiting,
    - iv. Pilonidal cyst,
    - v. Port wine stain,
    - vi. Sebaceous cyst,
    - vii. Simple nevi, and
    - viii. Skin tag.
- 11. Metabolic CRS condition(s) that qualify for CRS medical eligibility:
  - a. Amino acid or organic acidopathy,
  - b. Biotinidase deficiency,
  - c. Homocystinuria,
  - d. Inborn error of metabolism,
  - e. Maple syrup urine disease,
  - f. Phenylketonuria, and
  - g. Storage disease.
- 12. Hemoglobinopathies CRS condition(s) that qualify for CRS medical eligibility:
  - a. Sickle cell anemia, and
  - b. Thalassemia.
- 13. Additional medical/behavioral condition(s) which are not medically eligible for CRS:
  - a. Allergies,
  - b. Anorexia nervosa or obesity,
  - c. Attention deficit disorder,
  - d. Autism,
  - e. Cancer,
  - f. Depression or other mental illness,
  - g. Developmental delay,
  - h. Dyslexia or other learning disabilities,
  - i. Failure to thrive,
  - j. Hyperactivity, and
  - k. Immunodeficiency, such as AIDS and HIV.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21

A.A.R. 2022, effective October 1, 2015 (Supp. 15-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1304. Referral and Disposition of CRS Medical Eligibility Determination**

- A. To refer an individual for a CRS medical eligibility determination a person shall submit to the Administration the following information:
  - 1. CRS application;
  - 2. Documentation from a specialist who diagnosed the individual, stating the individual's diagnosis;
  - 3. Diagnostic test results that support the individual's diagnosis; and
  - 4. Documentation of the individual's need for specialized treatment of the CRS condition through medical, surgical, or therapy modalities.
- B. The Administration shall notify the CRS applicant, member or authorized representative of the outcome of the determination within 60 days of receipt of information required under subsection (A). The member may appeal the determination under Chapter 34.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 21 A.A.R. 2022, effective October 1, 2015 (Supp. 15-3).

**R9-22-1305. CRS Redetermination**

- A. Continued eligibility for CRS services shall be redetermined by verifying active treatment status of the CRS qualifying medical condition(s) as follows:
  - 1. The contractor is responsible for notifying the AHCCCS Administration of the date when a member with a CRS Designation is no longer in active treatment for the qualifying condition(s).
  - 2. The Administration may request, at any time, that the contractor submit the medical documentation to the Administration for a CRS medical redetermination within the specified time-frames in contract.
  - 3. The Administration shall notify the member or authorized representative of the outcome of the redetermination.
- B. If the Administration determines that a member is no longer medically eligible for a CRS Designation, the Administration shall provide the member or authorized representative a written notice that informs the member that the Administration is ending the member's CRS Designation. The member may appeal the redetermination under A.A.C. Title 9, Chapter 34.
- C. Upon reaching his or her 21st birthday, the member's CRS Designation will be ended.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3).

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Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1306. Repealed****Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3). Repealed by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-1307. Covered Services**

The Administration will cover medically necessary services as described within Article 2 unless otherwise specified in contract.

**Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1). Section made by exempt rulemaking at 18 A.A.R. 2074, effective August 1, 2012 (Supp. 12-3). Rulemaking exemption repealed by Laws, 2012, Ch. 299, Section 7; therefore a new Section was made by final rulemaking at 19 A.A.R. 2954, effective November 10, 2013 (Supp. 13-3).

**R9-22-1308. Repealed****Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**R9-22-1309. Repealed****Historical Note**

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3317, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004 (Supp. 04-1).

**ARTICLE 14. AHCCCS MEDICAL COVERAGE FOR HOUSEHOLDS****R9-22-1401. General Information**

- A. Scope. This Article contains eligibility criteria to determine whether a household or individual is eligible for AHCCCS medical coverage. Eligibility criteria described under Article 3 applies to this Article.
- B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article, Article 3 and Article 15 have the following meanings unless the context explicitly requires another meaning:
  - “Burial plot” means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.

“Caretaker relative” means:

A parent of a dependent child with whom the child is living;

When the dependent child does not live with a parent or the parent in the home is incapacitated, another relative of the child by blood, adoption, or marriage in the home who assumes primary responsibility for the child’s care; or

A woman in her third trimester of pregnancy with no other dependent children.

“Cash assistance” means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.

“Dependent child” means a child under the age of 18, or if age 18 is a full-time student in secondary school or equivalent vocational or technical training, if reasonably expected to complete such school or training before turning age 19.

“MAGI – based income” means Modified Adjusted Gross Income as defined under 42 CFR 435.603(e).

“Medical expense deduction” or “MED” means the cost of the following expenses if incurred in the United States:

A medical service or supply that would be covered if provided to an AHCCCS member of any age under Articles 2 and 12 of this Chapter;

A medical service or supply that would be covered if provided to an Arizona Long-term Care System member under 9 A.A.C. 28, Articles 2 and 11;

Other necessary medical services provided by a licensed practitioner or physician;

Assistance with daily living if the assistance is documented in an individual plan of care by a nurse, social service worker, registered therapist, or dietitian under the supervision of a physician except when provided by the spouse of an applicant or the parent of a minor child;

Medical services provided in a licensed nursing home or in an alternative HCBS setting under R9-28-101;

Purchasing and maintaining an animal guide or service animal for the assistance of a member of the MED family unit under R9-22-1436; and

Health insurance premiums, deductibles, and coinsurance, if the insured is a member of the MED family unit.

“Monthly income” means the gross countable income received or projected to be received during the month or the monthly equivalent.

“Monthly equivalent” means a monthly countable income amount established by averaging, prorating, or converting a person’s income.

“Spendthrift restriction” means a legal restriction on the use of a resource that prevents a payee or beneficiary from alienating the resource.

“Tax dependent” is described under 42 CFR 435.4.

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“Taxpayer” means a person who expects to file a tax return, and does not expect to be claimed as a tax dependent by another person.

“Title IV-D” means Title IV-D of the Social Security Act, 42 U.S.C. 651-669, the statutes establishing the child support enforcement and paternity program.

“Title IV-E” means Title IV-E of the Social Security Act 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Punctuation error corrected with a parenthesis added at the beginning of the definition “Caretaker” (Supp. 20-4).

**R9-22-1402. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1403. Agency Responsible for Determining Eligibility**

The Administration or its designee shall determine eligibility under the provisions of this Article. The Administration or its designee shall not discriminate against an applicant or member because of race, color, creed, religion, ancestry, national origin, age, sex, or physical or mental disability.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1404. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1405. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1406. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1407. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 19 A.A.R. 3309, November 30, 2013 (Supp. 13-4). Section repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; this Section was slated to be codified as repealed in Supp. 14-1. Due to a clerical error the Section wasn't repealed in this Chapter until Supp. 20-4.

**R9-22-1408. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1409. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192,



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with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1410. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1411. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1412. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1413. Time-frames, Reinstatement of an Application**

- A.** The Administration or its designee shall complete an eligibility determination under R9-22-306(A)(1) unless:
1. The applicant is pregnant. The Administration or its designee shall complete an eligibility determination for a pregnant woman within 20 days after the application date unless additional information is required to determine eligibility; or
  2. The applicant is in a hospital as an inpatient at the time of application. Within seven days of the Administration or its designee's receipt of a signed application the Administration or its designee shall complete an eligibility determination if the Administration or its designee does not need additional information or verification to determine eligibility.
- B.** The Administration or its designee shall redetermine eligibility of an individual who is discontinued for failure to submit the renewal form or necessary information, without requiring a new application, if the individual submits the renewal form or

necessary information within 90 days after the date of discontinuance.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 30 A.A.R. 3749 (December 13, 2024), effective February 2, 2025 (Supp. 24-4).

**R9-22-1414. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1415. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1416. Effective Date of Eligibility**

- A.** Except as provided in R9-22-303 and subsections (B), (C) and (D), the effective date of eligibility is the first day of the month that the applicant files an application if the applicant is eligible that month, or the first day of the first eligible month following the application month except for:
1. The MED program under R9-22-1439, and
  2. Eligibility for a newborn under R9-22-1429.
- B.** The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
- C.** The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.
- D.** The effective date of eligibility for a newborn is no sooner than the date of birth.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192,

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with an immediate effective date of January 7, 2014  
(Supp. 14-1).

**R9-22-1417. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1418. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1419. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1419.01. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1419.02. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1419.03. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1419.04. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Section repealed by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1420. Income Eligibility Criteria**

- A.** Evaluation of income. In determining eligibility, the Administration or its designee shall evaluate the following types of income received by a person identified in subsection (B):
1. Earned income, including in-kind income, before any deductions. For purposes of this Section, in-kind income means room, board, or provision for other needs in exchange for work performed. The person identified in subsection (B) shall ensure that the provider of the in-kind income establishes and verifies the monetary value of the item provided. The provider may be, but is not limited to:
    - a. A landlord who provides all or a portion of rent or utilities in exchange for services;
    - b. A store owner who gives goods such as groceries, clothes, or furniture in exchange for services; or
    - c. An individual who trades goods such as a car, tools, trailer, building material, or gasoline in exchange for services;
  2. Self-employment income under R9-22-1424, including gross business receipts minus business expenses; and
  3. Unearned income, including deemed income under R9-22-317 from the sponsor of a non-citizen applicant.
- B.** MAGI income group. The Administration or its designee shall include the following persons in the MAGI income group:
1. When the applicant is a taxpayer include:
    - a. The applicant,
    - b. Everyone the applicant expects to claim as a tax dependent for the current year, and
    - c. The applicant's spouse, when living with the applicant.
  2. Except as provided in subsection (B)(3), when the applicant expects to be claimed as a tax dependent for the current year include:
    - a. The taxpayer claiming the applicant,
    - b. Everyone else the taxpayer expects to claim as a tax dependent,
    - c. The taxpayer's spouse when living with the taxpayer, and
    - d. The applicant's spouse, when living with the applicant.
  3. When any of the following apply, determine the persons whose income is included as described in subsection (4)(a) or (4)(b) based on the applicant's age:
    - a. The applicant expects to be claimed as a tax dependent by someone other than a spouse or natural, adopted or step-parent;
    - b. The applicant is under age 19, expects to be claimed as a tax dependent by a natural, adopted or step-parent, lives with more than one such parent and the parents do not expect to file a joint tax return; or
    - c. The applicant is under age 19 and expects to be claimed as a tax dependent by a non-custodial parent.
  4. When the applicant is not a taxpayer, does not expect to be claimed as a tax dependent and is:
    - a. Under age 19. Include the income of the applicant and when living with the applicant, the applicant's:
      - i. Spouse;
      - ii. Natural, adopted and step-children;

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- iii. Natural, adopted and step-parents;
- iv. Natural, adopted and step-siblings; and
- b. Age 19 or older. Include the income of the applicant and when living with the applicant, the applicant's:
  - i. Spouse;
  - ii. Natural, adopted and step-children under age 19.

5. When the applicant is a pregnant woman, the Administration or its designee shall also include the number of expected babies only for the pregnant woman's income group.

6. When the taxpayer cannot reasonably establish that a person is the taxpayer's tax dependent, inclusion of the person in the taxpayer's MAGI income group is determined as provided in subsection (B)(4).

C. A person whose income is counted. The Administration or its designee shall count the MAGI-based income of all members of an applicant's MAGI income group with the following exceptions:

1. The income of an individual who is included in the MAGI income group of his or her natural, adoptive or step parent and is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined, is not counted whether or not the individual files a tax return.
2. The income of a tax dependent other than the taxpayer's spouse or biological, adopted or stepchild who is not expected to be required to file a tax return for the year in which eligibility for Medicaid is being determined is not counted when the tax dependent is included in the taxpayer's MAGI income group, whether or not the tax dependent files a tax return.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1421. MAGI-based Income Eligibility**

- A. In determining eligibility, if an individual would otherwise be ineligible under this Article due to excess income, the Administration or its designee shall subtract an amount equivalent to five percentage points of the Federal Poverty Level (FPL) from the household income.
- B. A person is eligible under this Article when:
  1. Subject to subsection (A), the monthly household income does not exceed the appropriate percentage of the FPL under R9-22-1427;
  2. If ineligible under (B)(1), the household income determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL; or
  3. For eligibility under R9-22-1437, the person's income during the period defined in R9-22-1437(C) does not exceed the percentage of the FPL under R9-22-1437(B).
- C. The Administration or its designee shall consider the following factors when determining the income period to use to determine monthly income:
  1. Type of income,
  2. Frequency of income,

3. If source of income is new or terminated, or
4. Income fluctuation.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 30 A.A.R. 3749 (December 13, 2024), effective February 2, 2025 (Supp. 24-4).

**R9-22-1422. Methods for Calculating Monthly Income**

- A. Projecting income.
  1. Description. Projecting income is a method of determining the amount of income that a person will receive.
  2. Calculation. The Administration or its designee shall project income by:
    - a. Converting income to a monthly equivalent,
    - b. Using unconverted income, or
    - c. Prorating income to determine a monthly equivalent.
  3. Exclusion. When calculating projected monthly income, the Administration or its designee shall exclude an unusual variation in income under R9-22-1424(E), except for a month in which the variation is anticipated to occur.
- B. Averaged income.
  1. Description. Averaging income proportionally distributes the person's income received on a regular basis.
  2. Calculation. To average income, the Administration or its designee shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration or its designee shall:
    - a. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
    - b. Use the averaged monthly or semi-monthly amounts to project monthly income; and
    - c. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (A).
- C. Prorated income.
  1. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
  2. Calculation. To prorate income, the Administration or its designee shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.
- D. Converted income.
  1. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
  2. Calculation.
    - a. The Administration or its designee shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past

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income fluctuates and the fluctuation is expected to recur.

- b. To convert income paid weekly to a monthly equivalent, the Administration or its designee shall multiply the weekly average by 4.3 weeks.
- c. To convert income paid bi-weekly to a monthly equivalent, the Administration or its designee shall multiply the bi-weekly average by 2.15 weeks.

**E. Unconverted income.**

- 1. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
- 2. Calculation. The Administration or its designee shall sum the actual amount of income received or projected to be received during a month.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1423. Calculations and Use of Methods Listed in R9-22-1422 Based on Frequency of Income**

- A. Monthly income.** If otherwise countable income is received monthly or in a lump sum, the Administration or its designee shall use the unconverted method for calculating monthly income.
  - 1. Lump sum means a nonrecurring payment that serves as a complete payment.
  - 2. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Railroad Retirement, or other benefits.
  - 3. A lump sum payment may include a portion intended for the current month.
- B. Weekly income.** If income is received weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- C. Bi-weekly income.** If income is received bi-weekly, the Administration or its designee shall convert the income to a monthly equivalent under R9-22-1422(D).
- D. Semi-monthly or daily income.** If income is received semi-monthly or daily, the Administration or its designee shall use the unconverted method for calculating monthly income under R9-22-1422(E).
- E. Bimonthly, quarterly, semi-annual, or annual income.** If income is received bimonthly, quarterly, semi-annually, or annually, the Administration or its designee shall prorate the income received or projected to be received under R9-22-1422(C).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192,

with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1424. Use of Methods Listed in R9-22-1423 Based on Type of Income**

**A. New income.**

- 1. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
- 2. Calculating monthly income.
  - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
  - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**B. Terminated income.**

- 1. Terminated income is income received during the last calendar month when no more income is expected to be received from that source.
- 2. Calculating monthly income.
  - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
  - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**C. Break in income.**

- 1. Description. A break in income is a break in established frequency of income of one calendar month or more.
- 2. Calculating monthly income.
  - a. If a full month's income is received, the Administration or its designee shall use the appropriate method described in R9-22-1423 to calculate the monthly income.
  - b. If less than a full month's income is received, the Administration or its designee shall use the unconverted method to calculate the monthly income.

**D. Contract or regular seasonal income.**

- 1. Descriptions.
  - a. Contract income is income a person earns under a contract that specifies a length of time the contract covers, the amount of income to be paid, and the frequency of payment.
  - b. Regular seasonal income is income that fluctuates based on season or is only received during a certain season, and can reasonably be anticipated based on history or other verification.
- 2. Calculating monthly income.
  - a. When the contract or regular seasonal income will not fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall use the appropriate income calculation method in R9-22-1423 for the frequency of receipt.
  - b. When the contract or regular seasonal income is anticipated to fluctuate over the 12-month period beginning with the month the application or renewal is submitted, the Administration or its designee shall calculate the monthly income as follows:
    - i. For a one-time contract that ends between the month the application or renewal is submitted and the end of the calendar year, divide the

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income that will be received from the application or renewal month through the end of the calendar year by the number of months in that period to get a monthly equivalent;

- ii. For contracts that extend into the next calendar year, contracts that are anticipated to be renewed and regular seasonal income, the Administration or its designee shall divide the income that will be received in the 12-month period beginning with the application or renewal month by 12 to get the monthly equivalent.

**E. Unusual variation in the amount of income.**

1. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
2. Calculating monthly income.
  - a. When calculating income for the month in which an unusual variation in income occurs, the Administration or its designee shall include the unusual variation in the income calculation.
  - b. When an unusual variation in income occurs during the month, the Administration or its designee shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
  - c. When projecting income for the months following the month in which the unusual variation occurs, the Administration or its designee shall exclude the unusual variation in income from the income calculation.

**F. Self-employment income.**

1. Description. Self-employment income is income a person earns from the person's own trade or business less allowable expenses.
2. Calculating monthly income. The Administration or its designee shall prorate the income under R9-22-1422.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1425. Repealed**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1426. Repealed**

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7

A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1427. Eligibility Under MAGI**

- A. Caretaker Relatives.** An individual is eligible for AHCCCS medical coverage as a Caretaker Relative when the individual meets the following requirements:

1. Is a caretaker relative as defined in R9-22-1401.
2. The total countable income under R9-22-1420(B) does not exceed 106 percent of the FPL for the number of people in the MAGI income group.

**B. Continued medical coverage.**

1. A caretaker relative eligible under subsection (A) and all dependent children eligible under subsection (D) in the caretaker relative's MAGI income group are entitled to continued AHCCCS coverage for up to 12 months if eligible under subsection (B)(1)(c)(i) and up to four months if eligible under subsection (B)(1)(c)(ii) if the MAGI income group's income exceeds the limit for the income group's size and the following conditions are met:
  - a. The caretaker relative still lives with a dependent child;
  - b. A caretaker relative in the income group received AHCCCS medical coverage under this Section for three calendar months out of the most recent six months; and
  - c. The loss of AHCCCS coverage under this Section is due to:
    - i. Increased earned income of a caretaker relative, or
    - ii. Increased spousal support.

2. An applicant may be added to the continued medical coverage under subsection (B)(1), if the applicant did not reside in the household at the time continued medical coverage under this Section was determined and the applicant is:

- a. The spouse or dependent child of a caretaker relative receiving continued medical coverage, or
- b. The parent of a dependent child who is receiving continued medical coverage.

- C. Pregnant Women.** A pregnant woman is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed 156 percent of the FPL for the number of people in the MAGI income group. A pregnant woman who applies for AHCCCS medical coverage during the pregnancy or postpartum period and is determined eligible, remains eligible throughout the postpartum period. The postpartum period begins the day the pregnancy terminates and ends the last day of the month in which the 60th day following pregnancy termination occurs.

- D. Children.** A child less than 19 years of age is eligible for AHCCCS medical coverage when the total countable income under R9-22-1420(B) does not exceed the following percentage of the FPL for the number of people in the MAGI income group:

1. 147 percent for a child under one year of age,
2. 141 percent for a child age one through five years of age, or
3. 133 percent for all other persons.

- E. Adults.** An individual is eligible for AHCCCS medical coverage when the individual meets the following eligibility requirements:

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1. Is 19 years of age or older but less than 65 years of age;
2. Is not pregnant;
3. Is not eligible for AHCCCS Medical Coverage under any other coverage group listed in 42 U.S.C. 1396a(a)(10)(A)(i);
4. Is not entitled to or enrolled for Medicare benefits under Part A or Part B;
5. The total countable income under R9-22-1420(B) does not exceed 133 percent of the FPL for the number of people in the MAGI income group; and
6. When the individual is a caretaker relative, but has income exceeding the limit in subsection (A)(2), each child under age 19 living with the individual is receiving AHCCCS medical coverage or KidsCare, or is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Section R9-22-1427 repealed; new Section R9-22-1427 made by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1428. Postpartum Extended Eligibility**

- A. Eligibility for 12-months postpartum coverage. Individuals who applied and were determined eligible while pregnant, including prior quarter months under R9-22-303(A), remain eligible through the last day of the month in which a 12-month postpartum period, beginning on the last day of the pregnancy, ends.
- B. Copayments during the Postpartum Extended Eligibility period. Individuals eligible under this section are subject to copayments after the end of the 60-day postpartum period described in R9-22-1427.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). New Section made by final rulemaking at 29 A.A.R. 1866 (August 25, 2023), with an immediate effective date of August 1, 2023 (Supp. 23-3).

**R9-22-1429. Eligibility for a Newborn**

A child born to a mother eligible for and receiving medical coverage under this Article, Article 15 of the Chapter, or 9 A.A.C. 28, is automatically eligible for AHCCCS medical coverage for a period not to exceed 12 months. Automatic eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age one.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1430. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1431. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 2633, effective July 10, 2007 (Supp. 07-3). Amended by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Repealed by final rulemaking at 21 A.A.R. 1241, effective September 5, 2015 (Supp. 15-3).

**R9-22-1432. Young Adult Transitional Insurance**

An individual is eligible for AHCCCS medical coverage when the individual meets all of the following eligibility requirements:

1. Is 18 through 25 years of age;
2. Was in foster care under the responsibility of the State or Tribe within the State on the individual's 18th birthday;
3. Was eligible for and receiving AHCCCS Medical Coverage on the individual's 18th birthday; and
4. Is not eligible for AHCCCS Medical Coverage under 42 U.S.C. 1396a(a)(10)(A)(i)(I) - (VII).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 30 A.A.R. 3749 (December 13, 2024), effective February 2, 2025 (Supp. 24-4).

**R9-22-1433. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

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Section repealed; new Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1434. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4).

**R9-22-1435. Eligibility for a Person With Medical Expenses Whose Income is Over 100 Percent FPL**

An applicant who is not eligible for AHCCCS medical coverage due to excess income may become AHCCCS eligible by deducting medical expenses from the applicant's income. This coverage is called Medical Expense Deduction (MED).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1436. MED Family Unit**

- A. For the purpose of this Section, a child is an unmarried person under age 18.
- B. The Department shall consider each of the following to be a family when living together:
  1. A parent and the parent's children;
  2. A married couple without children;
  3. A married couple and the children of either or both spouses;
  4. Unmarried parents who live with at least one child in common, and the parents' other children, whether in common or not; and
  5. A person without children.
- C. If an applicant is pregnant, the family unit includes the number of unborn children.
- D. A child of the children included in subsections (B)(1), (B)(3), or (B)(4) is considered part of the family unit when living together.
- E. The Department shall not include a SSI-cash recipient in the MED family unit even if the SSI-cash recipient is a parent, spouse, or child.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1437. MED Income Eligibility Requirements**

- A. Income exclusions. The exclusions in R9-22-1420(C) apply to the MED family unit.
- B. Income standard.

1. The Department shall divide the annual FPL for the MED family unit that is in effect during each month of the income period by 12 to determine the monthly FPL.
2. The Department shall add the monthly FPLs for the income period and multiply the resulting amount by 40 percent.
3. Changes to the annual FPL are implemented in April of each year.
- C. Income period. The income period is the month of application and the next two months. The Department shall add together the three months' income to establish the MED family unit's income amount.
- D. Medical expense deduction period. The medical expense deduction period is a three-month period consisting of:
  1. For a new application, the month before the application month, the month of application, and month following the application month; or
  2. For a MED eligibility review, the last month of the prior MED eligibility period and the following two months.
- E. The Department shall calculate the amount of countable monthly income as follows:
  1. Subtract a \$90 cost of employment allowance from the gross amount of earned income for each person whose earned income is counted;
  2. Disregard from the remaining earned income an amount billed by the provider for the care of each dependent child under age 18 or incapacitated adult member of the MED family unit if the care is for the purpose of allowing the person to work. If more than one person in the household is responsible for and billed for the care of a dependent child, the disregard may be split between the wage earners if splitting the disregard is to the benefit of the family, but shall not exceed the maximum disregards as follows:
    - a. A maximum of \$200 for a child under age two and \$175 for other dependents for a wage-earner employed full-time (86 or more hours per month); and
    - b. A maximum of \$100 for a child under age two, and \$88 for other dependents for a wage earner employed part-time (less than 86 hours a month);
  3. Add the remaining earned income for each MED family member to the unearned income of all MED family members;
  4. Compare the MED family's unit countable income amount to the income standard in subsection (B). The difference is the amount of medical expenses the family shall incur during the medical expense deduction period to become eligible;
  5. Subtract allowable medical expense deductions that were incurred by:
    - a. A member of the MED family unit;
    - b. A deceased spouse or minor child of a MED family unit if this person would have been a member of the MED unit during the MED expense deduction period;
    - c. A person who was a minor child of a MED family unit member when the expense was incurred but who is no longer a minor child; or
    - d. A minor child, including a child who is a runaway, who left home before the date of application to live with someone other than a parent; and
  6. Compare the net MED family income to the income standard listed in subsection (B).

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- F. The family is eligible if the net income in subsection (E)(6) does not exceed the income standard in subsection (B).

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1438. MED Resource Eligibility Requirements**

- A. Including countable resources. The Department shall include the resources not excluded that belong to and are available to members of the family of a qualified alien under A.R.S. § 36-2903.03 and the sponsor and sponsor's spouse of a person who is a qualified alien.
- B. Ownership and availability. The Department shall evaluate the ownership of resources to determine the availability of resources to a person listed in subsection (A).
1. Jointly owned resources with ownership records containing the words "and" or "and/or" between the owners' names are available to each owner except if one of the owners refuses to sell. A consent to sale is not required if all owners are members of the MED family unit.
  2. Jointly owned resources with ownership records containing the word "or" between the owners' names are presumed to be available in full to each owner. The applicant or member may rebut the presumption by providing clear and convincing evidence of intent to establish a different type of ownership. If the presumption is rebutted, the resource is available to the owners:
    - a. Consistent with the intent of the owners, or
    - b. Based on each owner's proportionate net contribution if there is not clear and convincing evidence of a different allocation.
  3. The Department shall establish availability of a trust under 42 U.S.C. 1396p(d)(4)(A) or (C).
- C. Unavailability. The Department shall consider the following resources unavailable:
1. Property subject to spendthrift restriction, such as:
    - a. Accounts established by the SSA, Veteran's Administration, or similar sources that mandate that the funds in the account be used for the benefit of a person not residing with the MED family unit; or
    - b. Trusts established by a will or funded solely by the income and resources of someone other than a member of the MED family unit.
  2. A resource being disputed in a divorce proceeding or probate matter;
  3. Real property located on a Native American reservation;
  4. A resource held by a conservator to the extent court-imposed restrictions make the resource unavailable to the applicant, member, or member of the family unit for:
    - a. Medical care,
    - b. Food,
    - c. Clothing, or
    - d. Shelter.
- D. Resource exclusion. The Department shall exclude the following resources from the calculation of resources under subsection (E):
1. One burial plot for each person listed in R9-22-1436;
  2. Household furnishings and personal items that are necessary for day-to-day living;
  3. Up to \$1500 of the value of one prepaid funeral plan for each person listed in R9-22-1436 that specifically covers only funeral-related expenses as evidenced by a written contract;
  4. The value of one motor vehicle regularly used for transportation. If the MED family unit owns more than one vehicle, the exclusion is applied to the vehicle with the highest equity value;
  5. The value of a vehicle used to earn income and not used simply for transportation to and from employment;
  6. The value of a vehicle in which a SSI-cash recipient has an ownership interest; and
  7. The value of any vehicle used for medical treatment, employment, or transportation of a SSI-cash disabled child, and that is excluded by SSI for that reason.
  8. Funds set aside in an Individual Development Account under 6 A.A.C. 12, Article 4; and
  9. Any other resource specifically excluded by federal law.
- E. Calculation of resources. The Department shall determine the value of all household resources as follows:
1. Calculate the total amount of countable liquid resources;
  2. Calculate the equity value of each countable non-liquid resource. The Department shall determine the equity value of a countable non-liquid resource by subtracting the amount of valid encumbrances on that resource from:
    - a. The market value of real property if there is no assessor's evaluation of the property,
    - b. The market value of real property if the assessor's value of the real property does not include the value of permanent structures on that property,
    - c. The assessor's full cash value if subsections (E)(2)(a) and (E)(2)(b) do not apply, and
    - d. The market value of a non-liquid resource that is not real property;
  3. Not assign an equity value to a resource that is less than zero; and
  4. Determine the MED family unit's resources by adding the totals determined in subsections (1) and (2).
- F. Resource standard to be eligible for MED. A person is not eligible for MED if the resources determined in subsection (E) exceed \$100,000 or if more than \$5,000 are liquid resources.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1439. MED Effective Date of Eligibility**

- A. A MED family unit is eligible on the day the income and resource eligibility requirements are met but no earlier than the first day of the month of application. If the family unit meets the income requirements in the application month but does not meet the resource limit until the following month, the family unit's effective date of eligibility is the first day of the month following the month of application.
- B. The Department shall adjust the effective date of eligibility under subsection (A) to an earlier date if:
1. A member presents verification of additional allowable medical expenses incurred on an earlier date during the medical expense deduction period that allow the member to meet the income requirements, and
  2. The member presents the verification within 60 days of approval of eligibility under this Section.
- C. The Department shall not adjust an effective date of eligibility more than one time per application.
- D. The Department shall adjust the effective date no later than 30 days after the end of the 60-day period under subsection (B)(2).
- E. The Department shall deny an application and provide the applicant a denial notice when the applicant does not meet the



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MED requirements under this Article during the month of application or the month following the month of application.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1440. MED Eligibility Period**

The Department shall approve eligibility for six months. Changes in circumstances do not affect eligibility for the first three months.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1441. Eligibility Appeals**

- A.** Adverse actions. An applicant or member may appeal by requesting a hearing from the Department concerning any of the following adverse actions:
1. Complete or partial denial of eligibility under R9-22-1413;
  2. Suspension, termination, or reduction of AHCCCS medical coverage under R9-22-1415;
  3. Delay in the eligibility determination beyond the timeframes under this Article;
  4. The imposition of or increase in a premium or copayment; or
  5. The effective date of eligibility.
- B.** Notice of Adverse Action. The Department shall personally deliver or send, by regular mail, a Notice of Adverse Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Adverse Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.
- C.** Automatic change and hearing rights.
1. An applicant or a member is not entitled to a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
  2. An applicant or a member is entitled to a hearing if a federal or state law requires an automatic change and the applicant or member timely files an appeal that alleges a misapplication of the facts to the law.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1442. Cessation of MED Coverage**

The Department shall not approve any individual or family who has applied on or after May 1, 2011 as eligible for MED coverage. With respect to any applications that are pending as of May 1, 2011, the Department shall not approve any individual or family as eligible for MED coverage who has not met all eligibility requirements prior to May 1, 2011.

**Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 1028, effective May 1, 2011 (Supp. 11-2).

**R9-22-1443. Repealed****Historical Note**

New Section made by exempt rulemaking at 17 A.A.R. 1345, effective July 8, 2011 (Supp. 11-3). Amended by exempt rulemaking at 17 A.A.R. 2624, effective July 8, 2011 (Supp. 11-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**ARTICLE 15. AHCCCS MEDICAL COVERAGE FOR PEOPLE WHO ARE AGED, BLIND, OR DISABLED****R9-22-1501. General Information**

- A.** General. The Administration shall determine eligibility for AHCCCS medical coverage for the following applicants or members using the eligibility criteria and requirements in this Article and Article 3:
1. A person who is aged, blind, or disabled and does not receive SSI cash; and
  2. A person terminated from the SSI cash program under R9-22-1505.
- B.** Definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Aged” means a person who is 65 years of age or older as specified in 42 U.S.C. 1382c(a)(1)(A).

“Blind” means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2) and 42 CFR 435.530 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

“Disabled” means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E) and 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

**C. Eligibility effective date.**

1. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
2. The effective date of eligibility for an applicant who moves into Arizona is no sooner than the date Arizona residency is established.
3. The effective date of eligibility for an inmate applying for medical coverage is the date the applicant no longer meets the definition of an inmate of a public institution.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 23, effective December 9, 2003 (Supp. 03-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, effective January 7, 2014 (Supp. 14-1). Amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4). Section amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014; amendments

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to this Section were slated to be codified in Supp. 14-1 but due to a clerical error, were not published. The amendments to this Section were published in Supp. 20-4 and no additional amendments have been made to this Section since January 7, 2014 (Supp. 20-4).

**R9-22-1502. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Repealed by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1503. Financial Eligibility Criteria**

- A.** General income eligibility. Except as provided under subsection (B) of this rule, the Administration or its designee shall count the identified income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K.
- B.** Exceptions.
  1. In-kind support and maintenance under 42 U.S.C. 1382a(a)(2)(A) is excluded.
  2. For a person living with a spouse, the Administration or its designee calculates net income for an eligible couple under 20 CFR 416.1160 as of April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments, even if the spouse is not eligible for or applying for SSI or coverage under this Article.
  3. In determining the net income of a married couple living with a child or the net income of a person who is not living with a spouse but living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, and under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology under 20 CFR 416.1163(b)(1) and (2) as of April 1, 2013, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
  4. In determining the income deemed available to an applicant who is a child from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income under 20 CFR 416.1165(b). The child's allocation is reduced by that child's income, including public income maintenance payments.
  5. In determining the income of a person who receives an annual Title II Cost of Living Allowance (COLA) increase, the COLA amount is disregarded from January until the Administration applies the effective income limits under R9-22-1504 based on the FPL for the calendar year.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1504. Eligibility For A Person Who is Aged, Blind, or Disabled**

- A.** To be eligible for AHCCCS medical coverage, an applicant shall meet the conditions of eligibility and requirements in this Article and:
  1. Meet one of the income tests described in subsection (B) or (C), or
  2. The special requirements in R9-22-1505.
- B.** The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, is less than or equal to 100 percent of the SSI FBR, as adjusted annually.
- C.** The Administration shall determine whether the applicant's countable income, as described in R9-22-1503, without deducting the amount from earned income under 42 U.S.C. 1382a(b)(4)(B)(iii), is less than or equal to 100 percent FPL as adjusted annually.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4).

**R9-22-1505. Eligibility for Special Groups**

- A.** The following are considered special groups:
  1. A person meeting the requirements in A.R.S. § 36-2903.03 who:
    - a. Is aged, blind, or disabled under 42 CFR 435.520, 42 CFR 435.530, or 42 CFR 435.540 as of October 1, 2012, which are incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
    - b. Received SSI cash or AHCCCS medical coverage under this subsection, or subsections (A)(2), (A)(3), or (A)(4) on or before August 21, 1996;
    - c. Was residing in the United States under color of law on or before August 21, 1996; and
    - d. Meets the requirements under this Article;
  2. A disabled child (DC) under 42 U.S.C. 1396a(a)(10)(A)(i)(II). A disabled child is a child who:
    - a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
    - b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d) of Subtitle B of P.L. 104-193;
    - c. Continues to meet the disability requirements for a child that were in effect on August 21, 1996; and
    - d. Meets the requirements under this Article;
  3. A disabled adult child (DAC), under 42 U.S.C. 1383c(c) who:

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- a. Was determined disabled by the Social Security Administration before attaining the age of 22 years,
- b. Became entitled to or received an increase in child's insurance benefits under Title II of the Act on the basis of blindness or disability,
- c. Was terminated from SSI cash benefits due to entitlement to or an increase in income under Title II of the Act,
- d. Meets the requirements under this Article, and
- e. Is 18 years of age or older;
- 4. A disabled widow or widower (DWW) under 42 U.S.C. 1383c(b) and (d) who:
  - a. Is blind or disabled,
  - b. Is ineligible for Medicare Part A benefits,
  - c. Received SSI cash benefits the month before Title II of the Act benefit payments began,
  - d. Meets the requirements under this Article;
  - e. Is at least 50 years of age but under age 65; and
  - f. Is unmarried.
- 5. Under 42 CFR 435.135, a person who:
  - a. Is aged, blind, or disabled;
  - b. Receives benefits under Title II of the Act;
  - c. Received SSI cash benefits in the past;
  - d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least one month anytime after April 1977;
  - e. Became ineligible for SSI cash benefits while receiving SSI and benefits under Title II of the Act concurrently; and
  - f. Meets the requirements under this Article.
- B. Income for special groups.
  - 1. Except as provided in subsection (B)(2), income eligibility is determined using the income criteria in R9-22-1503.
  - 2. Exceptions to income for special groups.
    - a. For a person in the DAC coverage group under subsection (A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c).
    - b. For a person in the DWW coverage group, under subsection (A)(4), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d).
    - c. For an applicant or member in the coverage group under subsection (A)(5), the portion of the applicant's or member's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135.
- C. 100 percent FBR. As a condition of eligibility for all special groups, countable income shall be equal to or less than 100 percent of the SSI FBR, as adjusted annually.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 11 A.A.R. 4942, effective December 31, 2005 (Supp. 05-4). Amended by final

rulemaking at 20 A.A.R. 192, with an immediate effective date of January 7, 2014 (Supp. 14-1).

**R9-22-1506. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1507. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1508. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**ARTICLE 16. HOSPITAL PRESUMPTIVE ELIGIBILITY****R9-22-1601. General Eligibility Requirements**

- A. Notwithstanding Article 3, a qualified hospital may determine Hospital Presumptive Eligibility (HPE), on the basis of preliminary information, that an individual is eligible for AHC-CCS medical coverage during the presumptive eligibility period described in this section, if the individual is a United States citizen or eligible qualified alien, and the individual is:
  - 1. Pregnant with gross household income that does not exceed 156% of the FPL;
  - 2. An adult who meets the requirements of R9-22-1427(E);
  - 3. A caretaker relative as defined in R9-22-1401(B) with gross household income that does not exceed 106% of the FPL;
  - 4. Under age 19 with gross household income that does not exceed the limit set in R9-22-1427(D) for the child's age;
  - 5. A woman screened for breast or cervical cancer by an Arizona program of the National Breast and Cervical Cancer Early Detection Program who meets the requirements of R9-22-2003(A); or
  - 6. A former foster care child who meets the requirements of R9-22-1432.
- B. Definitions. In addition to definitions contained in R9-22-101 and A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning: "Qualified hospital" means a hospital that has signed an agreement with the Administration to process HPE applications and has not been disqualified.
- C. Application Process:
  - 1. Right to apply. A person may apply for presumptive eligibility for AHCCCS medical coverage by submitting an Administration-approved application to the qualified hospital.
  - 2. Application. To initiate the application process, the qualified hospital will accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Service (IRS) Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for

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the applicant by submitting a written or online application under 42 CFR 435.907.

- D.** To establish presumptive eligibility, an applicant must complete and submit an AHCCCS-approved presumptive eligibility application signed under penalty of perjury to a qualified hospital. The applicant must attest to the name(s), relationship(s), and income of all persons in the household. In addition, the applicant must provide and attest to the following information regarding each household member on whose behalf AHCCCS medical coverage is sought:
1. The individual's date of birth;
  2. Whether the individual is pregnant;
  3. Whether the individual has been determined eligible for Breast and Cervical Cancer Treatment Program, described under Article 20;
  4. Whether the individual is a former foster child, described under R9-22-1432;
  5. The U.S. citizenship status or eligible qualified alien status under A.R.S. 36-2903.03 of the individual; and
  6. The individual's permanent and mailing addresses;
  7. The individual's Arizona residency status; and
  8. Whether the individual has Medicare coverage.
- E.** Presumptive eligibility begins on the date the hospital determines an individual's presumptive eligibility and ends with the earlier of:
1. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or
  2. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.
- F.** An individual may not be determined presumptively eligible more often than once every two years.
- G.** Coverage and reimbursement of services.
1. The Administration shall provide coverage of medically necessary services described under Article 2 to persons determined eligible for HPE on a fee-for-service basis.
  2. Providers shall submit claims for services provided to persons determined eligible for HPE to the Administration as described under Article 7.
- H.** A member may withdraw from HPE coverage by notifying the Administration or its designee.
- I.** Upon determining an individual presumptively eligible, the qualified hospital shall:
1. Notify the applicant at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of the determination for each individual on whose behalf presumptive eligibility was requested and the effective date of the presumptive eligibility;
  2. Provide the applicant with a regular AHCCCS-approved application form and inform the applicant that the applicant may file an application for Medicaid with the Administration or its designee;
  3. Notify AHCCCS of the presumptive eligibility determination;
  4. Notify the applicant at the time the determination is made that presumptive eligibility ends with the earlier of:
    - a. In the case of an individual on whose behalf an application has been submitted to AHCCCS or its designee under Article 3, the day on which AHCCCS or its designee makes a determination on that application; or

CCS or its designee makes a determination on that application; or

- b. In the case of an individual on whose behalf an application has not been submitted to AHCCCS or its designee under Article 3, on the last day of the following month in which the determination of presumptive eligibility was made by the qualified hospital.

- J.** A determination by a qualified hospital that an individual is not presumptively eligible is not appealable under Chapter 34. If a qualified hospital denies an individual presumptive eligibility, the individual may apply for coverage by submitting an application to the Administration or its designee.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4). New Section made by final rulemaking at 20 A.A.R. 3436, effective January 1, 2015 (Supp. 14-4).

**R9-22-1602. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1603. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1604. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1605. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by

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New Section adopted by final rulemaking at 5 A.A.R.  
294, effective January 8, 1999 (Supp. 99-1). Section

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repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1618. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1619. Expired****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). New Section made by exempt rulemaking at 12 A.A.R. 3892, effective October 1, 2006 (Supp. 06-3). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 2384, effective October 31, 2011 (Supp. 11-4).

**R9-22-1620. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1621. Reserved****R9-22-1622. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1623. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1624. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1625. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1626. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1627. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1628. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1629. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1630. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1631. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1632. Reserved****R9-22-1633. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1634. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

**R9-22-1635. Reserved****R9-22-1636. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Section repealed by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3).

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**ARTICLE 17. ENROLLMENT****R9-22-1701. Enrollment-Related Definitions**

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Annual enrollment choice” means the annual opportunity for a person to change contractors.

“Auto-assignment algorithm” or “Algorithm” means a formula used by the Administration to assign to a contractor a member who did not make a timely choice under R9-22-1702.

“CMDP” means Comprehensive Medical and Dental Program.

“Disenrollment” means the discontinuance of a person’s entitlement to receive covered services from a contractor of record.

“Enrollment” means the process by which an eligible person becomes a member of a contractor’s plan.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Amended by exempt rulemaking at 7 A.A.R. 5701, effective December 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 4588, effective October 12, 2004 (Supp. 04-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1702. Enrollment of a Member with an AHCCCS Contractor**

**A.** General enrollment requirements. The Administration shall enroll a member with a contractor as described in this Section, unless the member has pre-selected a contractor on the application:

1. Except as provided in subsections (A)(3), (A)(5), and (C), a member who is determined to be eligible under this Chapter and resides in an area served by more than one contractor, may choose an available contractor serving the member’s GSA within 30 days from the date of notice of enrollment. A Native American member may select IHS or another available contractor.
2. If the member does not make a choice under subsection (A)(1), the Administration shall immediately auto-assign the member to:
  - a. IHS if the member is a Native American living on a reservation,
  - b. A contractor based on family continuity, or
  - c. A contractor by using the auto-assignment algorithm.
3. If the member’s period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days, the Administration shall enroll the member with the member’s most recent contractor of record, if available, except if:
  - a. The member no longer resides in the contractor’s GSA;
  - b. The contractor’s contract is suspended or terminated;

- c. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
  - d. The member chooses another contractor or chooses IHS, if available to the member, during the annual enrollment choice period; or
  - e. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.
4. When the member’s disenrollment period is more than 90 days, the member may select a contractor as described in subsection (A)(1).
5. The Administration shall not enroll a member with a contractor if a member:
  - a. Is eligible for the FESP under R9-22-1419;
  - b. Is eligible for less than 30 days from the date the Administration receives notification of a member’s eligibility, except for a member who is enrolled with CMDP or IHS;
  - c. Is eligible only for a retroactive period of eligibility, except for a member who is enrolled with CMDP or IHS; or
  - d. Resides in an area not served by a contractor.
- B.** Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(5) shall obtain covered medical services from an AHCCCS-registered provider on a fee-for-service basis under Article 7.
- C.** Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S. § 8-512.
- D.** Family Planning Services Extension Program. A member eligible for the Family Planning Services Extension Program under R9-22-1431, shall remain enrolled with the member’s contractor of record or IHS.
- E.** Contractor or IHS enrollment change for a member.
  1. The Administration shall change a member’s enrollment if the member requests a change to an available contractor or IHS during an annual enrollment period. A Native American may change from an available contractor to IHS or from IHS to an available contractor at any time.
  2. The Administration shall approve a change in enrollment for any member if the change is a result of the final outcome of a grievance under 9 A.A.C. 34.
  3. A member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (A)(2).
  4. The Administration shall provide the member 60-day advance notice of the member’s option to change plans by the member’s annual enrollment date.
  5. A member may disenroll from a plan if:
    - a. The member moves out of the GSA;
    - b. The plan does not, because of moral or religious objections, cover the service a member seeks; or
    - c. The member needs related services to be performed at the same time; not all related services are available within the network; and the member’s primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

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6. For exceptions to this Article, the Administration shall approve a change for an enrolled member as determined by the Director.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1703. Effective Date of Enrollment with a Contractor**

- A. Effective date of enrollment. A member's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the member's enrollment anniversary date.
- B. Financial liability of the contractor. The contractor shall be financially liable for an enrolled member's care as specified in contract.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1704. Newborn Enrollment**

- A. General.
1. The Administration shall enroll a newborn child of an eligible mother with an available contractor or IHS, based on the mother's enrollment.
  2. The Administration shall auto-assign a newborn child of an eligible mother who is not enrolled with a contractor or IHS or who is enrolled with CMDP. When a mother enrolled in CMDP has a newborn and the newborn is surrendered to Administration on Children, Youth and Families (ACYF), the newborn is then enrolled with CMDP.
  3. The Administration shall notify the mother of the right to choose a different contractor for her newborn child. The mother may make her choice within 30 days from the date of notice of enrollment.
- B. Financial liability for newborns. The contractor shall be financially liable for the medical care of a newborn as specified in contract.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 294, effective January 8, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 2435, effective June 9, 2000 (Supp. 00-2). Amended by exempt rulemaking at 7 A.A.R. 4593, effective October 1, 2001 (Supp. 01-3). Amended to correct a typographical error, filed in the Office of the Secretary of State October 30, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**R9-22-1705. Guaranteed Enrollment Period**

- A. General. Except for members enrolled with IHS or CMDP, the Administration shall provide a guaranteed enrollment period for a one-time period that begins on the effective date of the member's initial enrollment with a contractor and ends on the

last day of the fifth full calendar month after the date of the member's initial enrollment.

- B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:
1. Did not meet the conditions of eligibility when initially enrolled with the contractor;
  2. Except as provided in 9 A.A.C. 22, Article 12, is an inmate of a public institution as defined in 42 CFR 435.1010;
  3. Dies;
  4. Moves out-of-state;
  5. Voluntarily withdraws from the AHCCCS program;
  6. Is adopted; or
  7. Has whereabouts that are unknown.
- C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period to which the member is not entitled effective on:
1. The date the member is admitted to a public institution under subsection (B);
  2. The member's date of death;
  3. The last day of the month in which the Administration receives notification that a member moved out-of-state;
  4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
  5. The last day of the month in which the Administration receives notification that a member's adoption proceedings are finalized; or
  6. The last day of the month in which the Administration receives notification that a member's whereabouts are unknown.
- D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively under subsection (C).

**Historical Note**

New Section made by final rulemaking at 14 A.A.R. 1598, effective May 31, 2008 (Supp. 08-2).

**ARTICLE 18. PROVIDER EXCLUSION RULES****R9-22-1801. Definitions**

"Administration" has the meaning defined in A.R.S. § 36-2901.

"Affiliation" has the meaning defined in 42 C.F.R. § 424.502.

"Managing employee" has the meaning defined in 42 C.F.R. § 455.101.

"Member" has the meaning defined in A.R.S. § 36-2901.

"Person with an ownership or control interest" has the meaning defined in 42 C.F.R. § 455.101 and 42 C.F.R. § 455.102.

"System" has the meaning defined in A.R.S. § 36-2901.

**Historical Note**

Section made by emergency rulemaking at 29 A.A.R. 1577 (July 14, 2023), with an immediate effective date of July 3, 2023; effective for 180 days (Supp. 23-3). Emergency renewed at 30 A.A.R. 69 (January 12, 2024), with an immediate effective date of December 21, 2023; effective for 180 days (Supp. 23-4). New Section made by final rulemaking at 30 A.A.R. 1977 (May 31, 2024), effective June 26, 2024; AHCCCS was granted an earlier



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effective date one day before the renewed emergency was due to expire to maintain continuity of administering this Section (Supp. 24-2).

**R9-22-1802. Basis for Exclusion**

- A.** In addition to such grounds for exclusion set for in subsections A and B of A.R.S. § 36-2930.05, the Administration, in its sole discretion, may exclude:
- Any individual or entity which has failed to comply with any requirement, term, or condition set forth in any agreement with the Administration;
  - Any individual or entity which has failed to remit any indebtedness or overpayment as required by A.A.C. R9-22-713;
  - Any entity which has a managing employee or any entity with a person with an ownership or control interest that:
    - Has failed to remit any indebtedness or overpayment as required by A.A.C. R9-22-713;
    - Has an affiliation with an organization which has failed to remit any indebtedness or overpayment as required by A.A.C. R9-22-713;
  - Any individual or any entity with a managing employee or a person with an ownership or control interest that has been convicted of a criminal offense which the Administration, in its sole discretion, determines may represent an undue risk of fraud, waste, or abuse of the system or an undue risk of harm to members;
  - Any individual or entity who employs any person to furnish items or services who has been excluded from participation in the system pursuant to A.R.S. § 36-2930.05;
  - Any individual who is or was a managing employee or a person with an ownership or control interest who participated in, condoned, or was willfully ignorant of any action or failure to act of an entity which was or could have been the basis for exclusion of the entity;
  - Any individual who was an organizer, leader, manager, or supervisor of any entity activity which was or could have been the basis for exclusion of the entity; or
  - Any individual or entity in order to protect the health of members.
- B.** The delineation of grounds for exclusion herein does not exclude any other basis for exclusion pursuant to A.R.S. § 36-2930.05(C).

**Historical Note**

Section made by emergency rulemaking at 29 A.A.R. 1577 (July 14, 2023), with an immediate effective date of July 3, 2023; effective for 180 days (Supp. 23-3). Emergency renewed at 30 A.A.R. 69 (January 12, 2024), with an immediate effective date of December 21, 2023; effective for 180 days (Supp. 23-4). New Section made by final rulemaking at 30 A.A.R. 1977 (May 31, 2024), effective June 26, 2024; AHCCCS was granted an earlier effective date one day before the renewed emergency was due to expire to maintain continuity of administering this Section (Supp. 24-2).

**R9-22-1803. Period of Exclusion**

- A.** Pursuant to A.R.S. § 36-2930.05 and 42 C.F.R. § 1002.210, any exclusion from participation in the system shall be for such period as determined in the discretion of the Administration, but in no event shall such period be less than five years.
- B.** In determining the period of exclusion, the Administration, in its sole discretion, may consider aggravating and mitigating

factors set forth in any provision of Code of Federal Regulations Chapter 42 part 1001, Subpart C or part 1003.

**Historical Note**

Section made by emergency rulemaking at 29 A.A.R. 1577 (July 14, 2023), with an immediate effective date of July 3, 2023; effective for 180 days (Supp. 23-3). Emergency renewed at 30 A.A.R. 69 (January 12, 2024), with an immediate effective date of December 21, 2023; effective for 180 days (Supp. 23-4). New Section made by final rulemaking at 30 A.A.R. 1977 (May 31, 2024), effective June 26, 2024; AHCCCS was granted an earlier effective date one day before the renewed emergency was due to expire to maintain continuity of administering this Section (Supp. 24-2).

**R9-22-1804. Appeal of Exclusion**

- A.** Any exclusion of an individual or entity pursuant to A.R.S. § 36-2930.05 is an appealable agency action subject to the Uniform Administrative Appeals Procedures, A.R.S. § 41-1092, et seq.
- B.** The Administration shall set forth in the notice of an appealable agency action required by A.R.S. § 41-1092.03 the period of exclusion and the earliest date on which AHCCCS will consider a request for reinstatement.

**Historical Note**

Section made by emergency rulemaking at 29 A.A.R. 1577 (July 14, 2023), with an immediate effective date of July 3, 2023; effective for 180 days (Supp. 23-3). Emergency renewed at 30 A.A.R. 69 (January 12, 2024), with an immediate effective date of December 21, 2023; effective for 180 days (Supp. 23-4). New Section made by final rulemaking at 30 A.A.R. 1977 (May 31, 2024), effective June 26, 2024; AHCCCS was granted an earlier effective date one day before the renewed emergency was due to expire to maintain continuity of administering this Section (Supp. 24-2).

**R9-22-1805. Reinstatement of Participation**

- A.** If the period of exclusion has expired, an individual or entity may apply for reinstatement of participation in the system by submission of the following:
- An application for participation as a provider.
  - Information to demonstrate reasonable assurances that the type of actions that formed the basis for the original exclusion have not recurred and will not recur.
  - Such other information as may be requested by the Administration.
- B.** In making the reinstatement determination, the Administration may consider:
- Conduct of the individual or entity occurring prior to the date of the exclusion, if not known to the Administration at the time of the exclusion;
  - Conduct of the individual or entity after the date of the exclusion;
  - Whether all fines and all debts due and owing (including overpayments) to any Federal, State, or local government that relate to Medicare, Medicaid, and all other Federal health care programs have been paid;
  - Whether the individual or entity otherwise qualifies for participation in the system;
  - Whether reinstatement is in the best interest of the system;
  - Such other information as deemed relevant by the Administration.

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**R9-22-1806. Denial of Reinstatement**

- A. If an application for reinstatement is denied, the Administration shall give written notice to the requesting individual or entity.
- B. Within 30 days of the date on the notice of denial of reinstatement, the excluded individual or entity may submit documentary evidence and written argument against the continued exclusion.
- C. After evaluating any additional evidence submitted by the excluded individual or entity (or at the end of the 30-day period if none is submitted), the Administration will send written notice either confirming the denial and indicating that a subsequent request for reinstatement will not be considered until at least one year after the date of the denial or approving the request for reinstatement of participation.
- D. Any notice confirming a denial of reinstatement is an appealable agency action subject to the Uniform Administrative Appeals Procedures, A.R.S. § 41-1092, et seq.

**Historical Note**

Section made by emergency rulemaking at 29 A.A.R. 1577 (July 14, 2023), with an immediate effective date of July 3, 2023; effective for 180 days (Supp. 23-3). Emergency renewed at 30 A.A.R. 69 (January 12, 2024), with an immediate effective date of December 21, 2023; effective for 180 days (Supp. 23-4). New Section made by final rulemaking at 30 A.A.R. 1977 (May 31, 2024), effective June 26, 2024; AHCCCS was granted an earlier effective date one day before the renewed emergency was due to expire to maintain continuity of administering this Section (Supp. 24-2).

**ARTICLE 19. FREEDOM TO WORK**

*Article 19, consisting of Sections R9-22-1901 through R9-22-1922, made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).*

**R9-22-1901. General Freedom to Work Requirements**

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:

1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income eligible under A.R.S. § 36-2901(6)(a).

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1902. General Administration Requirements**

The Administration shall comply with the confidentiality rule under R9-22-512(C).

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1903. Application for Coverage**

- A. A person may apply by submitting an application to an Administration office.
- B. The application date is the date the application is received at an Administration office or outstation location approved by the Director as described under R9-22-1406(A).
- C. The provisions in R9-22-302 apply to this Section.
- D. The applicant or representative who files the application may withdraw the application for coverage either orally or in writing. An applicant withdrawing an application shall receive a denial notice under R9-22-1904.
- E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5123, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1904. Notice of Approval or Denial**

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:

1. If approved, the notice shall contain:
  - a. The effective date of eligibility,
  - b. The amount the person shall pay, and
  - c. An explanation of the person's hearing rights specified in 9 A.A.C. 34.
2. If denied, R9-22-307 applies.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1905. Reporting and Verifying Changes**

An applicant or member shall report and verify changes, as described under R9-22-306, to the Administration.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1906. Actions that Result from a Redetermination or Change**

The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,

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3. A change in premium amount, or
4. A change in the coverage group under which a person receives AHCCCS medical coverage.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1907. Notice of Adverse Action Requirements**

- A. The requirements under R9-22-312 apply.
- B. Advance notice of a change in eligibility or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to discontinue eligibility, or increase the premium amount.
- C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:
  1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
  2. A member provides information that requires termination of eligibility or reduction of services, indicates that the member understands that this must be the result of supplying that information, and the member signs a written statement waiving advance notice;
  3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 431.231(d);
  4. A member has been admitted to a public institution where a person is ineligible for coverage;
  5. A member has been approved for Medicaid in another state; or
  6. The Administration receives information confirming the death of a member.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1908. Request for Hearing**

An applicant or member may request a hearing under 9 A.A.C. 34.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1909. Conditions of Eligibility**

An applicant or member shall meet the following conditions to qualify for the Freedom to Work program:

1. Furnish a valid Social Security Number (SSN);
2. Be a resident of Arizona;
3. Be a citizen of the United States, or meet requirements for a qualified alien under A.R.S. § 36-2903.03(B);
4. Be at least 16 years of age, but less than 65 years of age;
5. Have countable income that does not exceed 250 percent of FPL. The Administration shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:

- a. The unearned income of the applicant or member shall be disregarded,
  - b. The income of a spouse or other family member shall be disregarded, and
  - c. The deduction for a minor child shall not apply;
6. Comply with the member responsibility provisions under R9-22-306.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Section repealed; new Section made by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1910. Prior Quarter Eligibility**

A person may be made eligible during a prior quarter period when applying for the Freedom to Work program, as described under Article 3.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). New Section made by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

**R9-22-1911. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1912. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1913. Premium Requirements**

- A. As a condition of eligibility, an applicant or member shall:
  1. Pay the premium required under subsection (B).
  2. Not have any unpaid premiums for more than one month's premium amount.
- B. The Administration shall process premiums under 9 A.A.C. 31, R9-31-1409 through R9-31-1419 with the following exceptions:
  1. A member who has countable income:
    - a. Under \$500, the monthly premium payment shall be \$0.
    - b. Over \$500 but not greater than \$750, the monthly premium payment shall be \$10.
  2. The premium for a member shall be increased by \$5 for each \$250 increase in countable income above \$750.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R.

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2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1914. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1915. Institutionalized Person**

A. A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 22 through age 64 and is residing in an ICF/IID except when allowed under the Administration's Section 1115 Demonstration Project or allowed under a managed care contract approved by CMS.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1916. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1917. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1918. Additional Eligibility Criteria for the Basic Coverage Group**

An applicant or member shall meet the following eligibility criteria:

1. Disabled. As a condition of eligibility, an applicant or member shall be disabled. Disabled means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), except employment activity, earnings, and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant or member's work.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1919. Additional Eligibility Criteria for the Medically Improved Group**

As a condition of eligibility for the Medically Improved Group, a member shall:

1. Be employed. Under this Section, employed means an individual who:
  - a. Earns at least the minimum wage and works at least 40 hours per month, or
  - b. Has gross monthly earnings at least equal to those earned by an individual who is earning the minimum wage working 40 hours per month.
2. Cease to be eligible for medical coverage under R9-22-1918 or a similar Basic Coverage Group program administered by another state because the member, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be disabled; and
3. Continues to have a severe medically determinable impairment, as determined under 42 U.S.C. 1396d(v)(1).

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**R9-22-1920. Repealed****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Section repealed by final rulemaking at 15 A.A.R. 220, effective March 7, 2009 (Supp. 09-1).

**R9-22-1921. Enrollment**

The Administration shall enroll members under Article 17 of this Chapter. If a member has not paid a required premium, the Administration shall not grant a guaranteed enrollment period.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4).

**R9-22-1922. Redetermination of Eligibility**

- A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.
- B. Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.
- C. Medical Improvement. If a member is no longer disabled under R9-22-1918, the Administration shall determine if the member is eligible under other coverage groups including the medically improved group.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 95, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 30 A.A.R. 2674 (August 30, 2024), effective October 8, 2024 (Supp. 24-3).

**ARTICLE 20. BREAST AND CERVICAL CANCER TREATMENT PROGRAM****R9-22-2001. Breast and Cervical Cancer Treatment Program Related Definitions**

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In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meaning unless the context explicitly requires another meaning:

“AZ-NBCCEDP” means the Arizona programs of the National Breast and Cervical Cancer Early Detection Program. AZ-NBCCEDP provides breast and cervical cancer screening and diagnosis in Arizona.

“Cryotherapy” means the destruction of abnormal tissue using an extremely cold temperature.

“LEEP” means the loop electrosurgical excision procedure that passes an electric current through a thin wire loop.

“Peer-reviewed study” means that, prior to publication, a medical study has been subjected to the review of medical experts who:

- Have expertise in the subject matter of the study,
- Evaluate the science and methodology of the study,
- Are selected by the editorial staff of the publication, and
- Review the study without knowledge of the identity or qualifications of the author.

“WWHP” means the Well Women Healthcheck Program administered by the Arizona Department of Health Services. The WWHP is one of the programs within AZ-NBCCEDP that provides breast and cervical cancer screening and diagnosis.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2002. General Requirements**

- A. Confidentiality. The Administration shall maintain the confidentiality of a woman’s records and shall not disclose a woman’s financial, medical, or other confidential information except as allowed under R9-22-512.
- B. Covered services. A woman who is eligible under this Article receives all medically necessary services under Articles 2 and 12 of this Chapter.
- C. Choice of health plan. A woman who is eligible under this Article shall be enrolled with a contractor under Article 17 of this Chapter.
- D. A Native American woman who receives services through Indian Health Service (IHS) or through a tribal health program qualifies for services provided under this Article if all eligibility requirements are met.
- E. A woman qualified under this Article shall pay co-pays as described in R9-22-711.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2003. Eligibility Criteria**

- A. General. To be eligible under this Article, a woman shall meet the requirements of this Article and:
  1. Be screened for breast and cervical cancer through AZ-NBCCEDP;
  2. Be less than 65 years of age;
  3. Be ineligible for Title XIX under Articles 14 and 15 in this Chapter;
  4. Receive a positive screen under subsection (A)(1), a confirmed diagnosis through AZ-NBCCEDP, and need treat-

ment for breast cancer or cervical cancer, including a pre-cancerous cervical lesion, as specified in R9-22-2004;

5. Not be covered under creditable coverage as specified in Section 2701(c) of the Public Health Services Act, 42 U.S.C. 300gg(c). For purposes of this Article, IHS or Tribal health coverage is not considered creditable coverage as specified in 42 U.S.C. 1396a(a)(10)(A)(ii), as amended by the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2002; and
  6. Meet the requirements under R9-22-1417 and R9-22-1418.
- B. Ineligible woman. A woman is ineligible under this Article if the woman:
    1. Is an inmate of a public institution and federal financial participation (FFP) is not available,
    2. Is at least age 21 but less than age 65 and resides in an Institution for Mental Disease (IMD) as defined in R9-22-112, except if allowed under the Administration’s Section 1115 waiver, or
    3. No longer meets an eligibility requirement under this Article.
  - C. Metastasized cancer. The AHCCCS Chief Medical Officer may continue a woman’s eligibility under this Article if a metastasized cancer is found in another part of the woman’s body and that metastasized cancer is a known or a presumed complication of the breast or cervical cancer as determined by the treating physician.
  - D. Reoccurrence of cancer. A woman shall have eligibility reestablished after eligibility under this Article ends if the woman is screened under the AZ-NBCCEDP program and additional breast cancer or cervical cancer, including a pre-cancerous cervical lesion, is found.
  - E. Ineligible male. A male is precluded from receiving screening and diagnostic services under the AZ-NBCCEDP program and is ineligible under this Article.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2004. Treatment**

- A. Breast cancer. Coverage for treatment for breast cancer under this Article shall conclude on the last provider visit for the specific treatment of the cancer or at the end of hormonal therapy for the cancer, whichever is later. For purposes of this subsection treatment means:
  1. Lumpectomy or surgical removal of breast cancer;
  2. Chemotherapy;
  3. Radiation therapy; and
  4. A treatment for breast cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
- B. Pre-cancerous cervical lesion. Coverage for treatment for a pre-cancerous cervical lesion under this Article, including moderate or severe cervical dysplasia or carcinoma in situ, shall conclude on the last provider visit for specific treatment for the pre-cancerous lesion. For purposes of this subsection treatment means:
  1. Conization;
  2. LEEP;
  3. Cryotherapy; and

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4. A treatment for pre-cancerous cervical lesion that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
- C. Cervical cancer. Coverage for treatment for cervical cancer under this Article shall conclude on the last provider visit for the specific treatment for the cancer. For purposes of this subsection treatment means:
  1. Surgery;
  2. Radiation therapy;
  3. Chemotherapy; and
  4. A treatment for cervical cancer that, as determined by the AHCCCS Chief Medical Officer, is considered the standard of care as supported by a peer-reviewed study published in a medical journal.
5. Information regarding the woman's appeal and request for hearing rights.
- D. Discontinuance.
  1. Except as specified in subsection (D)(2), if a woman no longer meets an eligibility requirement under this Article, the Administration shall provide the woman a Notice of Action no later than 10 days before the effective date of the discontinuance.
  2. The Administration may mail the Notice of Action no later than the effective date of the discontinuance if the Administration:
    - a. Receives a written statement from the woman voluntarily withdrawing from AHCCCS,
    - b. Receives information confirming the death of the woman,
    - c. Receives returned mail with no forwarding address from the post office and the woman's whereabouts are unknown, or
    - d. Receives information confirming that the woman has been approved for Title XIX services outside the state of Arizona.
  3. The Notice of Action shall contain the:
    - a. Name of the ineligible woman,
    - b. Effective date of the discontinuance,
    - c. Specific reason why the woman is discontinued,
    - d. Legal citations supporting the reason for the discontinuance,
    - e. Location where the woman can review the legal citations, and
    - f. Information regarding the woman's appeal and request for hearing rights.
- E. Request for hearing. A woman who is denied, or discontinued for the Breast and Cervical Cancer Treatment Program may request a hearing under Chapter 34.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2005. Application Process**

- A. Application. A woman may apply for eligibility under this Article by submitting a complete application as specified in R9-22-1406.
- B. Submitting the application. The woman may complete and submit an application at the time of the AZ-NBCCEDP screening. The AZ-NBCCEDP staff may mail or fax the application directly to the Administration.
- C. Date of application. The date of the application is the date of the diagnostic procedure that results in a positive diagnosis for breast cancer or cervical cancer, including a pre-cancerous cervical lesion.
- D. Responsibility of a woman who is applying or who is a member. A woman who is applying or who is a member shall:
  1. Provide medical insurance information, including any changes in medical insurance; and
  2. Inform the Administration about a change in address, residence, and alienage status.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2006. Approval, Denial, or Discontinuance of Eligibility**

- A. Eligibility determination. The Administration shall determine eligibility under this Article and send the notice under subsection (B) or (C) within seven days of receiving a complete application.
- B. Approval. If a woman meets all the eligibility requirements in this Article, the Administration shall provide the woman with an approval notice. The approval notice shall contain:
  1. The name of the eligible woman, and
  2. The effective date of eligibility.
- C. Denial. If the Administration denies eligibility, the Administration shall provide the woman with a denial notice. The denial notice shall contain:
  1. The name of the ineligible woman,
  2. The specific reason why the woman is ineligible,
  3. The legal citations supporting the reason for the denial,
  4. The location where the woman can review the legal citations, and

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**R9-22-2007. Effective and End Date of Eligibility**

- A. Eligibility is effective on the first day of the month that all eligibility requirements are met, including the period described under R9-22-303.
- B. The end date of eligibility:
  1. For breast cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer or at the end of hormonal therapy for the cancer, whichever is later.
  2. For pre-cancerous cervical lesion, is four months after the last provider visit for a treatment specified in R9-22-2004 for the pre-cancerous lesion.
  3. For cervical cancer, is 12 months after the last provider visit for a treatment specified in R9-22-2004 for the cancer.

**Historical Note**

New Section made by final rulemaking at 7 A.A.R. 5814, effective December 6, 2001 (Supp. 01-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4). Section amended by final rulemaking at 19 A.A.R. 3309, effective November 30, 2013 (Supp. 13-4).

**R9-22-2008. Redetermination of Eligibility**

## TITLE 9. HEALTH SERVICES

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

- A. Redetermination. Except as provided in subsection (B), the Administration shall redetermine eligibility at least once a year. If a woman continues to meet the requirements of eligibility for the Breast and Cervical Cancer Treatment Program under this Article, the Administration shall notify the woman of continued eligibility. A woman is not required to be screened for breast and cervical cancer through AZ-NBC-CEDP at redetermination.
- B. Change in circumstance. The Administration shall complete a redetermination of eligibility if there is a change in the woman's circumstances that may affect eligibility, including a change in treatment.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 4488, effective January 6, 2007 (Supp. 06-4).

**ARTICLE 21. TRAUMA AND EMERGENCY SERVICES FUND**

*Article 21, consisting of Sections R9-22-2101 through R9-22-2103, made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).*

**R9-22-2101. General Provisions**

- A. A.R.S. § 36-2903.07 establishes the Administration as the authority to administer the Trauma and Emergency Services Fund.
- B. The Administration shall distribute 90% of monies from the trauma and emergency services fund to a level I trauma center, as defined in subsection (F) of this Section, for unrecovered trauma center readiness costs as defined in subsection (F) of this Section. Reimbursement is limited to no more than the amount of unrecovered trauma center readiness costs as determined in subsections (D) and (E) of this Section. Unexpended funds may be used to reimburse unrecovered emergency room costs under subsection (C) of this Section.
- C. The Administration shall distribute 10% of monies from the trauma and emergency services fund, for unrecovered emergency services costs, to a hospital having an emergency department, using criteria under R9-22-2103. Reimbursement is limited to no more than the amount of unrecovered emergency services costs as determined in R9-22-2103. The Administration may distribute more than 10% of the monies for unrecovered emergency room costs when there are unexpended monies under subsection (B) of this Section.
- D. The Administration shall distribute a reporting tool and guidelines to level I trauma centers to determine, on an annual basis, the unrecovered trauma center readiness costs for level I trauma centers as defined in subsection (F) of this Section. The reporting time-frame is July 1 of the prior year through June 30 of the reporting year. A level I trauma center shall submit the requested data and a copy of the most recently completed uniform accounting report under A.R.S. § 36-125.04 to the Administration no later than October 31 of each reporting year.
- E. When a level I trauma center closes in a county where there are one or more level I trauma center(s) remaining in operation, the following shall occur:
  - 1. The closing level I trauma center shall submit the requested data under subsection (D) of this Section for the months of the reporting time-frame in which it met the definition of a level I trauma center, and
  - 2. The data under subsection (D) of this Section, which is submitted by the closing level I trauma center, shall be

added to the remaining level I trauma center(s) in that county for the current reporting time-frame only.

- F. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:
  - 1. "Level I trauma center" means any acute care hospital designated by the Arizona Department of Health Services as a level I trauma center, a provisional level I trauma center, a pediatric level I trauma center or an initial level I trauma center.
  - 2. "Unrecovered trauma center readiness costs" means losses incurred treating trauma patients:
    - a. Determined in accordance with Generally Accepted Accounting Principles,
    - b. Based on both clinical and professional costs incurred by a level I trauma center necessary for the provision of level I trauma care, and
    - c. Based on administrative and overhead costs directly associated with providing level I trauma care.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by final rulemaking at 24 A.A.R. 2855, effective November 16, 2018 (Supp. 18-3).

**R9-22-2102. Distribution of Trauma and Emergency Services Fund: Level I Trauma Centers**

- A. On or after November 1, 2003, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall take into consideration the proportion of those hospitals' trauma case volume. The Administration shall:
  - 1. Recalculate the November 2003 payments in July 2004 using the formula in subsection (B) of this Section;
  - 2. Recoup November 2003 overpayments by reducing the July 2004 distributions under subsection (C) as appropriate; and
  - 3. Redistribute recouped funds, with the July 2004 payment, to level I trauma centers underpaid in November 2003.
- B. On or after January 31 of each year, the Administration shall distribute monies, under R9-22-2101(B), to level I trauma centers using monies available in the trauma and emergency services fund at the time of payment. The Administration shall determine each hospital's unrecovered trauma center readiness costs for the current fiscal year using data from the most recent reporting year as provided under R9-22-2101(D) and (E). The proportion of each hospital's share of the fund for unrecovered trauma center readiness costs is determined after considering:
  - 1. The professional, clinical, administrative, and overhead costs directly associated with providing level I trauma care, and
  - 2. The volume and acuity of trauma care provided by each hospital.
- C. On or after July 31 of each year, the Administration shall distribute monies to level I trauma centers using monies, under R9-22-2101(B), available in the trauma and emergency services fund at the time of payment according to the proportions calculated and used for the January payments in the same year, under subsection (B) of this Section.

**Historical Note**

## TITLE 9. HEALTH SERVICES

## CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3).

**R9-22-2103. Distribution of Trauma and Emergency Services Fund: Emergency Services**

On or after June 30 of each year, the Administration shall distribute monies available in the trauma and emergency services fund at the time of payment as follows:

1. As allocated under R9-22-2101(C),
2. To hospitals that had an emergency department from July 1 through June 30 of the prior year, and
3. On a pro rata share of each hospital's cost of uncompensated emergency care as a percentage of the total statewide cost of uncompensated emergency care provided by hospitals under subsection (2) as reported in the uniform accounting reports to the Arizona Department of Health Services under A.R.S. § 36-125.04.

**Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 4001, effective October 19, 2003 (Supp. 03-3). Amended by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).

**R9-22-2104. Additional Trauma and Emergency Services Payments under the Section 1115 Waiver**

- A. Notwithstanding R9-22-2101(D), for the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the balance of the Trauma and Emergency Services fund in the following manner:
1. Ninety percent of the amount shall be distributed to Level I trauma centers based upon each center's pro rata share of each center's acuity-adjusted volume as a percentage of the total acuity-adjusted volume for all centers in the state. The acuity-adjusted volume is calculated by multiplying the Injury Severity Score employed by trauma.org by the number of trauma cases at that level treated at the center during the reporting year. Hospitals shall report trauma scores and case volume on a worksheet prescribed by the Administration.
  2. Ten percent of the amount shall be distributed proportionately to hospitals that had an emergency department from July 1 through June 30 of the reporting year based the pro rata share of each hospital's cost of emergency care as a percentage of the total statewide cost of emergency care provided by hospitals as reported on the Worksheet B,

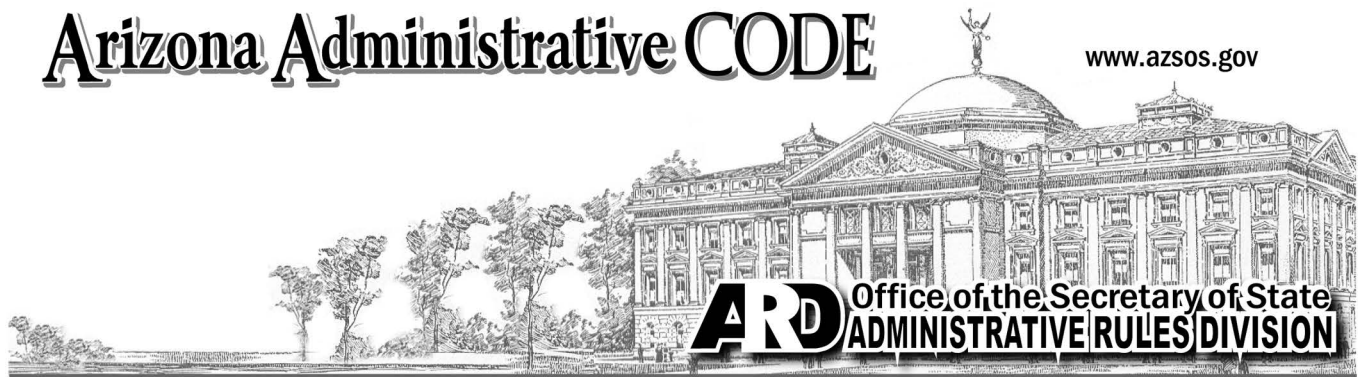
column 27, line 61 of the hospital's most current Medicare Cost Report as of January 31 following the end of each reporting year.

- B. For the reporting years ending June 30, 2011 and June 30, 2012, the Administration shall distribute an amount equal to the federal financial participation made available under the section 1115 waiver for the purpose of making payments for unrecovered trauma and emergency services as follows:
1. Thirty percent of such funds to a Level I trauma center, in amounts calculated in the same manner as described in subsection (A)(1) of this Section, for any unrecovered trauma center readiness costs not reimbursed under subsection (A) of this Section;
  2. Thirty percent of such funds to a hospital having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsection (A) of this Section; and
  3. Forty percent of such funds to rural hospitals, as defined in R9-22-718 that are not Level 1 trauma centers as defined in R9-22-2101(F), having an emergency department from July 1 through June 30 of the reporting year, in amounts calculated in the same manner as described in subsection (A)(2) of this Section, for any unrecovered emergency services costs not reimbursed under subsections (A) and (B)(2) of this Section.
- C. For the reporting years ending June 30, 2011 and June 30, 2012, payments made under this Article shall not be made in an amount that results in aggregate payments to the hospital by the Administration and contractors exceeding of the upper payment limit for the hospital services as calculated in accordance with 42 CFR 447.
- D. For the reporting years ending June 30, 2011 and June 30, 2012, to ensure compliance with subsection (C), payments under this Article shall be reconciled to the federal fiscal year that is two years subsequent to the payment.
- E. Any payments that are determined under subsection (D) to exceed the limit in subsection (C) shall be distributed as described in this Article to hospitals that have not received payments in excess of the limit in subsection (C).

**Historical Note**

New Section made by exempt rulemaking at 18 A.A.R. 1748, effective July 1, 2012 (Supp. 12-2).





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Supp. 24-4

## TITLE 9. HEALTH SERVICES

### CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

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Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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#### Questions about these rules? Contact:

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**The release of this Chapter in Supp. 24-4 replaces Supp. 24-3, 1-112 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

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### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 9. HEALTH SERVICES

## CHAPTER 25. DEPARTMENT OF HEALTH SERVICES - EMERGENCY MEDICAL SERVICES

Authority: A.R.S. §§ 36-136(F) and 36-2209(A) et seq.

## Supp. 24-4

*Editor's Note: Article 5 consisting of Sections R9-25-501 through R9-25-508 were recodified from Sections in Article 8 effective September 21, 2004 (Supp. 04-3). The Sections recodified from Article 8 were originally made or amended under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6).*

*Editor's Note: The Office of the Secretary of State publishes all Chapters on white paper.*

*Editor's Note: This Chapter contains rules which were adopted, amended, and repealed under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 36-2205(C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper.*

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**ARTICLE 4. EMCT CERTIFICATION**

*Article 4 repealed; new Article 4 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).*

*Article 4, consisting of Sections R9-25-401 through R9-25-411 and Exhibits I through K, adopted effective October 15, 1996 (Supp. 96-4).*

Section	
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R9-25-407.	Notification Requirements (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1) and (6), and 36-2211)
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R9-25-409.	Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H), 36-2204(1), (6), and (7), and 36-2211)

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*Article 5, consisting of R9-25-501 through R9-25-508, recodified from Article 8 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).*

*Article 5 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).*

*Article 5, consisting of Sections R9-25-501 through R9-25-515 and Exhibit P, adopted effective October 15, 1996 (Supp. 96-4).*

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Table 5.4.	Repealed
R9-25-503.	Testing of Medical Treatments, Procedures, Medications, and Techniques that May Be Administered or Performed by an EMCT
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R9-25-515.	Repealed

**ARTICLE 6. STROKE CARE**

*Article 6, consisting of new Sections R9-25-601 and R9-25-602 made by exempt rulemaking effective April 5, 2013 (Supp. 13-1).*

*Article 6 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).*

*Article 6, consisting of Sections R9-25-601 through R9-25-616 and Exhibits L through O and Q through S, adopted effective October 15, 1996 (Supp. 96-4).*

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*Article 8, consisting of R9-25-801 through R9-25-808, recodified to Article 5 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).*

*Article 8, consisting of R9-25-801, R9-25-802, Exhibits 1 through 4, and R9-25-803 Exhibit 1, recodified from A.A.C. R9-13-1501, R9-13-1502, Exhibits 1 through 4, and R9-13-1503 Exhibit 1; originally filed under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 98-1).*

*Article 8, consisting of Section R9-25-805 and Exhibits 1 through 3, adopted effective May 19, 1997, under an exemption from the provisions of A.R.S. Title 41, Chapter 6; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2).*

Section	
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R9-25-807.	Renumbered
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R9-25-808.	Recodified

**ARTICLE 9. GROUND AMBULANCE CERTIFICATE OF NECESSITY**

*Article 9, consisting of Sections R9-25-901 through R9-25-*

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Editor's Note: Article 11 introductory paragraph from Supp. 01-1 was inadvertently removed in Supp. 23-1. The Article introductory paragraph has been reinstated (Supp. 23-2).

Article 11, consisting of Sections R9-25-1101 through R9-25-1110, adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

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*Article 14, consisting of Sections R9-25-1401 through R9-25-1406 and Table 1, made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4).*

Section	
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## ARTICLE 1. GENERAL

**R9-25-101. Definitions (Authorized by A.R.S. §§ 36-2201, 36-2202, 36-2204, and 36-2205)**

In addition to the definitions in A.R.S. § 36-2201, the following definitions apply in this Chapter, unless otherwise specified:

1. "Administer" or "administration" means to directly apply or the direct application of an agent to the body of a patient by injection, inhalation, ingestion, or any other means and includes adjusting the administration rate of an agent.
2. "AEMT" has the same meaning as "advanced emergency medical technician" in A.R.S. § 36-2201.
3. "Agent" means a chemical or biological substance that is administered to a patient to treat or prevent a medical condition.
4. "ALS" has the same meaning as "advanced life support" in A.R.S. § 36-2201.
5. "ALS base hospital" has the same meaning as "advanced life support base hospital" in A.R.S. § 36-2201.
6. "Applicant" means a person requesting certification, licensure, approval, or designation from the Department under this Chapter.
7. "BLS" has the same meaning as "basic life support" in A.R.S. § 36-2201.
8. "Chain of custody" means the transfer of physical control of and accountability for an item from one individual to another individual, documented to indicate the:
  - a. Date and time of the transfer,
  - b. Integrity of the item transferred, and
  - c. Signatures of the individual relinquishing and the individual accepting physical control of and accountability for the item.
9. "Chief administrative officer" means:
  - a. For a hospital, the same as in A.A.C. R9-10-101; and
  - b. For a training program, an individual assigned to act on behalf of the training program by the body organized to govern and manage the training program.
10. "Clinical training" means experience and instruction in providing direct patient care in a health care institution.
11. "Controlled substance" has the same meaning as in A.R.S. § 32-1901.
12. "Course" means didactic instruction and, if applicable, hands-on practical skills training, clinical training, or field training provided by a training program to prepare an individual to become or remain EMR or an EMCT.
13. "Course session" means an offering of a course, during a period of time designated by a training program certificate holder, for a specific group of students.
14. "Current" means up-to-date and extending to the present time.
15. "Day" means a calendar day.
16. "Document" or "documentation" means signed and dated information in written, photographic, electronic, or other permanent form.
17. "Drug" has the same meaning as in A.R.S. § 32-1901.
18. "Electronic signature" has the same meaning as in A.R.S. § 44-7002.
19. "EMCT" has the same meaning as "emergency medical care technician" in A.R.S. § 36-2201.
20. "EMR" has the same meaning as "emergency medical responder" in A.R.S. § 36-2201.
21. "EMT" has the same meaning as "emergency medical technician" in A.R.S. § 36-2201.
22. "EMT-I(99)" means an individual, other than a Paramedic, who:
  - a. Was certified as an EMCT by the Department before January 28, 2013 to perform ALS, and
  - b. Has continuously maintained the certification.
23. "EMS" has the same meaning as "emergency medical services" subsections (18)(a) through (d) in A.R.S. § 36-2201.
24. "Field training" means emergency medical services experience and training outside of a health care institution or a training program facility.
25. "General hospital" has the same meaning as in A.A.C. R9-10-101.
26. "Health care institution" has the same meaning as in A.R.S. § 36-401.
27. "Hospital" has the same meaning as in A.A.C. R9-10-101.
28. "In use" means in the immediate physical possession of an EMCT and readily accessible for potential imminent administration to a patient.
29. "Infusion pump" means a device approved by the U.S. Food and Drug Administration that, when operated mechanically, electrically, or osmotically, releases a measured amount of an agent into a patient's circulatory system in a specific period of time.
30. "Interfacility transport" means an ambulance transport of a patient from one health care institution to another health care institution.
31. "IV" means intravenous.
32. "Locked" means secured with a key, including a magnetic, electronic, or remote key, or combination so that opening is not possible except by using the key or entering the combination.
33. "Medical direction" means administrative medical direction or on-line medical direction.
34. "Medical record" has the same meaning as in A.R.S. § 36-2201.
35. "Minor" means an individual younger than 18 years of age who is not emancipated.
36. "Monitor" means to observe the administration rate of an agent and the patient's response to the agent and may include discontinuing administration of the agent.
37. "On-line medical direction" means emergency medical services guidance or information provided to an EMCT by a physician through two-way voice communication.
38. "Patient" means an individual who is sick, injured, or wounded and who requires medical monitoring, medical treatment, or transport.
39. "Pediatric" means pertaining to a child.
40. "Person" has the same meaning as in A.R.S. § 1-215 and includes governmental agencies.
41. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
42. "Practical nurse" has the same meaning as in A.R.S. § 32-1601.
43. "Practicing emergency medicine" means acting as an emergency medicine physician in a hospital emergency department.
44. "Prehospital incident history report" has the same meaning as in A.R.S. § 36-2220.
45. "Refresher challenge examination" means a test given to an individual to assess the individual's knowledge, skills, and competencies compared with the national education



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standards established for the applicable EMCT classification level.

46. "Refresher course" means a course intended to reinforce and update the knowledge, skills, and competencies of an individual who has previously met the national educational standards for a specific level of EMS personnel.
47. "Registered nurse" has the same meaning as in A.R.S. § 32-1601.
48. "Registered nurse practitioner" has the same meaning as in A.R.S. § 32-1601.
49. "Scene" means the location of the patient to be transported or the closest point to the patient at which an ambulance can arrive.
50. "Special hospital" has the same meaning as in A.A.C. R9-10-101.
51. "STR skill" means "Specialty Training Requirement skill," a medical treatment, procedure, or technique or administration of a medication for which an EMCT needs specific training beyond the training required in 9 A.A.C. 25, Article 4 in order to perform or administer.
52. "Transfer of care" means to relinquish to the control of another person the ongoing medical treatment of a patient.
53. "Transport agent" means an agent that an EMCT at a specified level of certification is authorized to administer only during interfacility transport of a patient for whom the agent's administration was started at the sending health care institution.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-102. Individuals to Act for a Person Regulated Under This Chapter (Authorized by A.R.S. § 36-2202)**

When a person regulated under this Chapter is required by this Chapter to provide information on or sign an application form or other document, the following individual shall satisfy the requirement on behalf of the person regulated under this Chapter:

1. If the person regulated under this Chapter is an individual, the individual; or
2. If the person regulated under this Chapter is a business organization, political subdivision, government agency, or tribal government, the individual who the business organization, political subdivision, government agency, or tribal government has designated to act on behalf of the business organization, political subdivision, government agency, or tribal government and who:
  - a. Is a U.S. citizen or legal resident, and
  - b. Has an Arizona address.

**Historical Note**

New Section made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**ARTICLE 2. MEDICAL DIRECTION; ALS BASE HOSPITAL CERTIFICATION****R9-25-201. Administrative Medical Direction (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), 36-2204(5), (6), and (7), 36-2204.01, and 36-2205(A) and (D))**

A. An emergency medical services provider or ambulance service shall:

1. Except as specified in subsection (B) or (C), designate a physician as administrative medical director who meets one of the following:
  - a. Has emergency medicine certification issued by a member board of the American Board of Medical Specialties;
  - b. Has emergency medical services certification issued by the American Board of Emergency Medicine;
  - c. Has emergency medicine certification issued by the American Osteopathic Board of Emergency Medicine;
  - d. Has emergency medicine certification issued by the American Board of Physician Specialties;
  - e. Has completed an emergency medicine residency training program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association; or
  - f. Is an emergency medicine physician in an emergency department located in Arizona and has current certification in:
    - i. Advanced emergency cardiac life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association;
    - ii. Advanced emergency trauma life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American College of Surgeons; and
    - iii. Pediatric advanced emergency life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association;
2. If the emergency medical services provider or ambulance service designates a physician as administrative medical director according to subsection (A)(1), notify the Department in writing:
  - a. Of the identity and qualifications of the designated physician within 10 days after designating the physician as administrative medical director; and
  - b. Within 10 days after learning that a physician designated as administrative medical director is no longer qualified to be an administrative medical director; and
3. Maintain for Department review:
  - a. A copy of the policies, procedures, protocols, and documentation required in subsection (E); and
  - b. Either:
    - i. The name, email address, telephone number, and qualifications of the physician providing administrative medical direction on behalf of the emergency medical services provider or ambulance service; or
    - ii. If the emergency medical services provider or ambulance service provides administrative medical direction through an ALS base hospital or a centralized medical direction communica-

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- tions center, a copy of a written agreement with the ALS base hospital or centralized medical direction communications center documenting that the administrative medical director is qualified under subsection (A)(1).
- B.** Except as provided in R9-25-502(A)(3), if an emergency medical services provider or ambulance service provides only BLS, the emergency medical services provider or ambulance service is not required to have an administrative medical director.
- C.** If an emergency medical services provider or ambulance service provides administrative medical direction through an ALS base hospital or a centralized medical direction communications center, the emergency medical services provider or ambulance service shall ensure that the ALS base hospital or centralized medical direction communications center designates a physician as administrative medical director who meets one of the requirements in subsections (A)(1)(a) through (f).
- D.** An emergency medical services provider or ambulance service may provide administrative medical direction through an ALS base hospital certified according to R9-25-203(C), if the emergency medical services provider or ambulance service:
1. Uses the ALS base hospital for administrative medical direction only for patients who are children, and
  2. Has a written agreement for the provision of administrative medical direction with an ALS base hospital that meets the requirements in R9-25-203(B)(1) or a centralized medical direction communications center.
- E.** An emergency medical services provider or an ambulance service shall ensure that:
1. An EMCT receives administrative medical direction as required by A.R.S. Title 36, Chapter 21.1 and this Chapter;
  2. Protocols are established, documented, and implemented by an administrative medical director, consistent with A.R.S. Title 36, Chapter 21.1 and this Chapter, that include:
    - a. A communication protocol for:
      - i. How and from what sources an EMCT requests and receives on-line medical direction,
      - ii. When and how an EMCT notifies a health care institution of the EMCT's intent to transport a patient to the health care institution, and
      - iii. What procedures an EMCT follows in the event of a communications equipment failure;
    - b. A triage protocol for:
      - i. How an EMCT assesses and prioritizes the medical condition of a patient,
      - ii. How an EMCT selects a health care institution to which a patient may be transported,
      - iii. How a patient is transported to the health care institution, and
      - iv. When on-line medical direction is required;
    - c. A treatment protocol for:
      - i. How an EMCT performs a medical treatment on a patient or administers an agent to a patient, and
      - ii. When on-line medical direction is required while an EMCT is providing treatment; and
    - d. A protocol for the transfer of information to the emergency receiving facility for:
      - i. What information is required to be communicated to emergency receiving facility staff concurrent with the transfer of care and by what method, including the condition of the patient, the treatment provided to the patient, and the patient's response to the treatment;
  - ii. What information is required to be documented on a prehospital incident history report; and
  - iii. The time-frame, which is associated with the transfer of care, for completion and submission of a prehospital incident history report;
- 3.** Policies and procedures are established, documented, and implemented by an administrative medical director, consistent with A.R.S. Title 36, Chapter 21.1 and this Chapter, that:
- a. Are consistent with an EMR's or EMCT's scope of practice, as specified in Table 5.1;
  - b. Cover for an EMCT:
    - i. Medical recordkeeping;
    - ii. Medical reporting, including to whom and by what method medical reporting is accomplished;
    - iii. Completion and submission of prehospital incident history reports;
    - iv. Obtaining, storing, transferring, and disposing of agents to which an EMCT has access including methods to:
      - (1) Identify individuals authorized by the administrative medical director to have access to agents,
      - (2) Maintain chain of custody for controlled substances, and
      - (3) Minimize potential degradation of agents due to temperature extremes;
    - v. Administration, monitoring, or assisting in patient self-administration of an agent;
    - vi. Monitoring and evaluating an EMCT's compliance with treatment protocols, triage protocols, and communications protocols specified in subsection (E)(2);
    - vii. Monitoring and evaluating an EMCT's compliance with medical recordkeeping, medical reporting, and prehospital incident history report requirements;
    - viii. Monitoring and evaluating an EMCT's compliance with policies and procedures for agents to which the EMCT has access;
    - ix. Monitoring and evaluating an EMCT's competency in performing skills authorized for the EMCT by the EMCT's administrative medical director and within the EMCT's scope of practice, as specified in Table 5.1;
    - x. Ongoing education, training, or remediation necessary to maintain or enhance an EMCT's competency in performing skills within the EMCT's scope of practice, as specified in Table 5.1;
    - xi. The process by which administrative medical direction is withdrawn from an EMCT; and
    - xii. The process for reinstating an EMCT's administrative medical direction;
  - c. Cover for an EMR:
    - i. If applicable, the process and criteria for the administrative medical director to approve an individual to function as an EMR for the emergency medical services provider, according to A.R.S. § 36-2201(16), including:

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- (1) Verifying that the individual has documentation of hands-on training in cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations;
      - (2) Ensuring that the individual has competency in using an automated external defibrillator;
      - (3) Ensuring that the individual has competency in using noninvasive diagnostic devices; and
      - (4) Ensuring that the individual has competency in obtaining a patient's blood pressure, pulse, and respiratory rate,
    - ii. Monitoring and evaluating an EMR's competency in performing skills authorized for the EMR by the EMR's administrative medical director and within the EMR's scope of practice, as specified in Table 5.1;
    - iii. Ongoing education, training, or remediation necessary to maintain or enhance an EMR's competency in performing skills within the EMR's scope of practice, as specified in Table 5.1;
    - iv. If applicable, the process by which the administrative medical director may withdraw approval of the individual to function as an EMR; and
    - v. If applicable, the process for reinstating the administrative medical director's approval of the individual to function as an EMR; and
  - d. Include a quality assurance process to evaluate the effectiveness of the administrative medical direction provided to EMCTs;
4. Protocols in subsection (E)(2) and policies and procedures in subsection (E)(3) are reviewed annually by the administrative medical director and updated as necessary;
5. Requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter are reviewed annually by the administrative medical director;
6. The Department is notified in writing no later than ten days after the date:
  - a. Administrative medical direction is withdrawn from an EMCT; or
  - b. An EMCT's administrative medical direction is reinstated; and
7. If the emergency medical services provider's administrative medical director had approved an individual to function as an EMR for the emergency medical services provider, according to A.R.S. § 36-2201(16) and subsection (E)(3)(c)(i), the Department is notified no later than ten days after the date the administrative medical director:
  - a. Withdraws approval of the individual to function as an EMR, or
  - b. Reinstates approval of the individual to function as an EMR.
- F.** An administrative medical director for an emergency medical services provider or ambulance service shall ensure that:
1. An EMCT for whom the administrative medical director provides administrative medical direction:
    - a. Has access to at least the minimum supply of agents required for the highest level of service to be provided by the EMCT, consistent with requirements in Article 5 of this Chapter;
    - b. Administers, monitors, or assists in patient self-administration of an agent according to the requirements in policies and procedures; and
    - c. Has access to a copy of the policies and procedures required in subsection (F)(2) while on duty for the emergency medical services provider or ambulance service;
  2. Policies and procedures for agents to which an EMCT has access:
    - a. Specify that an agent is obtained only from a person:
      - i. Authorized by law to prescribe the agent, or
      - ii. Licensed under A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; and 4 A.A.C. 23 to dispense or distribute the agent;
    - b. Cover chain of custody and transfer procedures for each supply of agents, requiring an EMCT for whom the administrative medical director provides administrative medical direction to:
      - i. Document the name and the EMCT certification number or employee identification number of each individual who takes physical control of the supply of agents;
      - ii. Document the time and date that each individual takes physical control of the supply of agents;
      - iii. Inspect the supply of agents for expired agents, deteriorated agents, damaged or altered agent containers or labels, and depleted, visibly adulterated, or missing agents upon taking physical control of the supply of agents;
      - iv. Document any of the conditions in subsection (F)(2)(b)(iii);
      - v. Notify the administrative medical director of a depleted, visibly adulterated, or missing controlled substance;
      - vi. Obtain a replacement for each affected agent in subsection (F)(2)(b)(iii) for which the minimum supply is not present; and
      - vii. Record each administration of an agent on a prehospital incident history report;
    - c. Cover mechanisms for controlling inventory of agents and preventing diversion of controlled substances; and
    - d. Include that an agent is kept inaccessible to all individuals who are not authorized access to the agent by policies and procedures required under subsection (E)(3)(b)(iv)(1) and, when not being administered, is:
      - i. Secured in a dry, clean, washable receptacle;
      - ii. While on a motor vehicle or aircraft registered to the emergency medical services provider or ambulance service, secured in a manner that restricts movement of the agent and the receptacle specified in subsection (F)(2)(d)(i); and
      - iii. If a controlled substance, in a hard-shelled container that is difficult to breach without the use of a power cutting tool and:
        - (1) Locked inside a motor vehicle or aircraft registered to the emergency medical services provider or ambulance service,
        - (2) Otherwise locked and secured in such a manner as to deter misappropriation, or
        - (3) On the person of an EMCT authorized access to the agent;

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3. The Department is notified in writing within 10 days after the administrative medical director receives notice, as required subsection (F)(2)(b)(v), that any quantity of a controlled substance is depleted, visibly adulterated, or missing; and
  4. Except when the emergency medical services provider or ambulance service obtains all agents from an ALS base hospital pharmacy, which retains ownership of the agents, agents to which an EMCT has access are obtained, stored, transferred, and disposed of according to policies and procedures; A.R.S. Title 36, Chapter 27; A.R.S. Title 32, Chapter 18; 4 A.A.C. 23; and requirements of the U.S. Drug Enforcement Administration.
- G.** An administrative medical director may delegate responsibilities to an individual as necessary to fulfill the requirements in this Section, if the individual is:
1. Another physician,
  2. A physician assistant,
  3. A registered nurse practitioner,
  4. A registered nurse,
  5. A Paramedic, or
  6. An EMT-I(99).
- Historical Note**
- Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-201 renumbered to R9-25-207; new R9-25-201 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section R9-25-201 renumbered from R9-25-202 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).
- R9-25-202. On-line Medical Direction (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), 36-2204(5), (6), and (7), 36-2204.01, and 36-2205(A) and (D))**
- A.** In this Section, “physician” means an individual licensed:
1. According to A.R.S. Title 32, Chapter 13 or 17; or
  2. When working in a health care institution operating under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation, by a similar licensing board in another state.
- B.** An emergency medical services provider or ambulance service shall:
1. Except as provided in R9-25-203(C)(3), ensure that a physician provides on-line medical direction to EMCTs on behalf of the emergency medical services provider or ambulance service only if the physician meets one of the following:
    - a. Has emergency medicine certification issued by a member board of the American Board of Medical Specialties;
    - b. Has emergency medical services certification issued by the American Board of Emergency Medicine;
    - c. Has emergency medicine certification issued by the American Osteopathic Board of Emergency Medicine;
    - d. Has emergency medicine certification issued by the American Board of Physician Specialties;
    - e. Has completed an emergency medicine residency training program accredited by the Accreditation Council for Graduate Medical Education or
- approved by the American Osteopathic Association; or
- f. Is an emergency medicine physician in an emergency department located in Arizona and has current certification that meets the requirements in R9-25-201(A)(1)(f)(i) through (iii);
2. For each physician providing on-line medical direction on behalf of the emergency medical services provider or ambulance service, maintain for Department review either:
    - a. The name, email address, telephone number, and qualifications of the physician providing on-line medical direction on behalf of the emergency medical services provider or ambulance service; or
    - b. If the emergency medical services provider or ambulance service provides on-line medical direction through an ALS base hospital or a centralized medical direction communications center, a copy of a written agreement with the ALS base hospital or centralized medical direction communications center documenting that the physician providing on-line medical direction is qualified under subsection (B)(1);
  3. Ensure that the on-line medical direction provided to an EMCT on behalf of the emergency medical services provider or ambulance service is consistent with:
    - a. The EMCT’s scope of practice, as specified in Table 5.1; and
    - b. Communication protocols, triage protocols, treatment protocols, and protocols for prehospital incident history reports, specified in R9-25-201(E)(2); and
  4. Ensures that a physician providing on-line medical direction on behalf of the emergency medical services provider or ambulance service relays on-line medical direction only through one of the following individuals, under the supervision of the physician and consistent with the individual’s scope of practice:
    - a. Another physician,
    - b. A physician assistant,
    - c. A registered nurse practitioner,
    - d. A registered nurse,
    - e. A Paramedic, or
    - f. An EMT-I(99).
- C.** An emergency medical services provider or ambulance service may provide on-line medical direction through an ALS base hospital certified according to R9-25-203(C), if the emergency medical services provider or ambulance service:
1. Uses the ALS base hospital for on-line medical direction only for patients who are children, and
  2. Has an additional written agreement for the provision of on-line medical direction with an ALS base hospital that meets the requirements in R9-25-203(B)(1) or a centralized medical direction communications center.
- D.** An emergency medical services provider or ambulance service shall ensure that the emergency medical services provider or ambulance service, or an ALS base hospital or a centralized medical direction communications center providing on-line medical direction on behalf of the emergency medical services provider or ambulance service, has:
1. Operational and accessible communication equipment that will allow on-line medical direction to be given to an EMCT;

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2. A written plan for alternative communications with an EMCT in the event of a disaster, communication equipment breakdown or repair, power outage, or malfunction; and
3. A physician qualified under subsection (B)(1) available to give on-line medical direction to an EMCT 24 hours a day, seven days a week.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-202 renumbered to R9-25-208; new R9-25-202 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-202 renumbered to Section R9-25-201; new Section R9-25-202 renumbered from R9-25-203 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

**Exhibit A. Repealed****Historical Note**

Exhibit A adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-203. ALS Base Hospital General Requirements (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(5), (6), and (7))**

- A. A person shall not operate as an ALS base hospital without certification from the Department.
- B. The Department shall certify an ALS base hospital if the applicant:
  1. Is:
    - a. Licensed as a general hospital under 9 A.A.C. 10, Article 2; or
    - b. A facility operated as a hospital in this state by the United States federal government or by a sovereign tribal nation;
  2. Maintains at least one current written agreement described in A.R.S. § 36-2201(4);
  3. Has not been decertified as an ALS base hospital by the Department within five years before submitting the application;
  4. Submits an application that is complete and compliant with the requirements in this Article; and
  5. Has not knowingly provided false information on or with an application required by this Article.
- C. The Department may certify as an ALS base hospital a special hospital, which is licensed under 9 A.A.C. 10, Article 2 and provides surgical services and emergency services only to children, if the applicant:
  1. Meets the requirements in subsection (B)(2) through (5);
  2. Provides administrative medical direction or on-line medical direction only for patients who are children; and
  3. Ensures that:
    - a. Administrative medical direction is provided by a physician who meets the requirements in R9-25-201(A)(1); and
    - b. On-line medical direction is provided by a physician who meets one of the following:
      - i. Meets the requirements in R9-25-202(B)(1),
      - ii. Has board certification in pediatric emergency medicine from either the American Board of Pediatrics or the American Board of Emergency Medicine, or

- iii. Is board eligible in pediatric emergency medicine.

- D. An ALS base hospital certificate is valid only for the name and address listed by the Department on the certificate.
- E. At least every 36 months after certification, the Department shall assess an ALS base hospital to determine ongoing compliance with the requirements of this Article.
- F. The Department may inspect an ALS base hospital according to A.R.S. § 41-1009:
  1. As part of the substantive review time-frame required in A.R.S. §§ 41-1072 through 41-1079; or
  2. As necessary to determine compliance with the requirements of this Article.
- G. If the Department determines that an ALS base hospital is not in compliance with the requirements in this Article, the Department may:
  1. Take an enforcement action as described in R9-25-207; or
  2. Require that an ALS base hospital submit to the Department, within 15 days after written notice from the Department, a corrective action plan to address issues of compliance that do not directly affect the health or safety of a patient that:
    - a. Describes how each identified instance of non-compliance will be corrected and reoccurrence prevented, and
    - b. Includes a date for correcting each instance of non-compliance that is appropriate to the actions necessary to correct the instance of non-compliance.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-203 renumbered to Section R9-25-202; new Section R9-25-203 renumbered from R9-25-207 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

**R9-25-204. Application Requirements for ALS Base Hospital Certification (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(5))**

- A. An applicant for ALS base hospital certification shall submit to the Department an application, including:
  1. The following information in a Department-provided format:
    - a. The applicant's name, address, and telephone number;
    - b. The name, email address, and telephone number of the applicant's chief administrative officer;
    - c. The name, email address, and telephone number of the applicant's chief administrative officer's designee if the chief administrative officer will not be the liaison between the ALS base hospital and the Department;
    - d. Whether the applicant is applying for certification of a:
      - i. General hospital licensed under 9 A.A.C. 10, Article 2;
      - ii. Special hospital licensed under 9 A.A.C. 10, Article 2, that provides surgical services and emergency services only to children; or
      - iii. Facility operating as a federal or tribal hospital;

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- e. The name of each emergency medical services provider or ambulance service for which the applicant has a proposed written agreement described in A.R.S. § 36-2201(4) to provide administrative medical direction or on-line medical direction;
  - f. The name, address, email address, and telephone number of each administrative medical director;
  - g. The name of each physician providing on-line medical direction;
  - h. Attestation that the applicant meets the requirements in R9-25-202(D);
  - i. Attestation that the applicant will comply with all requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter;
  - j. Attestation that all information required as part of the application has been submitted and is true and accurate; and
  - k. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature;
2. A copy of the applicant's current hospital license issued under 9 A.A.C. 10, Article 2, if applicable; and
  3. A copy of each executed written agreement described in A.R.S. § 36-2201(4), including all attachments and exhibits.
- B.** The Department shall approve or deny an application under this Section according to Article 12 of this Chapter.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-204 renumbered to R9-25-209; new R9-25-204 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section R9-25-204 repealed; new Section R9-25-204 renumbered from R9-25-208 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

**R9-25-205. Changes Affecting an ALS Base Hospital Certificate (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(5) and (6))**

- A.** No later than 30 days after the date of a change in the name listed on the ALS base hospital certificate, an ALS base hospital certificate holder shall notify the Department of the change, in a Department-provided format, including:
1. The current name of the ALS base hospital;
  2. The ALS base hospital's certificate number;
  3. The new name and the effective date of the name change;
  4. Documentation supporting the name change;
  5. Documentation of compliance with the requirements in A.A.C. R9-10-109(A), if applicable;
  6. Attestation that all information submitted to the Department is true and correct; and
  7. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- B.** No later than 48 hours after changing the information provided according to R9-25-204(A)(1)(e) by terminating, adding, or amending a written agreement required in R9-25-203(B)(2), an ALS base hospital certificate holder shall notify the Department of the change, including:

1. The following information in a Department-provided format:
    - a. The name of the ALS base hospital;
    - b. The ALS base hospital's certificate number; and
    - c. As applicable, the name of the emergency medical services provider or ambulance service for which the ALS base hospital:
      - i. Has a newly executed or amended written agreement described in A.R.S. § 36-2201(4), or
      - ii. Is no longer providing administrative medical direction or on-line medical direction under a written agreement described in A.R.S. § 36-2201(4); and
  2. If applicable, a copy of the newly executed or amended written agreement described in A.R.S. § 36-2201(4), including all attachments and exhibits.
- C.** No later than 10 days after the date of a change in an administrative medical director provided according to R9-25-204(A)(1)(f), an ALS base hospital certificate holder shall notify the Department of the change, in a Department-provided format, including:
1. The name of the ALS base hospital,
  2. The ALS base hospital's certificate number,
  3. The name of the new administrative medical director and the effective date of the change,
  4. Attestation that the new administrative medical director meets the requirements in R9-25-201(A)(1),
  5. Attestation that all information submitted to the Department is true and correct, and
  6. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- D.** No later than 30 days after the date of a change in the address listed on an ALS base hospital certificate or a change in ownership, as defined in A.A.C. R9-10-101, an ALS base hospital certificate holder shall submit to the Department an application required in R9-25-204(A).

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Section R9-25-205 repealed; new Section R9-25-205 renumbered from R9-25-209 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

**R9-25-206. ALS Base Hospital Authority and Responsibilities (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), 36-2204(5) and (6), 36-2208(A), and 36-2209(A)(2))**

- A.** An ALS base hospital certificate holder shall:
1. Have the capability of providing both administrative medical direction and on-line medical direction;
  2. Provide administrative medical direction and on-line medical direction to an EMCT according to:
    - a. A written agreement described in A.R.S. § 36-2201(4);
    - b. The requirements in R9-25-201 for administrative medical direction; and
    - c. The requirements in R9-25-202 for on-line medical direction;

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3. Ensure that personnel are available to provide administrative medical direction and on-line medical direction; and
  4. Establish, document, and implement policies and procedures, consistent with A.R.S. Title 36, Chapter 21.1 and this Chapter, that include a quality assurance process to evaluate the effectiveness of the on-line medical direction provided to EMCTs.
- B.** An ALS base hospital certificate holder shall notify in writing:
1. The Department no later than 24 hours after:
    - a. Ceasing to meet a requirement in R9-25-203(B)(1) or (2); or
    - b. For a special hospital, ceasing to be licensed under 9 A.A.C. 10, Article 2, as a special hospital or to meet the requirement in R9-25-203(B)(2); and
  2. Each emergency medical services provider or ambulance service with which the ALS base hospital has a current written agreement to provide administrative medical direction or on-line medical direction no later than seven days before ceasing to provide administrative medical direction or on-line medical direction or as specified in the written agreement, whichever is earlier.
- C.** An ALS base hospital may act as a training program without training program certification from the Department, if the ALS base hospital:
1. Is eligible for training program certification as provided in R9-25-301(C); and
  2. Complies with the requirements in R9-25-301(D), R9-25-302, R9-25-303(B), (C), and (F), and R9-25-304 through R9-25-306.
- D.** If an ALS base hospital's pharmacy provides all of the agents for an emergency medical services provider or ambulance service, and the ALS base hospital owns the agents provided, the ALS base hospital's certificate holder shall ensure that:
1. Except as stated in subsections (D)(2) and (3), the policies and procedures for agents to which an EMCT has access that are established by the administrative medical director for the emergency medical services provider or ambulance service comply with requirements in R9-25-201(F)(2);
  2. The emergency medical services provider or ambulance service requires an EMCT for the emergency medical services provider or ambulance service to notify the pharmacist in charge of the hospital pharmacy of a missing, visibly adulterated, or depleted controlled substance; and
  3. The pharmacist in charge of the hospital pharmacy notifies the Department, as specified in R9-25-201(F)(3), of a missing, visibly adulterated, or depleted controlled substance.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Amended effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Former R9-25-206 renumbered to R9-25-210; new R9-25-206 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-206 repealed; new Section R9-25-206 renumbered from R9-25-210 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019 (Supp. 19-2).

*The following Exhibit was repealed under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205(C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit this change to the Secretary of State's Office for publication in the Arizona Administrative Register as proposed rules; the Department did not submit the change to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on the repealing of this Exhibit (Supp. 98-4).*

**Exhibit B. Repealed****Historical Note**

Exhibit B adopted effective October 15, 1996 (Supp. 96-4). Repealed effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4).

**R9-25-207. ALS Base Hospital Enforcement Actions (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (A)(4), and 36-2204(7))**

- A.** Except as provided in subsection (C), the Department may take an action listed in subsection (B) against an ALS base hospital certificate holder who:
1. Does not meet the certification requirements:
    - a. In R9-25-203(B)(1) or (2); or
    - b. For a special hospital, in R9-25-203(B)(2) and being licensed under 9 A.A.C. 10, Article 2, as a special hospital;
  2. Violates the requirements in A.R.S. Title 36, Chapter 21.1 or 9 A.A.C. 25;
  3. Does not submit a corrective action plan, as provided in R9-25-203(G)(2), that is acceptable to the Department;
  4. Does not complete a corrective action plan submitted according to R9-25-203(G)(2); or
  5. Knowingly or negligently provides false documentation or information to the Department.
- B.** The Department may take the following action against an ALS base hospital certificate holder:
1. After notice is provided according to A.R.S. Title 41, Chapter 6, Article 10, issue a letter of censure,
  2. After notice is provided according to A.R.S. Title 41, Chapter 6, Article 10, issue an order of probation,
  3. After notice and an opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10, suspend the ALS base hospital certificate, or
  4. After notice and an opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10, decertify the ALS base hospital.
- C.** An ALS base hospital operated as a hospital in this state by the United States federal government or by a sovereign tribal nation is under federal or tribal government jurisdiction.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-207 repealed; new R9-25-207 renumbered from R9-25-201 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-207 renumbered to Section R9-25-203; new Section R9-25-207 renumbered from Section R9-25-211 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 25 A.A.R. 953, effective July 1, 2019

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(Supp. 19-2).

**R9-25-208. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-208 repealed; new R9-25-208 renumbered from R9-25-202 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-208 renumbered to Section R9-25-204 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-209. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-209 repealed; new R9-25-209 renumbered from R9-25-204 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-209 renumbered to Section R9-25-205 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-210. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-210 repealed; new R9-25-210 renumbered from R9-25-206 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section R9-25-210 renumbered to Section R9-25-206 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-211. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Former R9-25-211 repealed; new R9-25-211 renumbered from R9-25-213 and amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-211 renumbered to Section R9-25-207 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-212. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-213. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section renumbered to R9-25-211 by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**ARTICLE 3. TRAINING PROGRAMS****R9-25-301. Application for Certification (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))**

A. To apply for certification as a training program, an applicant shall submit an application to the Department, in a Department-provided format, including:

1. The applicant's name, address, and telephone number;
2. The name, telephone number, and email address of the applicant's chief administrative officer;

3. The name of each course the applicant plans to provide;
4. Attestation that the applicant has the equipment and facilities that meet the requirements established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references) for the courses specified in subsection (A)(3);
5. The name, telephone number, and email address of the training program medical director;
6. The name, telephone number, and email address of the training program director;
7. If the applicant is a business organization, an attestation that business organization is active and in good standing with the Arizona Corporation Commission;
8. If the applicant is an educational institution, an attestation that the educational institution is in good standing with the Arizona School Boards Association or the Arizona Board of Private Postsecondary Education;
9. Attestation that the applicant will comply with all requirements in A.R.S. Title 36, Chapter 21.1 and 9 A.A.C. 25;
10. Attestation that all information required as part of the application has been submitted and is true and accurate; and
11. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.

B. An applicant may submit to the Department a copy of an accreditation report if the applicant is currently accredited by a national accrediting organization.

C. The Department shall certify a training program if the applicant:

1. Has not operated a training program that has been decertified by the Department within five years before submitting the application,
2. Submits an application that is complete and compliant with requirements in this Article, and
3. Has not knowingly provided false information on or with an application required by this Article.

D. The Department:

1. Shall assess a training program at least once every 24 months after certification to determine ongoing compliance with the requirements of this Article; and
2. May inspect a training program according to A.R.S. § 41-1009:
  - a. As part of the substantive review time-frame required in A.R.S. §§ 41-1072 through 41-1079, or
  - b. As necessary to determine compliance with the requirements of this Article.

E. The Department shall approve or deny an application under this Article according to Article 12 of this Chapter.

F. A training program certificate is valid only for the name of the training program certificate holder and the courses listed by the Department on the certificate and may not be transferred to another person.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).



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Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-302. Administration (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (4), and 36-2204(1) and (3))**

**A.** A training program certificate holder shall ensure that a training program medical director:

1. Is a physician or exempt from physician licensing requirements under A.R.S. § 32-1421(A)(7) or 32-1821(3);
2. Meets one of the following:
  - a. Has emergency medicine certification issued by a member board of the American Board of Medical Specialties,
  - b. Has emergency medical services certification issued by the American Board of Emergency Medicine,
  - c. Has completed an emergency medicine residency training program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic Association, or
  - d. Is an emergency medicine physician in an emergency department located in Arizona and has current certification that meets the requirements in R9-25-201(A)(1)(f)(i) through (iii); and
3. Before the start date of a course session, reviews the course content outline and final examinations to ensure consistency with, as applicable:
  - a. The national educational standards for the applicable EMCT classification level; or
  - b. Either:
    - i. The national educational standards for an EMR, or
    - ii. The topics specified in A.R.S. § 36-2201(17).

**B.** A training program certificate holder shall ensure that a training program director:

1. Is one of the following:
  - a. A physician with at least two years of experience providing emergency medical services as a physician;
  - b. A doctor of allopathic medicine or osteopathic medicine licensed in another state or jurisdiction with at least two years of experience providing emergency medical services as a doctor of allopathic medicine or osteopathic medicine;
  - c. An individual who meets the definition of registered nurse in A.R.S. § 32-1601 with at least two years of experience providing emergency medical services as a registered nurse;
  - d. A physician assistant with at least two years of experience providing emergency medical services as a physician assistant; or
  - e. An EMCT with at least two years of experience at that classification of EMCT, only for courses to prepare an individual for certification or recertification at the same or lower classification level of EMCT;
2. Has completed 24 hours of training related to instructional methodology including:

- a. Organizing and preparing materials for didactic instruction, clinical training, field training, and skills practice;
  - b. Preparing and administering tests and practical examinations;
  - c. Using equipment and supplies;
  - d. Measuring student performance;
  - e. Evaluating student performance;
  - f. Providing corrective feedback; and
  - g. Evaluating course effectiveness;
  3. Supervises the day-to-day operation of the courses offered by the training program;
  4. Supervises and evaluates the lead instructor for a course session;
  5. Monitors the training provided by all preceptors providing clinical training or field training; and
  6. Does not participate as a student in a course session, take a refresher challenge examination, or receive a certificate of completion for a course given by the training program.
- C.** A training program certificate holder shall:
1. Maintain with an insurance company authorized to transact business in this state:
    - a. A minimum single claim professional liability insurance coverage of \$500,000, and
    - b. A minimum single claim general liability insurance coverage of \$500,000 for the operation of the training program; or
  2. Be self-insured for the amounts in subsection (C)(1).
- D.** A training program certificate holder shall ensure that policies and procedures are:
1. Established, documented, and implemented covering:
    - a. Student enrollment, including verification that a student has proficiency in reading at the 9th grade level and meets all course admission requirements;
    - b. Maintenance of student records and medical records, including compliance with all applicable state and federal laws governing confidentiality, privacy, and security; and
    - c. For each course offered:
      - i. Student attendance requirements, including leave, absences, make-up work, tardiness, and causes for suspending or expelling a student for unsatisfactory attendance;
      - ii. Grading criteria, including the minimum grade average considered satisfactory for continued enrollment and standards for suspending or expelling a student for unsatisfactory grades;
      - iii. Administration of final examinations; and
      - iv. Student conduct, including causes for suspending or expelling a student for unsatisfactory conduct;
  2. Reviewed annually and updated as necessary; and
  3. Maintained on the premises and provided to the Department at the Department's request.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 31 A.A.R. 332 (January

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24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-303. Changes Affecting a Training Program Certificate (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))**

- A. No later than 10 days after a change in the name, address, or email address of the training program certificate holder listed on a training program certificate, the training program certificate holder shall notify the Department of the change, in a Department-provided format, including:
1. The current name, address, and email address of the training program certificate holder;
  2. The certificate number for the training program;
  3. The new name, new address, or new email address and the date of the name, address, or email address change;
  4. If applicable, attestation that the training program certificate holder has insurance required in R9-25-302(C) that is valid for the new name or new address;
  5. Attestation that all information submitted to the Department is true and correct; and
  6. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- B. No later than 10 days after a change in the training program medical director or training program director, a training program certificate holder shall notify the Department, in a Department-provided format, including:
1. The name and address of the training program certificate holder;
  2. The certificate number for the training program;
  3. The name, telephone number, and email address of the new training program medical director or training program director and the date of the change; and
  4. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- C. A training program certificate holder that intends to add a course shall submit to the Department a request for approval, in a Department-provided format, including:
1. The name and address of the training program certificate holder;
  2. The certificate number for the training program;
  3. The name, telephone number, and email address of the applicant's chief administrative officer;
  4. The name of each course the training program certificate holder plans to add;
  5. Attestation that the training program certificate holder has the equipment and facilities that meet the requirements established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references) for the courses specified in subsection (C)(4);
  6. Attestation that all information required as part of the request is true and accurate; and
  7. The signature or electronic signature of the applicant's chief administrative officer or the chief administrative officer's designated representative and date of signature or electronic signature.
- D. For notification made under subsection (A) of a change in the name or address of a certificate holder, the Department shall issue an amended certificate to the training program certificate

holder that incorporates the new name or address but retains the date on the current certificate.

- E. The Department shall approve or deny a request for the addition of a course in subsection (C) according to Article 12 of this Chapter.
- F. A training program certificate holder shall not conduct a course until an amended certificate is issued by the Department.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4).

**R9-25-304. Course and Examination Requirements (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (4), and 36-2204(1), (2), and (3))**

- A. For each course provided, a training program director shall ensure that:
1. The required equipment and facilities established for the course are available for use;
  2. The following are prepared and provided to course applicants before the start date of a course session:
    - a. A description of requirements for admission, course content, course hours, course fees, and course completion, including whether the course prepares a student:
      - i. For a national certification organization examination for a specific EMCT classification level,
      - ii. For a statewide standardized certification test under the state certification process,
      - iii. For recertification at a specific EMCT classification level, or
      - iv. To function as an EMR;
    - b. A list of books, equipment, and supplies that a student is required to purchase for the course;
    - c. Notification of eligibility for the course as specified in R9-25-305(D), (F), (G)(1) and (2), (I)(1) and (2), or (K)(1) and (2), as applicable;
    - d. Notification of any specific requirements for a student to begin any component of the course, including, as applicable:
      - i. Prerequisite knowledge, skill, and abilities;
      - ii. Physical examinations;
      - iii. Immunizations;
      - iv. Documentation of freedom from infectious tuberculosis;
      - v. Drug screening; and
      - vi. The ability to perform certain physical activities; and
    - e. The policies for the course on student attendance, grading, student conduct, and administration of final examinations, required in R9-25-302(D)(1)(c)(i) through (iv);
  3. Information is provided to assist an EMCT student to:
    - a. Register for and take an applicable national certification organization examination;

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- b. Complete application forms for registration in a national certification organization; and
    - c. Complete application forms for certification under 9 A.A.C. 25, Article 4;
  - 4. A lead instructor is assigned to each course session who:
    - a. Is one of the following:
      - i. A physician with at least two years of experience providing emergency medical services;
      - ii. A doctor of allopathic medicine or osteopathic medicine licensed in another state or jurisdiction with at least two years of experience providing emergency medical services;
      - iii. An individual who meets the definition of registered nurse in A.R.S. § 32-1601 with at least two years of experience providing emergency medical services;
      - iv. A physician assistant with at least two years of experience providing emergency medical services; or
      - v. An EMCT with at least two years of experience at that classification of EMCT, only for courses to prepare an individual:
        - (1) For certification or recertification at the same or lower EMCT classification level, or
        - (2) To function as an EMR;
    - b. Has completed training related to instructional methodology specified in R9-25-302(B)(2);
    - c. Except as provided in subsection (A)(4)(d), is available for student-instructor interaction during all course hours established for the course session; and
    - d. Designates an individual who meets the requirements in subsections (A)(4)(a) and (b) to be available and act as the lead instructor when the lead instructor is not available; and
  - 5. Clinical training and field training are provided:
    - a. Under the supervision of a preceptor who has at least two years of experience providing emergency medical services and is one of the following:
      - i. An individual licensed in this or another state or jurisdiction as a doctor of allopathic medicine or osteopathic medicine;
      - ii. An individual licensed in this or another state or jurisdiction as a registered nurse;
      - iii. An individual licensed in this or another state or jurisdiction as a physician assistant; or
      - iv. An EMCT, only for courses to prepare an individual:
        - (1) For certification or recertification at the same or lower EMCT classification level, or
        - (2) To function as an EMR;
    - b. Consistent with the clinical training and field training requirements established for the course; and
    - c. If clinical training or field training is provided by a person other than the training program certificate holder, under a written agreement with the person providing the clinical training or field training that includes a termination clause that provides sufficient time for a student to complete the training upon termination of the written agreement.
- B.** A training program director may combine the students from more than one course session for didactic instruction.
- C.** For a final examination or refresher challenge examination for each course offered, a training program director shall ensure that:
- 1. The final examination or refresher challenge examination for the course is completed onsite at the training program or at a facility used for course instruction;
  - 2. Except as provided in subsection (D), the final examination or refresher challenge examination for a course includes a:
    - a. Written test:
      - i. With one absolutely correct answer, two incorrect answers, and one distractor, none of which is "all of the above" or "none of the above";
      - ii. With 150 multiple-choice questions for the:
        - (1) Final examination for a refresher course, or
        - (2) Refresher challenge examination for a course;
      - iii. That covers the learning objectives of the course with representation from all topics covered by the course; and
      - iv. That requires a passing score of 75% or higher in no more than three attempts for a final examination and no more than one attempt for a refresher challenge examination; and
    - b. Comprehensive practical skills, hands-on test:
      - i. For a course preparing an individual for EMCT certification:
        - (1) Evaluating the student's technical proficiency in skills consistent with the national education standards for the applicable EMCT classification level, and
        - (2) Reflecting the skills necessary to pass a national certification organization examination at the applicable EMCT classification level; or
      - ii. For a course preparing an individual to function as an EMR, evaluating the student's technical proficiency in skills consistent with the topics in A.R.S. § 36-2201(17);
  - 3. The identity of each student taking the final examination or refresher challenge examination is verified;
  - 4. A student does not receive verbal or written assistance from any other individual or use notes, books, or documents of any kind as an aid in taking the examination;
  - 5. A student who violates subsection (C)(4) is not permitted to complete the examination or to receive a certificate of completion for the course or refresher challenge examination; and
  - 6. An instructor who allows a student to violate subsection (C)(4) or assists a student in violating subsection (C)(4) is no longer permitted to serve as an instructor.
- D.** A training program director shall ensure that a standardized certification test for a student under the state certification process includes:
- 1. A written test that meets the requirements in subsection (C)(2)(a); and
  - 2. Either:
    - a. A comprehensive practical skills test that meets the requirements in subsection (C)(2)(b), or
    - b. An attestation of practical skills proficiency on a Department-provided form.
- E.** A training program director shall ensure that:

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1. A student is allowed no longer than six months after the date of the last day of classroom instruction for a course session to complete all course requirements,
  2. There is a maximum ratio of four students to one preceptor for the clinical training portion of a course, and
  3. There is a maximum ratio of one student to one preceptor for the field training portion of a course.
- F.** A training program director shall:
1. For a student who completes a course, issue a certificate of completion containing:
    - a. Identification of the training program,
    - b. Identification of the course completed,
    - c. The name of the student who completed the course,
    - d. The date the student completed all course requirements,
    - e. Attestation that the student has met all course requirements, and
    - f. The signature or electronic signature of the training program director and the date of signature or electronic signature; and
  2. For an individual who passes a refresher challenge examination, issue a certificate of completion containing:
    - a. Identification of the training program,
    - b. Identification of the refresher challenge examination administered,
    - c. The name of the individual who passed the refresher challenge examination,
    - d. The date or dates the individual took the refresher challenge examination,
    - e. Attestation that the individual has passed the refresher challenge examination, and
    - f. The signature or electronic signature of the training program director and the date of signature or electronic signature.
- Historical Note**
- Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).
- R9-25-305. Supplemental Requirements for Specific Courses (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(3) and (4), and 36-2204(1) and (3))**
- A.** For the purposes of this Section, "contact hour" means a 60-minute period during which a student is:
1. For didactic instruction, in a classroom situation and receiving instruction, with the lead instructor for the course, as specified in R9-25-304(A)(4), or a designee, according to R9-25-304(A)(4)(d);
  2. For practical skills training, in a classroom situation and receiving instruction, with the lead instructor for the course, as specified in R9-25-304(A)(4), or a designee, according to R9-25-304(A)(4)(d), present on-site; and
  3. For clinical training or field training, with the student's preceptor, according to R9-25-304(A)(5)(a), and receiving supervised, one-on-one interaction with a patient or, if necessary, simulated patient.
- B.** A training program certificate holder shall ensure that, for a course to prepare an individual to provide services as an EMR, the course:
1. Covers the knowledge, skills, and competencies established for an emergency medical responder program, as defined in A.R.S. § 36-2201(17);
  2. Has a minimum course length of 75 hours, including:
    - a. A minimum of 70 contact hours of didactic instruction and practical skills training, and
    - b. A minimum of five contact hours of clinical training and field training, with at least five patient or simulated patient interactions; and
  3. Has no more than 24 students enrolled in each session of the course.
- C.** A training program certificate holder shall ensure that a certification course offered by the training program:
1. Covers knowledge, skills, and competencies comparable to the national education standards established for a specific EMCT classification level;
  2. Prepares a student for:
    - a. A national certification organization examination for the specific EMCT classification level, or
    - b. A standardized certification test under the state certification process;
  3. Has no more than 24 students enrolled in each session of the course; and
  4. Has a minimum course length of:
    - a. For an EMT certification course, 130 hours, including:
      - i. A minimum of 120 contact hours of didactic instruction and practical skills training, and
      - ii. A minimum of 10 contact hours of clinical training and field training, with at least 10 patient or simulated patient interactions;
    - b. For an AEMT certification course, 244 hours, including:
      - i. A minimum of 100 contact hours of didactic instruction and practical skills training, and
      - ii. A minimum of 144 contact hours of clinical training and field training; and
    - c. For a Paramedic certification course, 1000 hours, including:
      - i. A minimum of 500 contact hours of didactic instruction and practical skills training, and
      - ii. A minimum of 500 contact hours of clinical training and field training.
- D.** A training program director shall ensure that, in addition to the requirements in subsection (C), for an AEMT certification course or a Paramedic certification course, a student has one of the following:
1. Current certification from the Department as an EMT or higher EMCT classification level,
  2. Documentation of completion of prior training in an EMT course or a course for a higher EMCT classification level provided by a training program certified by the Department or an equivalent training program, or
  3. Documentation of current registration in a national certification organization at the EMT classification level or higher EMCT classification level.
- E.** A training program director shall ensure that for a course to prepare an EMT-I(99) for Paramedic certification:
1. A student has current certification from the Department as an EMT-I(99);

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2. The course covers the knowledge, skills, and competencies established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references);
  3. The minimum course length is 600 hours, including:
    - a. A minimum of 220 contact hours of didactic instruction and practical skills training; and
    - b. A minimum of 380 contact hours of clinical training and field training; and
  4. A minimum of 60 contact hours of training in anatomy and physiology are completed by the student:
    - a. As a prerequisite to the course;
    - b. As preliminary instruction completed at the beginning of the course session before the didactic instruction required in subsection (E)(3)(a) begins; or
    - c. Through integration of the anatomy and physiology material with the units of instruction required in subsection (E)(3).
- F.** A training program director shall ensure that for a course to prepare a Paramedic for an additional endorsement to provide critical care services:
1. A student has:
    - a. Current certification from the Department as a Paramedic; and
    - b. Worked for at least two years as a Paramedic;
  2. The course:
    - a. Covers the knowledge, skills, and competencies established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references);
    - b. Prepares a student for a national certification organization examination in critical care paramedicine; and
    - c. Has no more than 24 students enrolled in each session of the course; and
  3. The minimum course length is 200 hours, including:
    - a. A minimum of 135 contact hours of didactic instruction and practical skills training in:
      - i. Critical care transport;
      - ii. Patient assessment and safety;
      - iii. Advanced pharmacology;
      - iv. Advanced hemodynamics;
      - v. Neurologic, obstetric, and medical emergencies;
      - vi. Mechanical ventilation and airway management;
      - vii. Flight physiology, safety, and transport;
      - viii. Interpretation of laboratory values; and
      - ix. Sepsis; and
    - b. A minimum of 40 contact hours of clinical training and 25 contact hours of field training, which may include the use of high-fidelity patient simulators, life-like manikins that mimic human body functions and provide physiologically accurate reactions to procedures.
- G.** A training program director shall ensure that for an EMT refresher course:
1. A student has one of the following:
    - a. Current certification from the Department as an EMT or higher EMCT classification level;
    - b. Documentation of completion of prior training in an EMT course or a course for a higher EMCT classification level provided by a training program certified by the Department or an equivalent training program;
  - c. Documentation of current registration in a national certification organization at the EMT classification level or higher EMCT classification level; or
  - d. Documentation from a national certification organization requiring the student to complete the EMT refresher course to be eligible to apply for registration in the national certification organization;
2. A student has documentation of current certification in adult, pediatric, and infant cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations for emergency cardiovascular care by EMCTs;
3. The EMT refresher course covers the knowledge, skills, and competencies in the national education standards established at the EMT classification level;
4. No more than 32 students are enrolled in each session of the course; and
5. The minimum course length is 24 contact hours.
- H.** A training program authorized to provide an EMT refresher course may administer a refresher challenge examination covering materials included in the EMT refresher course to an individual eligible for admission into the EMT refresher course.
- I.** Except as provided in subsection (K), a training program director shall ensure that for an ALS refresher course:
1. A student has one of the following:
    - a. Current certification from the Department as an AEMT, an EMT-I(99), or a Paramedic;
    - b. Documentation of completion of a prior training course, at the AEMT classification level or higher, provided by a training program certified by the Department or an equivalent training program;
    - c. Documentation of current registration in a national certification organization at the AEMT or Paramedic classification level; or
    - d. Documentation from a national certification organization requiring the student to complete the ALS refresher course to be eligible to apply for registration in the national certification organization;
  2. A student has documentation of current certification, completed before beginning the ALS refresher course, in:
    - a. Adult, pediatric, and infant cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations for emergency cardiovascular care by EMCTs; and
    - b. For a student who has current certification as an EMT-I(99) or higher level of EMCT classification, advanced emergency cardiac life support;
  3. The ALS refresher course covers:
    - a. For a student who has current certification as an AEMT or documentation of completion of prior training at an AEMT classification level, the knowledge, skills, and competencies in the national education standards established for an AEMT;
    - b. For a student who has current certification as an EMT-I(99), the knowledge, skills, and competencies established according to A.R.S. § 36-2204 for an EMT-I(99) and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references); and
    - c. For a student who has current certification as a Paramedic or documentation of completion of prior training at a Paramedic classification level, the

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knowledge, skills, and competencies in the national education standards established for a Paramedic;

4. No more than 32 students are enrolled in each session of the course; and
5. The minimum course length is 48 contact hours.
- J. A training program authorized to provide an ALS refresher course may administer a refresher challenge examination covering materials included in the ALS refresher course to an individual eligible for admission into the ALS refresher course.
- K. A training program director shall ensure that for a refresher course for a Paramedic with an additional endorsement to provide critical care services:
  1. A student has current certification from the Department as a Paramedic with an additional endorsement to provide critical care services;
  2. A student has documentation of current certification, completed before beginning the refresher course, in:
    - a. Adult, pediatric, and infant cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations for emergency cardiovascular care by EMCTs; and
    - b. Advanced emergency cardiac life support;
  3. The refresher course covers the knowledge, skills, and competencies established according to A.R.S. § 36-2204 for a Paramedic with an additional endorsement to provide critical care services and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references);
  4. No more than 32 students are enrolled in each session of the course; and
  5. The minimum course length is 60 contact hours and includes at least 8 contact hours on topics pertinent to providing critical care services.
- L. A training program authorized to provide a refresher course for a Paramedic with an additional endorsement to provide critical care services may administer a refresher challenge examination covering materials included in the refresher course to an individual eligible for admission into the refresher course.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**Exhibit F. Repealed****Historical Note**

Exhibit F adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R.

5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-306. Training Program Notification and Record-keeping (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))**

- A. At least 10 days before the start date of a course session, a training program certificate holder shall submit to the Department the following information in a Department-provided format:
  1. Identification of the training program;
  2. Identification of the course;
  3. The name of the training program medical director;
  4. The name of the training program director;
  5. The name of the course session's lead instructor;
  6. The course session start date and end date;
  7. The physical location at which didactic training and practical skills training will be provided;
  8. The days of the week and times of each day during which didactic training and practical skills training will be provided;
  9. The number of clock hours of didactic training and practical skills training;
  10. If applicable, the number of hours of clinical training and field training included in the course session;
  11. The date, start time, and location of the final examination for the course;
  12. Attestation that the lead instructor is qualified under R9-25-304(A)(4)(a); and
  13. The name and signature of the chief administrative officer or program director and the date signed.
- B. The Department shall review the information submitted according to subsection (A) and, within five days after receiving the information:
  1. Approve a course session, issue an identifying number to the course session, and notify the training program certificate holder of the approval and identifying number; or
  2. Disapprove a course session that does not comply with requirements in this Article and notify the training program certificate holder of the disapproval.
- C. A training program certificate holder shall ensure that:
  1. No later than 10 days after the date a student completes all course requirements, the training program director submits to the Department the following information in a Department-provided format:
    - a. Identification of the training program;
    - b. The name of the training program director;
    - c. Identification of the course and the start date and end date of the course session completed by the student;
    - d. The name, date of birth, and mailing address of the student who completed the course;
    - e. The date the student completed all course requirements;
    - f. The score the student received on the final examination;
    - g. Attestation that the student has met all course requirements;
    - h. Attestation that all information submitted is true and accurate; and
    - i. The signature of the training program director and the date signed; and
  2. No later than 10 days after the date an individual passes a refresher challenge examination administered by the training program, the training program director submits to the Department the following information in a Department-provided format;

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- a. Identification of the training program;
  - b. Identification of the:
    - i. Refresher challenge examination administered, and
    - ii. Course for which the refresher challenge examination substitutes;
  - c. The name of the training program medical director;
  - d. The name of the training program director;
  - e. The name, date of birth, and mailing address of the individual who passed the refresher challenge examination;
  - f. The date and location at which the refresher challenge examination was administered;
  - g. The score the individual received on the refresher challenge examination;
  - h. Attestation that the individual:
    - i. Met the requirements for taking the refresher challenge examination, and
    - ii. Passed the refresher challenge examination;
  - i. Attestation that all information submitted is true and accurate; and
  - j. The name and signature of the training program director and the date signed.
- D.** A training program certificate holder shall ensure that:
- 1. A record is established for each student enrolled in a course session, including:
    - a. The student's name and date of birth;
    - b. A copy of the student's enrollment agreement or contract;
    - c. Identification of the course in which the student is enrolled;
    - d. The start date and end date for the course session;
    - e. Documentation supporting the student's eligibility to enroll in the course;
    - f. Documentation that the student meets prerequisites for the course, established as specified in R9-25-304(A)(2)(d)(i);
    - g. The student's attendance records;
    - h. The student's clinical training records, if applicable;
    - i. The student's field training records, if applicable;
    - j. The student's grades;
    - k. Documentation of the final examination for the course, including:
      - i. A copy of each scored written test attempted or completed by the student, and
      - ii. All forms used as part of the comprehensive practical skills test attempted or completed by the student; and
    - l. A copy of the student's certificate of completion required in R9-25-304(F)(1);
  - 2. A student record required in subsection (D)(1) is maintained for at least three years after the end date of a student's course session and provided to the Department at the Department's request;
  - 3. A record is established for each individual to whom a refresher challenge examination is administered, including:
    - a. The individual's name and date of birth;
    - b. Identification of the refresher challenge examination administered to the individual;
    - c. Documentation supporting the individual's eligibility for a refresher challenge examination;
    - d. The date the refresher challenge examination was administered;
    - e. Documentation of the refresher challenge examination, including:
      - i. A copy of the scored written test attempted or completed by the individual, and
      - ii. All forms used as part of the comprehensive practical skills test attempted or completed by the individual; and
    - f. A copy of the individual's certificate of completion required in R9-25-304(F)(2); and
  - 4. A record required in subsection (D)(3) is maintained for at least three years after the date the refresher challenge examination was administered and provided to the Department at the Department's request.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 553, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). R9-25-306 repealed; new Section R9-25-306 renumbered from R9-25-316 and amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

**R9-25-307. Training Program Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))**

- A.** The Department may take an action listed in subsection (B) against a training program certificate holder who:
- 1. Violates the requirements in A.R.S. Title 36, Chapter 21.1 or 9 A.A.C. 25; or
  - 2. Knowingly or negligently provides false documentation or information to the Department.
- B.** The Department may take the following action against a training program certificate holder:
- 1. After notice is provided according to A.R.S. Title 41, Chapter 6, Article 10, issue:
    - a. A letter of censure, or
    - b. An order of probation; or
  - 2. After notice and opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10:
    - a. Suspend the training program certificate, or
    - b. Decertify the training program.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3). New Section R9-25-307 renumbered from R9-25-317 and amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective Decem-

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ber 1, 2013 (Supp. 13-4).

**Exhibit H. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-308. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-309. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 11 A.A.R. 553, effective March 5, 2005 (Supp. 05-1). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-310. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-311. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**Exhibit D. Repealed****Historical Note**

Exhibit D adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit C. Repealed****Historical Note**

Exhibit C adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R.

5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit E. Repealed****Historical Note**

Exhibit E adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-312. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-313. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-314. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-315. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-316. Renumbered****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). R9-25-316 renumbered to R9-25-306 by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-317. Renumbered****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). R9-25-317 renumbered to R9-25-307 by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**R9-25-318. Repealed****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section repealed; new Section made by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).



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tive January 28, 2013 (Supp. 13-1).

**Exhibit A. Repealed**

**Historical Note**

New Exhibit made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Exhibit A repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**Exhibit B. Expired**

**Historical Note**

New Exhibit made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Exhibit B expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

**Exhibit C. Repealed**

**Historical Note**

New Exhibit made by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 3014, effective October 6, 2007 (Supp. 07-3). Exhibit C repealed by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1).

**ARTICLE 4. EMCT CERTIFICATION**

*Article 4 repealed; new Article 4 made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).*

**R9-25-401. EMCT General Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H) and 36-2204(1), (6), and (7))**

- A.** In addition to the definitions in R9-25-101, the following definition applies in this Article: "Moral turpitude" has the same meaning as in A.R.S. § 1-215.
- B.** Except as provided in R9-25-404(G) and R9-25-405, an individual shall not act as an EMCT unless the individual has current certification or recertification from the Department.
- C.** An EMCT shall act as an EMCT only:
  1. As authorized under the EMCT's scope of practice as specified in Article 5 of this Chapter; and
  2. For an EMCT required to have medical direction according to A.R.S. Title 36, Chapter 21.1 and R9-25-502, as authorized by the EMCT's administrative medical director under:
    - a. Treatment protocols, triage protocols, and communication protocols approved by the EMCT's administrative medical director as specified in R9-25-201(E)(2); and
    - b. Medical recordkeeping, medical reporting, and pre-hospital incident history report requirements approved by the EMCT's administrative medical director as specified in R9-25-201(E)(3)(b).
- D.** Except as provided in A.R.S. § 36-2211, the Department shall certify or recertify an individual as an EMCT for a period of two years.
- E.** An individual whose EMCT certificate is expired shall not apply for recertification, except as provided in R9-25-404(A).
- F.** The Department shall comply with the confidentiality requirements in A.R.S. §§ 36-2220(E) and 36-2245(M).

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 13 A.A.R. 1713, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-402. EMCT Certification and Recertification Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H) and 36-2204(1), (6), and (7))**

- A.** The Department shall not certify an EMCT if the applicant:
  1. Is currently:
    - a. Incarcerated for a criminal conviction,
    - b. On parole for a criminal conviction,
    - c. On supervised release for a criminal conviction, or
    - d. On probation for a criminal conviction;
  2. Within 10 years before the date of filing an application for certification required by this Article, has been convicted of any of the following crimes, or any similarly defined crimes in this state or in any other state or jurisdiction, unless the conviction has been absolutely discharged, expunged, or vacated:
    - a. 1st or 2nd degree murder;
    - b. Attempted 1st or 2nd degree murder;
    - c. Sexual assault;
    - d. Attempted sexual assault;
    - e. Sexual abuse of a minor;
    - f. Attempted sexual abuse of a minor;
    - g. Sexual exploitation of a minor;
    - h. Attempted sexual exploitation of a minor;
    - i. Commercial sexual exploitation of a minor;
    - j. Attempted commercial sexual exploitation of a minor;
    - k. Molestation of a child;
    - l. Attempted molestation of a child; or
    - m. A dangerous crime against children as defined in A.R.S. § 13-705;
  3. Within five years before the date of filing an application for certification required by this Article, has been convicted of a misdemeanor involving moral turpitude or a felony in this state or any other state or jurisdiction, other than a misdemeanor involving moral turpitude or a felony listed in subsection (A)(2), unless the conviction has been absolutely discharged, expunged, or vacated;
  4. Within five years before the date of filing an application for certification required by this Article, has had EMCT certification or recertification revoked in this state or certification, recertification, or licensure at an EMCT classification level revoked in any other state or jurisdiction; or
  5. Knowingly provides false information in connection with an application required by this Article.
- B.** The Department shall not re-certify an EMCT, if:
  1. While certified, the applicant has been convicted of a crime listed in subsection (A)(2), or any similarly defined crimes in this state or in any other state or jurisdiction, unless the conviction has been absolutely discharged, expunged, or vacated; or
  2. The applicant knowingly provides false information in connection with an application required by this Article.

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- C. The Department shall make probation a condition of EMCT certification if, within two years before the date of filing an application under R9-25-403, an applicant has been convicted of a misdemeanor in this state or in any other state or jurisdiction, involving:
1. Possession, use, administration, acquisition, sale, manufacture, or transportation of an intoxicating liquor, dangerous drug, or narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated; or
  2. Driving or being in physical control of a vehicle while under the influence of an intoxicating liquor, a dangerous drug, or a narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated.
- D. Except as provided in subsection (E), the Department shall make probation a condition of EMCT recertification if an applicant:
1. Is currently:
    - a. Incarcerated for a criminal conviction,
    - b. On parole for a criminal conviction,
    - c. On supervised release for a criminal conviction, or
    - d. On probation for a criminal conviction; or
  2. Within five years before the date of filing an application under R9-25-404, has been convicted of a misdemeanor involving moral turpitude or a felony in this state or any other state or jurisdiction, other than those listed in subsection (A)(2), unless the conviction has been absolutely discharged, expunged, or vacated.
- E. As specified in R9-25-409, the Department may make probation a condition of EMCT recertification if an applicant, within two years before the date of filing an application under R9-25-404, has been convicted of a misdemeanor in this state or in any other state or jurisdiction, involving:
1. Possession, use, administration, acquisition, sale, manufacture, or transportation of an intoxicating liquor, dangerous drug, or narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated; or
  2. Driving or being in physical control of a vehicle while under the influence of an intoxicating liquor, a dangerous drug, or a narcotic drug, as defined in A.R.S. § 13-3401, unless the conviction has been absolutely discharged, expunged, or vacated.
- F. If the Department makes probation a condition of EMCT certification or recertification, the Department shall fix the period and terms of probation that will:
1. Protect the public health and safety, and
  2. Rehabilitate and educate the applicant.
- Historical Note**  
 Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).
- R9-25-403. Application Requirements for EMCT Certification or Paramedic Endorsement for Providing Critical Care Services (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (H) and 36-2204(1) and (6))**
- A. An individual may apply for initial EMCT certification if:
1. The individual is at least 18 years of age;
  2. The individual complies with the requirements in A.R.S. § 41-1080;
  3. The individual is not ineligible under R9-25-402; and
  4. One of the following applies to the individual:
    - a. The individual has not previously applied for certification from the Department or has withdrawn an application for certification;
    - b. An application for certification submitted by the individual was denied by the Department two or more years before the present date;
    - c. Except as provided in R9-25-404(A)(2) or (3), the individual's certification as an EMCT is expired;
    - d. The individual's certification as an EMCT was revoked by the Department five or more years before the present date; or
    - e. The individual has current certification as an EMCT and is applying for certification at a different classification level of EMCT.
- B. An applicant for initial EMCT certification shall submit to the Department an application, including:
1. The following information in a Department-provided format:
    - a. The applicant's name, address, telephone number, email address, date of birth, gender, and Social Security number;
    - b. The level of EMCT certification being requested;
    - c. Responses to questions addressing the applicant's criminal history according to R9-25-402(A)(1) through (3) and (C);
    - d. Whether the applicant has within the five years before the date of the application had:
      - i. EMCT certification or recertification revoked in Arizona;
      - ii. Certification, recertification, or licensure at an EMCT classification level revoked, suspended, or voluntarily surrendered in another state or jurisdiction; or
      - iii. Certification or licensure as a health professional, as defined in A.R.S. § 36-3201, revoked, suspended, or voluntarily surrendered in Arizona or in another state or jurisdiction;
    - e. Attestation that all information required as part of the application has been submitted and is true and accurate; and
    - f. The applicant's signature or electronic signature and date of signature;
  2. For each affirmative response to a question addressing the applicant's criminal history required in subsection (B)(1)(c), a detailed explanation in a Department-provided format and supporting documentation;
  3. For each affirmative response to subsection (B)(1)(d), a detailed explanation in a Department-provided format and supporting documentation;
  4. If applicable, a copy of certification, recertification, or licensure at an EMCT classification level issued to the applicant in another state or jurisdiction;
  5. Documentation for the applicant that complies with A.R.S. § 41-1080; and
  6. One of the following:
    - a. Documentation of current registration in a national certification organization at the applicable or higher level of EMCT classification;
    - b. Documentation of completion of training and testing by a branch of the U.S. Armed Forces that is compa-

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able to requirements of a national certification organization for the applicable or higher level of EMCT classification; or

- c. A certificate of completion showing that, within the two years before the date of the application, the applicant completed statewide standardized training and a statewide standardized certification test.
- C. A Paramedic applying for endorsement for providing critical care services shall submit to the Department an application, including:
  1. The following information in a Department-provided format:
    - a. The applicant's name, address, telephone number, email address, date of birth, and Social Security number;
    - b. The applicant's current certification number as a Paramedic;
    - c. Attestation that all information required as part of the application has been submitted and is true and accurate; and
    - d. The applicant's signature or electronic signature and date of signature; and
  2. Documentation of passing a critical care examination given by a national certification organization.
- D. The Department shall approve or deny an application for initial EMCT certification according to Article 12 of this Chapter.
- E. If the Department denies an application for initial EMCT certification, the applicant may request a hearing according to A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-403 repealed; new Section R9-25-403 renumbered from Section R9-25-404 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-404. Application Requirements for EMCT Recertification (Authorized by A.R.S. §§ 36-2202(A)(2), (3), (4), and (6), (B), and (H) and 36-2204(1), (4), and (6))**

- A. An individual may apply for recertification at the same classification level of EMCT certification held or at a lower classification level of EMCT certification:
  1. Within 90 days before the expiration date of the individual's current EMCT certification;
  2. Within the 30-day period after the expiration date of the individual's EMCT certification, as provided in subsection (G); or
  3. Within the extension time period granted under R9-25-405.
- B. To apply for recertification, an applicant shall submit to the Department an application, including:
  1. The following information in a Department-provided format:
    - a. The applicant's name, address, telephone number, email address, date of birth, and Social Security number;

- b. The applicant's current certification number;
  - c. Responses to questions addressing the applicant's criminal history according to R9-25-402(B), (D), and (E);
  - d. Whether the applicant has within the five years before the date of the application had:
    - i. EMCT certification or recertification revoked in Arizona;
    - ii. Certification, recertification, or licensure at an EMCT classification level revoked, suspended, or voluntarily surrendered in another state or jurisdiction; or
    - iii. Certification or licensure as a health professional, as defined in A.R.S. § 36-3201, revoked, suspended, or voluntarily surrendered in Arizona or in another state or jurisdiction;
  - e. An indication of the classification level of EMCT certification held currently or within the past 30 days and of the classification level of EMCT certification for which recertification is requested;
  - f. If the applicant is employed, the name of the employer;
  - g. Attestation that all information required as part of the application has been submitted and is true and accurate; and
  - h. The applicant's signature or electronic signature and date of signature;
2. For each affirmative response to a question addressing the applicant's criminal history required in subsection (B)(1)(c), a detailed explanation in a Department-provided format and supporting documentation;
  3. For an affirmative response to subsection (B)(1)(d), a detailed explanation in a Department-provided format; and
  4. For an application submitted within 30 days after the expiration date of EMCT certification, a nonrefundable certification extension fee of \$150.
- C. In addition to the application in subsection (B), an applicant for EMCT recertification shall submit one of the following to the Department:
    1. A certificate of course completion issued by the training program director under R9-25-304(F) showing that within two years before the date of the application, the applicant completed either:
      - a. The refresher course in R9-25-305(G), (I), or (K), as applicable; or
      - b. The refresher challenge examination in R9-25-305(H), (J), or (L), as applicable;
    2. Documentation of:
      - a. Current registration in a national certification organization at the applicable or higher classification level of EMCT classification; and
      - b. For a recertifying Paramedic applying for continued endorsement for providing critical care services, current certification in critical care paramedicine by a national certification organization; or
    3. Attestation in a Department-provided format that the applicant:
      - a. Has documentation of current certification in adult, pediatric, and infant cardiopulmonary resuscitation through instruction consistent with American Heart Association recommendations for emergency cardiovascular care by EMCTs;

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- b. For EMT-I(99) recertification or Paramedic recertification, has documentation of current certification in advanced emergency cardiac life support;
- c. Has documentation of having completed within the previous two years the following number of hours of continuing education in topics that are consistent with the content of the applicable refresher course:
  - i. For EMT recertification, a minimum of 24 hours;
  - ii. For AEMT recertification, EMT-I(99) recertification, or Paramedic recertification without endorsement for providing critical care services, a minimum of 48 hours;
  - iii. For Paramedic recertification and continuing endorsement for providing critical care services, a minimum of 60 hours, with at least 8 hours on topics pertinent to providing critical care services; and
  - iv. Included in the hours required in subsections (C)(3)(c)(i), (ii), or (iii), as applicable, a minimum of 5 hours in pediatric emergency care; and
- d. For EMT recertification, has functioned in the capacity of an EMT for at least 240 hours during the previous two years.
- D. An applicant who submits an attestation under subsection (C)(3) shall maintain the applicable documentation for at least three years after the date of the application.
- E. If an individual submits an application for recertification, with a certification extension fee, within 30 days after the expiration date of the individual's EMCT certification, the individual:
  - 1. Was authorized to act as an EMCT during the period between the expiration date of the individual's EMCT certification and the date the application was submitted, and
  - 2. Is authorized to act as an EMCT until the Department makes a final determination on the individual's application for recertification.
- F. If an individual does not submit an application for recertification before the expiration date of the individual's EMCT certification or, with a certification extension fee, within 30 days after the expiration date of the individual's EMCT certification, the individual:
  - 1. Is not an EMCT,
  - 2. Was not authorized to act as an EMCT during the 30-day period after the expiration date of the individual's EMCT certification, and
  - 3. May submit an application to the Department for initial EMCT certification according to R9-25-403.
- G. The Department shall approve or deny an application for recertification according to Article 12 of this Chapter.
- H. If the Department denies an application for recertification, the applicant may request a hearing according to A.R.S. Title 41, Chapter 6, Article 10.
- I. The Department may deny, based on failure to meet the standards for recertification in A.R.S. Title 36, Chapter 21.1 and this Article, an application submitted with a certification extension fee.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective

January 6, 2007 (Supp. 06-4). Section R9-25-404 renumbered to R9-25-403; new Section R9-25-404 renumbered from Section R9-25-406 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-405. Extension to File an Application for EMCT Recertification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H) and 36-2204(1), (4), (5), and (7))**

- A. Before the expiration of a current certificate, an EMCT who is unable to meet the recertification requirements in R9-25-404 because of personal or family illness, military service, or authorized federal or state emergency response deployment may apply to the Department in writing for an extension of time to file for recertification by submitting:
  - 1. The following information in a Department-provided format:
    - a. The EMCT's name, address, telephone number, and email address;
    - b. The EMCT's current certification number;
    - c. The reason for requesting the extension; and
    - d. The EMCT's signature or electronic signature and date of signature; and
  - 2. For an exemption based on military service or authorized federal or state emergency response deployment, a copy of the EMCT's military orders or documentation of authorized federal or state emergency response deployment.
- B. The Department may grant an extension of time to file for recertification:
  - 1. For personal or family illness, for no more than 180 days; or
  - 2. For each military service or authorized federal or state emergency response deployment, for the term of service or deployment plus 180 days.
- C. An individual applying for or granted an extension of time to file for recertification:
  - 1. Remains certified according to A.R.S. § 41-1092.11 during the extension period, and
  - 2. Shall submit an application for recertification according to R9-25-404.
- D. An individual who does not meet the recertification requirements in R9-25-404 within the extension period or has the application for recertification denied by the Department:
  - 1. Is not an EMCT, and
  - 2. May submit an application to the Department for initial EMCT certification according to R9-25-403.
- E. The Department shall approve or deny a request for an extension to file for EMCT recertification according to Article 12 of this Chapter.
- F. If the Department denies a request for an extension to file for EMCT recertification, the applicant may request a hearing according to A.R.S. Title 41, Chapter 6, Article 10.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-405 repealed; new Section R9-25-405 renumbered from Section R9-25-407 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective

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date of January 9, 2018 (Supp. 18-1).

**R9-25-406. Requirements for Downgrading of Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (H) and 36-2204(1) and (6))**

An individual who holds current EMCT certification at a classification level higher than EMT and who is not under investigation according to A.R.S. § 36-2211 may apply for:

1. Continued certification at a lower EMCT classification level for the remainder of the certification period by submitting to the Department:
  - a. A written request containing:
    - i. The EMCT's name, address, email address, telephone number, date of birth, and Social Security number;
    - ii. The lower EMCT classification level requested;
    - iii. Attestation that the applicant has not committed an act or engaged in conduct that would warrant revocation of a certificate under A.R.S. § 36-2211;
    - iv. Attestation that all information submitted is true and accurate; and
    - v. The applicant's signature or electronic signature and date of signature; and
  - b. Either:
    - i. A written statement from the EMCT's administrative medical director attesting that the EMCT is able to perform at the lower EMCT classification level requested; or
    - ii. If applying for continued certification as an EMT, an Arizona EMT refresher certificate of completion or an Arizona EMT refresher challenge examination certificate of completion signed by the training program director designated for the Arizona EMT refresher course; or
2. Recertification at a lower EMCT classification level according to R9-25-404.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by final rulemaking at 13 A.A.R. 1713, effective June 30, 2007 (Supp. 07-2). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Section R9-25-406 renumbered to Section R9-25-404; new Section R9-25-406 renumbered from Section R9-25-408 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1).

**R9-25-407. Notification Requirements (Authorized by A.R.S. §§ 36-2201, 36-2202(A)(2), (A)(3), and (A)(4), 36-2204(1) and (6), and 36-2211)**

- A. No later than 30 days after the date an EMCT's name legally changes, the EMCT shall submit to the Department:
  1. The following information in a Department-provided format:
    - a. The name under which the EMCT is currently certified by the Department;

- b. The EMCT's address, telephone number, and Social Security number; and
    - c. The EMCT's new name; and
  2. Documentation showing that the name has been legally changed.
- B. No later than 30 days after the date an EMCT's address or email address changes, the EMCT shall submit to the Department the following information in a Department-provided format:
  1. The EMCT's name, telephone number, and Social Security number; and
  2. The EMCT's new address or email address.
- C. An EMCT shall notify the Department in writing no later than 10 days after the date the EMCT:
  1. Is incarcerated or is placed on parole, supervised release, or probation for any criminal conviction;
  2. Is convicted of:
    - a. A crime specified in R9-25-402(A)(2),
    - b. A misdemeanor involving moral turpitude,
    - c. A felony in this state or any other state or jurisdiction, or
    - d. A misdemeanor specified in R9-25-402(E);
  3. Has registration revoked or suspended by a national certification organization;
  4. Has certification, recertification, or licensure at an EMCT classification level revoked, suspended, or voluntarily surrendered in another state or jurisdiction; or
  5. Has certification or licensure as a health professional, as defined in A.R.S. § 36-3201, revoked, suspended, or voluntarily surrendered in Arizona or in another state or jurisdiction.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-407 renumbered to Section R9-25-405; new Section R9-25-407 renumbered from Section R9-25-409 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-408. Unprofessional Conduct; Physical or Mental Incompetence; Gross Incompetence; Gross Negligence (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H), 36-2204(1), (6), and (7), and 36-2211)**

- A. For purposes of A.R.S. § 36-2211(A)(1), unprofessional conduct is an act or omission made by an EMCT that is contrary to the recognized standards or ethics of the Emergency Medical Technician profession or that may constitute a danger to the health, welfare, or safety of a patient or the public, including:
  1. Impersonating an EMCT of a higher classification level of certification or impersonating a health professional as defined in A.R.S. § 32-3201;
  2. Permitting or allowing another individual to use the EMCT's certification for any purpose;
  3. Aiding or abetting an individual who is not certified according to this Chapter in acting as an EMCT or in representing that the individual is certified as an EMCT;

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4. Engaging in or soliciting sexual relationships, whether consensual or nonconsensual, with a patient while acting as an EMCT;
  5. Physically or verbally harassing, abusing, threatening, or intimidating a patient or another individual while acting as an EMCT;
  6. Making false or materially incorrect entries in a medical record or wilful destruction of a medical record;
  7. Failing or refusing to maintain adequate records on a patient;
  8. Soliciting or obtaining monies or goods from a patient by fraud, deceit, or misrepresentation;
  9. Aiding or abetting an individual in fraud, deceit, or misrepresentation in meeting or attempting to meet the application requirements for EMCT certification or EMCT recertification contained in this Article, including the requirements established for:
    - a. Completing and passing a course provided by a training program; and
    - b. The national certification organization examination process and national certification organization registration process;
  10. Providing false information or making fraudulent or untrue statements to the Department or about the Department during an investigation conducted by the Department;
  11. Being incarcerated or being placed on parole, supervised release, or probation for any criminal conviction;
  12. Being convicted of a crime specified in R9-25-407(C)(2), which has not been set aside, pardoned, sealed, included on a certificate of second chance, expunged, or vacated;
  13. Having national certification organization registration revoked or suspended by the national certification organization for material noncompliance with national certification organization rules or standards;
  14. Having certification, recertification, or licensure at an EMCT classification level revoked or suspended in another state or jurisdiction; and
  15. Continuing to provide services as an EMCT without notifying the Department of having certification or licensure as a health professional, as defined in A.R.S. § 36-3201, revoked, suspended, or voluntarily surrendered in Arizona or in another state or jurisdiction.
- B.** Under A.R.S. § 36-2211, physical or mental incompetence of an EMCT is the EMCT's lack of physical or mental ability to provide emergency medical services as required under this Chapter.
- C.** Under A.R.S. § 36-2211 gross incompetence or gross negligence is an EMCT's wilful act or wilful omission of an act that is made in disregard of an individual's life, health, or safety and that may cause death or injury.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section R9-25-408 renumbered to Section R9-25-406; new Section R9-25-408 renumbered from Section R9-25-410 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025),

with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-409. Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), (A)(6), and (H), 36-2204(1), (6), and (7), and 36-2211)**

- A.** If the Department determines that an applicant or EMCT is not in substantial compliance with applicable laws and rules, under A.R.S. § 36-2204 or 36-2211, the Department may:
1. Take the following action against an applicant or EMCT:
    - a. After notice is provided according to A.R.S. § 36-2211 and, if applicable, A.R.S. Title 41, Chapter 6, Article 10, issue:
      - i. A decree of censure to the EMCT, or
      - ii. An order of probation to the EMCT; or
    - b. After notice and opportunity to be heard is provided according to A.R.S. Title 41, Chapter 6, Article 10:
      - i. Deny an application,
      - ii. Suspend the EMCT's certificate, or
      - iii. Revoke the EMCT's certificate; and
  2. Assess civil penalties against the EMCT.
- B.** In determining which action in subsection (A) is appropriate, the Department shall consider:
1. Prior disciplinary actions;
  2. The time interval since a prior disciplinary action, if applicable;
  3. The applicant's or EMCT's motive;
  4. The applicant's or EMCT's pattern of conduct;
  5. The number of offenses;
  6. Whether the applicant or EMCT failed to comply with instructions from the Department;
  7. Whether interim rehabilitation efforts were made by the applicant or EMCT;
  8. Whether the applicant or EMCT refused to acknowledge the wrongful nature of the misconduct;
  9. Whether the applicant or EMCT made timely and good-faith efforts to rectify the consequences of the misconduct;
  10. The submission of false evidence, false statements, or other deceptive practices during an investigation or disciplinary process;
  11. The vulnerability of a patient or other victim of the applicant's or EMCT's conduct, if applicable; and
  12. How much control the applicant or EMCT had over the processes or situation leading to the misconduct.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-409 renumbered to Section R9-25-407; new Section R9-25-409 renumbered from Section R9-25-411 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 31 A.A.R. 332 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).

**R9-25-410. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

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Section R9-25-410 renumbered to Section R9-25-408 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-411. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Section R9-25-411 renumbered to Section R9-25-409 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**Exhibit I. Repealed****Historical Note**

Exhibit I adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit J. Repealed****Historical Note**

Exhibit J adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit K. Repealed****Historical Note**

Exhibit K adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-412. Expired****Historical Note**

New Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

**ARTICLE 5. MEDICAL DIRECTION PROTOCOLS**

*Article 5, consisting of R9-25-501 through R9-25-508, recodified from Article 8 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).*

*Article 5 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).*

**R9-25-501. Definitions**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article, unless otherwise specified:

1. "ALS skill" means a medical treatment, procedure, or technique or administration of a medication that is indicated by a check mark in Table 5.1 under AEMT, EMT-I(99), or Paramedic, but not under EMT.
2. "Immunizing agent" means an immunobiologic recommended by the Advisory Committee on Immunization Practices of the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-501 recodified from R9-25-801 at 10 A.A.R. 4192, effective September

21, 2004 (Supp. 04-3). Amended by exempt rulemaking 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3).

Section R9-25-501 repealed; new Section R9-25-501 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-502. Scope of Practice for EMCTs**

**A.** An EMCT shall perform a medical treatment, procedure, or technique or administer a medication only:

1. If the skill is within the EMCT's scope of practice skills, as specified in Table 5.1;
2. For an ALS skill:
  - a. If authorized for the EMCT by the EMCT's administrative medical director; and
  - b. If the EMCT is able to receive on-line medical direction;
3. For a STR skill:
  - a. If the EMCT has documentation of having completed training specific to the skill that is consistent with the knowledge, skills, and competencies established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references);
  - b. If authorized for the EMCT by the EMCT's administrative medical director; and
  - c. If the EMCT is able to receive on-line medical direction;
4. If the medication is listed as an agent in a table of agents, established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references), that the EMCT's administrative medical director may authorize the EMCT to administer, monitor, or assist a patient in self-administration based on the classification for which the EMCT is certified;
5. If the EMCT is authorized to administer the medication by the:
  - a. EMCT's administrative medical director, if applicable; or
  - b. If the EMCT is an EMT with no administrative medical director, emergency medical services provider or ambulance service by which the EMCT is employed or for which the EMCT volunteers; and
6. In a manner consistent with standards described in R9-25-408 and, if applicable, with the training in 9 A.A.C. 25, Article 3.

**B.** An administrative medical director:

1. Shall:
  - a. Ensure that an EMCT has completed training in administration or monitoring of an agent before authorizing the EMCT to administer or monitor the agent;
  - b. Ensure that an EMCT has competency in an ALS skill before authorizing the EMCT to perform the ALS skill;
  - c. Before authorizing an EMCT to perform a STR skill, ensure that the EMCT has:
    - i. Completed training specific to the skill, consistent with the knowledge, skills, and competencies established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references); and
    - ii. Demonstrated competency in the skill;
  - d. Periodically thereafter assess an EMCT's competency in an authorized ALS skill and STR skill,

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according to policies and procedures required in R9-25-201(E)(3)(b)(ix), to ensure continued competency;

- e. Document the EMCT's:
    - i. Completion of training in administration or monitoring of an agent required in subsection (B)(1)(a),
    - ii. Competency in performing an ALS skill required in subsection (B)(1)(b),
    - iii. Specific training required in subsection (B)(1)(c)(i) and competency required in subsection (B)(1)(c)(ii); and
    - iv. Periodic reassessment required in subsection (B)(1)(d); and
  - f. Maintain documentation of an EMCT's completion of training in administration or monitoring of an agent and competency in performing an authorized ALS skill or STR skill; and
2. May authorize an EMCT to perform all of the ALS skills in Table 5.1 for the applicable level of EMCT or restrict the EMCT to a subset of the ALS skills in Table 5.1 for the applicable level of EMCT.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-502 recodified

from R9-25-802 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

**Table 1. Repealed****Historical Note**

Table 1 adopted by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 13 A.A.R. 578, effective January 31, 2007 (Supp. 07-1). Historical note added to Table 1; amended by exempt rulemaking 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 234, effective January 2, 2009 (Supp. 09-1). Amended by exempt rulemaking at 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3). Amended by exempt rulemaking at 15 A.A.R. 234, effective January 2, 2009 (Supp. 09-1). Amended by exempt rulemaking at 16 A.A.R. 2116, effective October 15, 2010 (Supp. 10-4). Amended by exempt rulemaking at 18 A.A.R. 102, effective January 1, 2012 (Supp. 11-4). Table 1 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).



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**Table 5.1. Arizona Scope of Practice Skills****KEY:**

✓ = Arizona Scope of Practice skill

STR = Special Training Required skill

\* = With training in R9-25-505

<b>A. Airway/Ventilation/Oxygenation</b>		<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>EMT-I (99)</b>	<b>Paramedic</b>	<b>Paramedic with Critical Care Endorsement</b>
1.	Airway - nasal	-	✓	✓	✓	✓	✓
2.	Airway - oral	✓	✓	✓	✓	✓	✓
3.	Airway - supraglottic		STR	✓	✓	✓	✓
4.	Airway obstruction - dislodgement by direct laryngoscopy	-	-	-	✓	✓	✓
5.	Airway obstruction - manual dislodgement techniques	✓	✓	✓	✓	✓	✓
6.	Automated transport ventilator	-	-	STR	✓	✓	✓
7.	Transport ventilator with advanced modes	-	-	-	-	-	✓
8.	Bag-valve-mask (BVM)	✓	✓	✓	✓	✓	✓
9.	BiPAP	-	-	-	-	✓	✓
10.	CPAP	-	STR	✓	✓	✓	✓
11.	Chest decompression - needle	-	-	-	✓	✓	✓
12.	Chest tube placement - assist only	-	-	-	-	✓	✓
13.	Chest tube monitoring and management	-	-	-	-	✓	✓
14.	Chest tube placement and management	-	-	-	-	-	✓
15.	Finger thoracostomy	-	-	-	-	-	✓
16.	Cricothyrotomy	-	-	-	-	✓	✓
17.	End tidal CO2 monitoring and interpretation of waveform capnography	-	STR	✓	✓	✓	✓
18.	Gastric decompression - NG tube	-	-	-	✓	✓	✓
19.	Gastric decompression - OG tube	-	-	-	✓	✓	✓
20.	Head-tilt chin lift	✓	✓	✓	✓	✓	✓
21.	Intubation - endotracheal	-	-	-	✓	✓	✓
22.	Intubation - nasotracheal	-	-	-	-	✓	✓
23.	Jaw-thrust	✓	✓	✓	✓	✓	✓
24.	Medication Assisted Intubation (paralytics)	-	-	-	-	STR	✓
25.	Mouth-to-barrier	✓	✓	✓	✓	✓	✓
26.	Mouth-to-mask	✓	✓	✓	✓	✓	✓
27.	Mouth-to-mouth	✓	✓	✓	✓	✓	✓
28.	Mouth-to-nose	✓	✓	✓	✓	✓	✓
29.	Mouth-to-stoma	✓	✓	✓	✓	✓	✓
30.	Oxygen therapy - high flow nasal cannula	-	-	-	-	✓	✓
31.	Oxygen therapy - humidifiers	-	✓	✓	✓	✓	✓
32.	Oxygen therapy - nasal cannula	✓	✓	✓	✓	✓	✓
33.	Oxygen therapy - non-rebreather mask	✓	✓	✓	✓	✓	✓
34.	Oxygen therapy - partial rebreather mask	-	✓	✓	✓	✓	✓
35.	Oxygen therapy - simple face mask	-	✓	✓	✓	✓	✓
36.	Oxygen therapy - Venturi mask	-	✓	✓	✓	✓	✓
37.	Pulse oximetry	-	✓	✓	✓	✓	✓
38.	Suctioning - upper airway	✓	✓	✓	✓	✓	✓
39.	Suctioning - tracheobronchial of an intubated patient	-	-	✓	✓	✓	✓
<b>B. Cardiovascular/Circulation</b>		<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>EMT-I (99)</b>	<b>Paramedic</b>	<b>Paramedic with Critical Care Endorsement</b>
1.	Cardiac monitoring - 12-lead ECG (interpretive)	-	-	-	✓	✓	✓
2.	Cardiac monitoring - 12-lead ECG acquisition and transmission	-	✓	✓	✓	✓	✓
3.	Cardiopulmonary resuscitation	✓	✓	✓	✓	✓	✓
4.	Cardioversion - electrical	-	-	-	✓	✓	✓
5.	Defibrillation - automated/semi-automated	✓	✓	✓	✓	✓	✓
6.	Defibrillation - manual	-	-	-	✓	✓	✓
7.	Hemorrhage control - direct pressure	✓	✓	✓	✓	✓	✓

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8.	Hemorrhage control - tourniquet	✓	✓	✓	✓	✓	✓
9.	Hemorrhage control - wound packing	✓	✓	✓	✓	✓	✓
10.	Mechanical CPR device	✓	✓	✓	✓	✓	✓
11.	Telemetric monitoring devices and transmission of clinical data, including video data	-	✓	✓	✓	✓	✓
12.	Transcutaneous pacing	-	-	-	✓	✓	✓
13.	Transvenous cardiac pacing - monitoring and maintenance	-	-	-	✓	✓	✓
14.	Hemodynamic monitoring - invasive (central and arterial)	-	-	-	-	-	✓
15.	ICP (Increased Intracranial Pressure) monitoring	-	-	-	-	-	✓
16.	Circulatory augmentation device monitoring and management (Intra-arterial balloon pump, Impella, etc.)	-	-	-	-	-	✓
17.	Ventricular Assist Device (VAD) - monitoring and management	-	-	-	-	-	✓
<b>C. Splinting/Spinal Motion Restriction/Patient Restraint</b>		<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>EMT-I (99)</b>	<b>Paramedic</b>	<b>Paramedic with Critical Care Endorsement</b>
1.	Cervical collar	✓	✓	✓	✓	✓	✓
2.	Long spine board	-	✓	✓	✓	✓	✓
3.	Manual cervical stabilization	✓	✓	✓	✓	✓	✓
4.	Seated spinal motion restriction (KED, etc.)	-	✓	✓	✓	✓	✓
5.	Extremity stabilization - manual	✓	✓	✓	✓	✓	✓
6.	Extremity splinting	✓	✓	✓	✓	✓	✓
7.	Splint-traction	-	✓	✓	✓	✓	✓
8.	Mechanical patient restraint	-	✓	✓	✓	✓	✓
9.	Emergency moves for endangered patients	✓	✓	✓	✓	✓	✓
<b>D. Medication Administration - routes/agent types</b>		<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>EMT-I (99)</b>	<b>Paramedic</b>	<b>Paramedic with Critical Care Endorsement</b>
1.	Aerosolized/nebulized	-	✓	✓	✓	✓	✓
2.	Endotracheal tube	-	-	-	✓	✓	✓
3.	Inhaled	-	✓	✓	✓	✓	✓
4.	Intradermal	-	-	-	-	✓	✓
5.	Intramuscular		STR	✓	✓	✓	✓
6.	Intramuscular - autoinjector	✓	✓	✓	✓	✓	✓
7.	Intranasal	-	✓	✓	✓	✓	✓
8.	Intranasal - unit dose, premeasured	✓	✓	✓	✓	✓	✓
9.	Intraosseous - initiation, pediatric or adult	-	-	✓	✓	✓	✓
10.	Intravenous	-	-	✓	✓	✓	✓
11.	Mucosal/Sublingual	-	✓	✓	✓	✓	✓
12.	Nasogastric	-	-	-	-	✓	✓
13.	Oral	-	✓	✓	✓	✓	✓
14.	Rectal	-	-	-	-	✓	✓
15.	Subcutaneous	-	-	✓	✓	✓	✓
16.	Topical	-	-	-	-	✓	✓
17.	Transdermal	-	-	-	-	✓	✓
18.	Use/monitoring of infusion pump for agent administration during interfacility transports	-	-	-	STR	STR	✓
19.	Use/monitoring of agents specified in <i>Table 3-Special Agents Eligible for Administration and Monitoring</i> , established according to A.R.S. § 36-2204 and available through the Department at <a href="http://www.azdhs.gov/ems-regulatory-references">www.azdhs.gov/ems-regulatory-references</a>	-	-	-	STR	STR	✓
20.	Epinephrine anaphylaxis-prepared kit; only for anaphylaxis when no auto-injector is available	-	STR	✓	✓	✓	✓
21.	Immunizations	-	-	-	✓*	✓*	✓*
22.	Thrombolytics	-	-	-	-	-	✓
<b>E. IV Initiation/Maintenance Fluids</b>		<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>EMT-I (99)</b>	<b>Paramedic</b>	<b>Paramedic with Critical Care Endorsement</b>
1.	Access indwelling catheters and implanted central IV ports	-	-	-	-	✓	✓
2.	Central line - monitoring	-	-	-	-	✓	✓

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3.	Intraosseous - initiation, pediatric or adult	-	-	✓	✓	✓	✓
4.	Intravenous access	-	STR	✓	✓	✓	✓
5.	Intravenous initiation - peripheral	-	STR	✓	✓	✓	✓
6.	Intravenous- maintenance of medicated IV fluids	-	-	-	✓	✓	✓
7.	Intravenous- maintenance of nonmedicated IV fluids	-	STR	✓	✓	✓	✓
8.	Initiation and maintenance of blood product transfusion	-	-	-	-	-	✓
9.	Intravenous initiation - ultrasound guided IV in a hospital setting	-	-	-	-	STR	✓
<b>F. Miscellaneous</b>		<b>EMR</b>	<b>EMT</b>	<b>AEMT</b>	<b>EMT-I (99)</b>	<b>Paramedic</b>	<b>Paramedic with Critical Care Endorsement</b>
1.	Assisted delivery (childbirth)	✓	✓	✓	✓	✓	✓
2.	Assisted complicated delivery (childbirth)	-	✓	✓	✓	✓	✓
3.	Blood chemistry analysis	-	-	-	-	✓	✓
4.	Blood glucose monitoring	-	✓	✓	✓	✓	✓
5.	Blood pressure - automated	-	✓	✓	✓	✓	✓
6.	Blood pressure - manual	✓	✓	✓	✓	✓	✓
7.	Eye irrigation	✓	✓	✓	✓	✓	✓
8.	Eye irrigation hands-free irrigation using sterile eye irrigation device	-	-	-	-	✓	✓
9.	Urinary catheterization	-	STR	STR	STR	STR	✓
10.	Venous blood sampling	-	STR	✓	✓	✓	✓
11.	Arterial blood sampling	-	-	-	-	-	✓
12.	Point of care and laboratory sampling and interpretation	-	-	-	-	-	✓
13.	External fetal monitoring	-	-	-	-	-	✓
14.	Neonatal Isolette monitoring	-	-	-	-	-	✓
15.	Ultrasound	-	-	-	-	-	✓

**Historical Note**

Table 5.1 made by exempt rulemaking at 19 A.A.R. 282, effective January 28, 2013 (Supp. 13-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final exempt rulemaking, pursuant to Laws 2014, Ch. 233, § 5 at 20 A.A.R. 3554, effective January 1, 2015 (Supp. 14-4). Amended by final exempt rulemaking, pursuant to Laws 2015, Ch. 222, § 3, at 21 A.A.R. 3241, effective November 24, 2015 (Supp. 15-4). Amended by final exempt rulemaking at 23 A.A.R. 1161, effective April 19, 2017 (Supp. 17-2). Amended by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3). Amended by exempt rulemaking at 27 A.A.R. 1385, with an immediate effective date of August 9, 2021 (Supp. 21-3). Amended by exempt rulemaking at 28 A.A.R. 3321 (October 14, 2022), with an immediate effective date of September 22, 2022 (Supp. 22-3). Subsection (B)(10) question marks corrected to check marks as published at 28 A.A.R. 3321 (Supp. 24-1). Amended by exempt rulemaking at 30 A.A.R. 3009 (October 11, 2024), with a delayed effective date of December 31, 2024 (Supp. 24-3).

**Table 5.2. Repealed****Historical Note**

Table 5.2 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final exempt rulemaking, pursuant to Laws 2014, Ch. 233, § 5 at 20 A.A.R. 3554, effective January 1, 2015 (Supp. 14-4). Amended by final exempt rulemaking, pursuant to Laws 2015, Ch. 222, § 3, at 21 A.A.R. 3241, effective November 24, 2015 (Supp. 15-4). Amended by final exempt rulemaking at 23 A.A.R. 1161, effective April 19, 2017 (Supp. 17-2). Amended by final exempt rulemaking at 23 A.A.R. 1161, effective April 19, 2017 (Supp. 17-2). Repealed by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

**Table 5.3. Repealed****Historical Note**

Table 5.3 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Repealed by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

**Table 5.4. Repealed****Historical Note**

Table 5.4 made by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Repealed by exempt rulemaking at 24 A.A.R. 2955, effective September 27, 2018 (Supp. 18-3).

**R9-25-503. Testing of Medical Treatments, Procedures, Medications, and Techniques that May Be Administered or Performed by an EMCT**

- A.** Under A.R.S. § 36-2205, the Department may authorize the testing and evaluation of a medical treatment, procedure, technique, practice, medication, or piece of equipment for possible use by an EMCT or an emergency medical services provider.
- B.** Before authorizing any test and evaluation according to subsection (A), the Department director shall approve the test and evaluation according to subsections (C), (D), (E).
- C.** The Department director shall consider approval of a test and evaluation conducted according to subsection (A), only if a written request for testing and evaluation:
- Is submitted to the Department director from:
    - The Department,
    - A state agency other than the Department,
    - A political subdivision of this state,
    - An EMCT,

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- e. An emergency medical services provider;
  - f. An ambulance service, or
  - g. A member of the public; and
- 2. Includes:
  - a. A cover letter, signed and dated by the individual making the request;
  - b. An identification of the person conducting the test and evaluation;
  - c. An identification of the medical treatment, procedure, technique, practice, medication, or piece of equipment to be tested and evaluated;
  - d. An explanation of the reasons for and the benefits of the test and evaluation;
  - e. The scope of the test and evaluation, including the:
    - i. Projected number of individuals, EMCTs, emergency medical services providers, or ambulance services involved; and
    - ii. Proposed length of time required to complete the test and evaluation; and
  - f. The methodology to be used to evaluate the test's and evaluation's findings.
- D. The Department director shall approve a test and evaluation if:
  - 1. The test and evaluation does not pose a threat to the public health, safety, or welfare;
  - 2. The test is necessary to evaluate the safest and most current advances in medical treatments, procedures, techniques, practices, medications, or equipment; and
  - 3. The medical treatment, procedure, technique, practice, medication, or piece of equipment being tested and evaluated may:
    - a. Reduce or eliminate the use of outdated or obsolete medical treatments, procedures, techniques, practices, medications, or equipment;
    - b. Improve patient care; or
    - c. Benefit the public's health, safety, or welfare.
- E. Within 180 days after receiving a written request for testing and evaluation that contains all of the information in subsection (C), the Department director shall send written notification of approval or denial of the test and evaluation to the individual making the request.
- F. Upon completion of a test and evaluation authorized by the Department director, the person conducting the test and evaluation shall submit a written report to the Department director that includes:
  - 1. An identification of the test and evaluation;
  - 2. A detailed evaluation of the test; and
  - 3. A recommendation regarding future use of the medical treatment, procedure, technique, practice, medication, or piece of equipment tested and evaluated.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-503 recodified from R9-25-803 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 13 A.A.R. 578, effective January 31, 2007 (Supp. 07-1). Amended by exempt rulemaking at 14 A.A.R. 3491, effective August 14, 2008 (Supp. 08-3). Section R9-25-503 renumbered to R9-25-505; new Section R9-25-503 renumbered from R9-25-506 and amended by exempt rulemaking at 19 A.A.R.

4032, effective December 1, 2013 (Supp. 13-4).

**Exhibit 1. Repealed****Historical Note**

New Exhibit 1 recodified from Article 8, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 1438, effective March 25, 2005 (Supp. 05-1). Amended by exempt rulemaking at 11 A.A.R. 2379, effective June 8, 2005 (Supp. 05-2). Amended by exempt rulemaking at 11 A.A.R. 3177, effective September 1, 2005 (Supp. 05-3). Exhibit 1 repealed by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4).

**Exhibit 2. Repealed****Historical Note**

New Exhibit 2 recodified from Article 8, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 11 A.A.R. 1438, effective March 25, 2005 (Supp. 05-1). Exhibit 2 repealed by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4).

**Exhibit 3. Repealed****Historical Note**

Exhibit made by exempt rulemaking at 11 A.A.R. 1438, effective March 25, 2005 (Supp. 05-1). Exhibit 3 repealed by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4).

**R9-25-504. Protocol for Selection of a Health Care Institution for Transport**

- A. Except as provided in subsection (B), an EMCT shall transport a patient accessing emergency medical services through a call to 9-1-1 or a similar public emergency dispatch number to:
  - 1. An emergency receiving facility, or
  - 2. A special hospital that is physically connected to an emergency receiving facility.
- B. Under A.R.S. §§ 36-2205(D) and 36-2232(F), an EMCT who responds to a call made to 9-1-1 or a similar public emergency dispatch number may refer, advise, or transport the patient at the scene to a health care institution other than a health care institution specified in subsection (A), if the EMCT determines that:
  - 1. The patient's condition does not pose an immediate threat to life or limb, based on medical direction; and
  - 2. The health care institution is the most appropriate for the patient, based on the following:
    - a. The patient's:
      - i. Medical condition,
      - ii. Choice of health care institution, and
      - iii. Health care provider;
    - b. The location of the health care institution and the emergency medical resources available at the health care institution; and
    - c. A determination by the administrative medical director that the health care institution is able to accept and capable of treating the patient.
- C. Before initiating transport of a patient accessing emergency medical services through a call to 9-1-1 or a similar public emergency dispatch number, an EMCT, emergency medical services provider, or ambulance service shall:
  - 1. Notify, by radio or telephone communication, a health care institution that is not an emergency receiving facility

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of the EMCT's intent to transport the patient to the health care institution; and

2. Receive confirmation of the willingness of the health care institution to accept the patient.
- D.** An EMCT transporting a patient accessing emergency medical services through a call to 9-1-1 or a similar public emergency dispatch number to a health care institution that is not an emergency receiving facility shall transfer care of the patient to a designee authorized by:
  1. A physician,
  2. A registered nurse practitioner,
  3. A physician assistant, or
  4. A registered nurse.
- E.** An emergency medical services provider or an ambulance service that implements this rule shall make available for Department review and inspection written records relating to the transport of a patient under subsections (B), (C), and (D).

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-504 recodified from R9-25-804 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Amended by exempt rulemaking at 14 A.A.R. 3124, effective July 9, 2008 (Supp. 08-3). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final exempt rulemaking, pursuant to Laws 2014, Ch. 233, § 5 at 20 A.A.R. 3554, effective January 1, 2015 (Supp. 14-4).

**R9-25-505. Protocol for an EMT-I(99) or a Paramedic to Become Eligible to Administer an Immunizing Agent**

- A.** An EMT-I(99) or a Paramedic may be authorized by the EMT-I(99)'s or Paramedic's administrative medical director to administer an immunizing agent if the EMT-I(99) or Paramedic completes training that:
  1. Includes:
    - a. Basic immunology and the human immune response;
    - b. Mechanics of immunity, adverse effects, dose, and administration schedule of available immunizing agents;
    - c. Response to an emergency situation, such as an allergic reaction, resulting from the administration of an immunization;
    - d. Routes of administration for available immunizing agents;
    - e. A description of the individuals to whom an EMCT may administer an immunizing agent; and
    - f. The requirements in 9 A.A.C. 6, Article 7 related to:
      - i. Obtaining written consent for administration of an immunizing agent,
      - ii. Providing immunization information and written immunization records, and
      - iii. Recordkeeping and reporting;
  2. Requires the EMT-I(99) or Paramedic to demonstrate competency in the subject matter listed in subsection (A)(1); and
  3. Is approved by the EMT-I(99)'s or Paramedic's administrative medical director based upon a determination that the training meets the requirements in subsections (A)(1) and (A)(2).
- B.** An administrative medical director of an EMT-I(99) or a Paramedic who completes the training required in subsection (A)

shall maintain for Department review and inspection written evidence that the EMT-I(99) or Paramedic has completed the training required in subsection (A), including at least:

1. The name of the training,
2. The date the training was completed, and
3. A signed and dated attestation from the administrative medical director that the training is approved.
- C.** Before administering an immunizing agent to an individual, an EMT-I(99) or a Paramedic shall:
  1. Receive written consent consistent with the requirements in 9 A.A.C. 6, Article 7;
  2. Provide immunization information and written immunization records consistent with the requirements in 9 A.A.C. 6, Article 7; and
  3. Provide documentary proof of immunity to the individual consistent with the requirements in 9 A.A.C. 6, Article 7.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-505 recodified from R9-25-805 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-505 repealed; new Section R9-25-505 renumbered from R9-25-503 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**Exhibit 1. Repealed****Historical Note**

New Exhibit 1 recodified from Article 8, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Exhibit 1 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**Exhibit 2. Repealed****Historical Note**

New Exhibit 2 recodified from Article 8, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Exhibit 2 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-506. Renumbered****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-506 recodified from R9-25-806 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-506 renumbered to R9-25-503 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-507. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-507 recodified from R9-25-807 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-507 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-508. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Sub-

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section (A)(2) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-1). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New R9-25-508 recodified from R9-25-808 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). Section R9-25-508 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-509. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 11 A.A.R. 2379, effective June 8, 2005 (Supp. 05-2). Section repealed by exempt rulemaking at 13 A.A.R. 3038, effective October 6, 2007 (Supp. 07-3).

**R9-25-510. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 11 A.A.R. 1502, effective April 1, 2005 (Supp. 05-1). Amended by exempt rulemaking at 11 A.A.R. 2379, effective June 8, 2005 (Supp. 05-2). Section R9-25-510 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**Exhibit P. Repealed****Historical Note**

Exhibit P adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-511. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Subsection (C) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-3). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 11 A.A.R. 4982, effective November 1, 2005 (Supp. 05-4). Section R9-25-511 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-512. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Subsection (A) corrected to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-1). Subsection (A) corrected again to reflect adopted rules on file with the Office of the Secretary of State, effective October 15, 1996 (Supp. 97-3). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 13 A.A.R. 27, effective January 6, 2007 (Supp. 06-4). Section repealed by exempt rulemaking at 16 A.A.R. 2116, effective October

15, 2010 (Supp. 10-4).

**R9-25-513. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 13 A.A.R. 3038, effective October 6, 2007 (Supp. 07-3). R9-25-513 repealed by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-514. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-515. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**ARTICLE 6. STROKE CARE**

*Article 6, consisting of new Sections R9-25-601 and R9-25-602, made by exempt rulemaking effective April 5, 2013 (Supp. 13-1).*

*Article 6 repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).*

**R9-25-601. Definitions (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article, unless otherwise specified:

1. "Acute stroke-ready hospital" means a hospital that is certified by a national stroke center certification organization as meeting national stroke care standards for the initial assessment, diagnosis, stabilization, and either:
  - a. Transfer of a stroke patient to a primary stroke center or comprehensive stroke center, or
  - b. Care of a stroke patient with input from the staff of a primary stroke center or comprehensive stroke center.
2. "Comprehensive stroke center" means a hospital that is certified by a national stroke center certification organization as meeting national stroke care standards for the assessment, diagnosis using advanced imaging devices, and treatment of stroke patients with complex cases of ischemic stroke, caused by the loss of the blood supply to a part of the brain, or hemorrhagic stroke, caused by bleeding into a part of the brain.
3. "Council" means the emergency medical services council established under A.R.S. § 36-2203.
4. "Health care provider" means an individual licensed according to A.R.S. Title 32, Chapter 13, 15, 17, 19, 25, or 34.
5. "Local EMS coordinating system" means the same as in A.R.S. § 36-2210.
6. "National stroke care standards" means criteria for the assessment and treatment of stroke that are consistent

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with guidelines established by the American Heart Association/American Stroke Association, an organization that focuses on reducing the impact of stroke.

7. "National stroke center certification organization" means an entity:
  - a. Such as:
    - i. The Joint Commission;
    - ii. The Healthcare Facilities Accreditation Program;
    - iii. Det Norske Veritas Healthcare, Inc.; or
    - iv. The American Heart Association/American Stroke Association;
  - b. That assesses the compliance of a hospital with national stroke care standards; and
  - c. That documents hospitals that meet national stroke care standards.
8. "Primary stroke center" means a hospital that is certified by a national stroke center certification organization as meeting national stroke care standards for the assessment, diagnosis, and treatment of stroke patients.
9. "Stroke patient" means an individual who has signs or symptoms of a stroke and is receiving assessment or treatment for a stroke.
10. "Transport" means the same as in A.A.C. R9-10-101.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 19 A.A.R. 643, effective April 5, 2013 (Supp. 13-1). Amended by final rulemaking at 23 A.A.R. 1728, effective July 1, 2017 (Supp. 17-2).

**R9-25-602. Emergency Stroke Care Protocols (Authorized by A.R.S. §§ 36-2202(A)(3) and (4) and 36-2204(1) and (3))**

- A. The council shall:
  1. Establish emergency stroke care protocols, and
  2. Support the adoption of emergency stroke care protocols by emergency medical services providers through local EMS coordinating systems.
- B. The council shall ensure that emergency stroke care protocols:
  1. Are developed and implemented in coordination with:
    - a. Local EMS coordinating systems,
    - b. National organizations that focus on heart disease and stroke,
    - c. Emergency medical services providers, and
    - d. Health care providers;
  2. Include procedures for the pre-hospital assessment and treatment of stroke patients, which may include education about identifying stroke patients who may have an emergent large vessel occlusion, the blockage of a large blood vessel that causes an individual to have an ischemic stroke;
  3. Provide for transport of stroke patients to the most appropriate emergency receiving facility, consistent with A.R.S. § 36-2205(E), taking into account the:
    - a. Needs of a stroke patient;
    - b. Availability of resources in urban areas, suburban areas, rural areas, and wilderness areas;
    - c. Capability of an emergency receiving facility to practice telemedicine, as defined in A.R.S. § 36-3601, with specialists in stroke care;
    - d. Location of emergency receiving facilities that:
      - i. Are:
        - (1) Acute stroke-ready hospitals,

- (2) Primary stroke centers, or
- (3) Comprehensive stroke centers; and
- ii. Participate in quality improvement activities, including the submission of data on stroke care provided by the emergency receiving facility that may be compiled on a statewide basis;
- e. Capability of an emergency receiving facility that is not a primary stroke center or comprehensive stroke center to stabilize a stroke patient before initiating a transfer to a primary stroke center or comprehensive stroke center;
- f. Capability of an emergency receiving facility that is not a primary stroke center or comprehensive stroke center to stabilize and admit a stroke patient; and
- g. Distance and duration of transport;
4. Are consistent with national stroke care standards; and
5. Are based on data on stroke care from:
  - a. National organizations that focus on heart disease and stroke;
  - b. U.S. Department of Transportation, National Highway Traffic Safety Administration; and
  - c. Statewide data on stroke care, as available.

- C. The council shall review and update, as necessary, the emergency stroke care protocols in subsection (A) after seeking input from:
  1. Local EMS coordinating systems,
  2. National organizations that focus on heart disease and stroke,
  3. Nonprofit organizations that focus on the development of stroke systems of care,
  4. Emergency medical services providers, and
  5. Health care providers.

**Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). New Section made by exempt rulemaking at 19 A.A.R. 643, effective April 5, 2013 (Supp. 13-1). Amended by final rulemaking at 23 A.A.R. 1728, effective July 1, 2017 (Supp. 17-2).

**R9-25-603. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-604. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-605. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-606. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective

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January 3, 2004 (Supp. 03-4).

2004 (Supp. 03-4).

**R9-25-607. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-608. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-609. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit R. Repealed****Historical Note**

Exhibit R adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-610. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-611. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-612. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-613. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-614. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**R9-25-615. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3,

**R9-25-616. Repealed****Historical Note**

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit S. Repealed****Historical Note**

Exhibit S adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit G. Repealed****Historical Note**

Exhibit G adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit L. Repealed****Historical Note**

Exhibit L adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit M. Repealed****Historical Note**

Exhibit M adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit N. Repealed****Historical Note**

Exhibit N adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit O. Repealed****Historical Note**

Exhibit O adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**Exhibit Q. Repealed****Historical Note**

Exhibit Q adopted effective October 15, 1996 (Supp. 96-4). Exhibit repealed by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

**ARTICLE 7. AIR AMBULANCE SERVICE LICENSING****R9-25-701. Definitions (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2215)**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article and in Article 8 of this Chapter, unless otherwise specified:

1. "Air ambulance" means an aircraft that is an "ambulance" as defined in A.R.S. § 36-2201.
2. "Air ambulance service" means an ambulance service that uses an air ambulance.
3. "Application packet" means the information, applicable fees, and documents required by the Department when making a decision for:



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- a. Licensing an air ambulance service, or
- b. Issuing a certificate of registration for an air ambulance.
4. "Base location" means a physical location at which a person houses an air ambulance or equipment and supplies used for the operation of an air ambulance service or provides administrative or other support for the operation of an air ambulance service.
5. "CAMTS" means the Commission on Accreditation of Medical Transport Systems, formerly known as the Commission on Accreditation of Air Medical Services.
6. "Certificate holder" means a person who holds a current and valid certificate of registration for an air ambulance.
7. "Change of ownership" means a transfer of controlling legal or controlling equitable interest and authority in an air ambulance service.
8. "Critical care" means pertaining to a patient who has an illness or injury acutely impairing one or more organ systems, such that the conditions are life-threatening and require constant monitoring to avoid deterioration of the patient's condition.
9. "Estimated time of arrival" means the number of minutes from the time that an air ambulance service agrees to perform a mission to the time that an air ambulance arrives at the scene.
10. "Interfacility" means between two health care institutions.
11. "Interfacility maternal transport" means an interfacility transport of a woman:
  - a. Whose pregnancy is considered by a physician to be high risk,
  - b. Who is in need of critical care services related to the pregnancy, and
  - c. Who is being transferred to a medical facility that has the specialized perinatal and neonatal resources and capabilities necessary to provide an appropriate level of care.
12. "Interfacility neonatal transport" means an interfacility transport of an infant who is 28 days of age or younger and who is in need of critical care services.
13. "Licensed respiratory care practitioner" has the same meaning as in A.R.S. § 32-3501.
14. "Licensee" means a person who holds a current and valid license from the Department to operate an air ambulance service.
15. "Medical team" means personnel whose main function on a mission is the medical care of the patient being transported.
16. "Mission" means a transport event that involves an air ambulance service's sending an air ambulance to a patient's location to provide transport of the patient from one location to another, whether or not transport of the patient is actually provided.
17. "Mission level" means critical care services or ALS services, based on the staffing and the services provided by the air ambulance service.
18. "Mission type" means an emergency medical services transport, interfacility transport, interfacility maternal transport, or interfacility neonatal transport provided by an air ambulance service.
19. "On-line medical guidance" means emergency medical services direction or information provided to a non-EMCT medical team member by a physician through two-way voice communication.
20. "Operate an air ambulance service" means to use an air ambulance:
  - a. To transport a patient from a location in this state to another location in this state,
  - b. From a base location in this state, or
  - c. To transport a patient from a location in this state to a location outside of this state more than once per month.
21. "Owner" means a person that holds a controlling legal or equitable interest and authority in a business organization.
22. "Personnel" means individuals who work for an air ambulance service, with or without compensation, whether as employees, contractors, or volunteers.
23. "Premises" means each physical location of air ambulance service operations and includes all equipment and records at each location.
24. "Proficiency in neonatal resuscitation" means current and valid certification in neonatal resuscitation obtained through completing a nationally recognized training program such as the American Academy of Pediatrics and American Heart Association NRP: Neonatal Resuscitation Program.
25. "Regularly" means at recurring, fixed, or uniform intervals.
26. "Subspecialization" means:
  - a. For a physician board certified by a specialty board approved by the American Board of Medical Specialties, subspecialty certification;
  - b. For a physician board certified by a specialty board approved by the American Osteopathic Association, attainment of either a certification of special qualifications or a certification of added qualifications; and
  - c. For a physician who has completed an accredited residency program, completion of at least one year of training pertaining to the specified area of medicine.
27. "Two-way voice communication" means that two individuals are able to convey information back and forth to each other orally, either directly or through a third-party relay.
28. "Valid" means that a license, certification, or other form of authorization is in full force and effect and not suspended.
29. "Working day" means the period between 8:00 a.m. and 5:00 p.m. on a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-702. Applicability (A.R.S. §§ 36-2202(A)(4) and 36-2217)**

This Article and Article 8 of this Chapter do not apply to persons and vehicles exempted from the provisions of A.R.S. Title 36, Chapter 21.1 as provided in A.R.S. § 36-2217(A).

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656,

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effective April 8, 2006 (Supp. 06-1).

**R9-25-703. Requirement and Eligibility for a License (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2215)**

- A. A person shall not operate an air ambulance service in this state unless the person has a current and valid air ambulance service license and, except as provided in A.R.S. § 36-2212(C), a current and valid certificate of registration for an air ambulance as required under Article 8 of this Chapter.
- B. To be eligible to obtain an air ambulance service license, an applicant shall:
  - 1. Have applied for a certificate of registration, issued by the Department under Article 8 of this Chapter, for each aircraft to be used as an air ambulance by the air ambulance service;
  - 2. Possess a copy of a current and valid registration, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4, for each aircraft to be used as an air ambulance by the air ambulance service;
  - 3. Have current and valid liability insurance coverage for the air ambulance service that complies with A.R.S. § 36-2215 and that has at least the following liability limits:
    - a. \$1 million for injuries to or death of any one person arising out of any one incident or accident;
    - b. \$3 million for injuries to or death of more than one person in any one incident or accident; and
    - c. \$500,000 for damage to property arising from any one incident or accident;
  - 4. Have current and valid malpractice insurance coverage for the air ambulance service that complies with A.R.S. § 36-2215 and that has a maximum liability limit of at least \$1 million per occurrence; and
  - 5. Comply with all applicable requirements of this Article, Articles 2 and 8 of this Chapter, and A.R.S. Title 36, Chapter 21.1.
- C. To maintain eligibility for an air ambulance service license, a licensee shall meet the requirements of subsections (B)(2) through (5) and hold a current and valid certificate of registration, issued by the Department under Article 8 of this Chapter, for each aircraft used as an air ambulance in Arizona by the air ambulance service.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-704. Application and Licensing Process (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2213, 36-2214, and 36-2215)**

- A. An applicant for an initial license shall submit an application packet to the Department, including:
  - 1. The following information in a Department-provided format:
    - a. The applicant's name; mailing address; email address; fax number, if any; and telephone number;
    - b. The names of all other business organizations operated by the applicant related to the air ambulance service;
    - c. The physical and mailing addresses to be used for the air ambulance service, if different from the applicant's mailing address;

- d. The name, title, address, email address, and telephone number of the applicant's statutory agent or the individual designated by the applicant to accept service of process and subpoenas for the air ambulance service;
  - e. The name, title, address, email address, and telephone number of the individual acting on behalf of the applicant according to R9-25-102;
  - f. If the applicant is a business organization:
    - i. The type of business organization; and
    - ii. The name; address; email address; telephone number; and fax number, if any, of the individual who is to serve as the primary contact for information regarding the application;
  - g. The name and Arizona license number for the physician who is to serve as the administrative medical director for the air ambulance service;
  - h. The intended hours of operation for the air ambulance service;
  - i. The intended schedule of rates for the air ambulance service;
  - j. Which of the following mission types is to be provided:
    - i. Emergency medical services transports,
    - ii. Interfacility transports,
    - iii. Interfacility maternal transports, or
    - iv. Interfacility neonatal transports;
  - k. Which of the following mission levels is to be provided:
    - i. Critical care, or
    - ii. Advanced life support;
  - l. Whether the applicant plans to use fixed-wing or rotor-wing aircraft for the air ambulance service;
  - m. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
  - n. Attestation that the applicant will comply with all applicable requirements in this Article, Articles 2 and 8 of this Chapter, and A.R.S. Title 36, Chapter 21.1;
  - o. Attestation that the information provided in the application packet, including the information in the accompanying documents, is accurate and complete; and
  - p. The signature of the applicant and the date signed;
- 2. Documentation for the individual specified according to subsection (A)(1)(e) that complies with A.R.S. § 41-1080;
  - 3. A copy of the business organization's articles of incorporation, articles of organization, or partnership documents, if applicable;
  - 4. For each aircraft to be used as an air ambulance by the air ambulance service:
    - a. An application for registration that includes all of the information and documents required under R9-25-801(B); and
    - b. A copy of a current and valid registration, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4;
  - 5. A certificate of insurance establishing that the applicant has current and valid liability insurance coverage for the air ambulance service as required under R9-25-703(B)(3);

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6. A certificate of insurance establishing that the applicant has current and valid malpractice insurance coverage for the air ambulance service as required under R9-25-703(B)(4);
  7. A list of each entity that or physician who is to provide on-line medical direction to EMCTs of the air ambulance service, including:
    - a. For each entity, such as an ALS base hospital, centralized medical direction communications center, or physician group practice, the name, mailing address, email address, and telephone number of the entity; or
    - b. For each physician who is to provide on-line medical direction, the name, professional license number, mailing address, email address, and telephone number for the physician; and
  8. If the applicant holds current CAMTS accreditation for the air ambulance service, a copy of the current CAMTS accreditation report.
- B.** No more than 30 days before the expiration date of the current license, a licensee shall submit to the Department a renewal application packet including:
1. The information required in subsection (A)(1), in a Department-provided format;
  2. The documents required in subsections (A)(5), (6), (7), and, if applicable, (8); and
  3. For each aircraft used or to be used as an air ambulance by the air ambulance service:
    - a. Either:
      - i. A copy of a current and valid certificate of registration issued by the Department under Article 8 of this Chapter, or
      - ii. An application packet for registration that includes all of the information and documents required under R9-25-801(B); and
    - b. A copy of a current and valid registration, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4.
- C.** Unless an applicant or licensee documents current CAMTS accreditation, as provided in subsection (A)(8), or is applying for an initial license because of a change of ownership as described in R9-25-710(D), the Department shall conduct an inspection, as required under A.R.S. § 36-2214(B) and R9-25-711, during the substantive review period for the application for a license.
- D.** The Department shall review each application packet as described in Article 12 of this Chapter, and:
1. Approve the application;
  2. Approve the application with a corrective action plan, as specified in R9-25-711(G)(2); or
  3. Deny the application.
- E.** The Department may deny an application if an applicant or licensee:
1. Fails to meet the eligibility requirements of R9-25-703(B);
  2. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
  3. Fails or has failed to comply with any provision in this Article or Article 2 or 8 of this Chapter;
  4. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
  5. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-705. Minimum Standards for Operations as an Air Ambulance Service (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), and 36-2213)**

- A.** A licensee shall ensure that the air ambulance service:
1. Maintains eligibility for licensure as required under R9-25-703(C);
  2. Makes a good faith effort to communicate information about its hours of operation to the general public through print media, broadcast media, the Internet, or other means;
  3. Makes the air ambulance service's schedule of rates available to any individual upon request and, if requested, in writing;
  4. Provides an accurate estimated time of arrival to the person requesting transport at the time that transport is requested and provides an amended estimated time of arrival to the person requesting transport if the estimated time of arrival changes;
  5. Except as provided in subsection (B), only transports patients for whom the air ambulance service has the resources to provide appropriate medical care;
  6. Does not perform interfacility transport of a patient unless:
    - a. The transport is initiated by the sending health care institution, and
    - b. The destination health care institution confirms that a bed is available for the patient;
  7. Ensures that the protocol for the transfer of information to be communicated to emergency receiving facility staff concurrent with the transfer of care, required in R9-25-201(E)(2)(d)(i), includes:
    - a. The date and time the call requesting service was received by the air ambulance service;
    - b. The unique number used by the air ambulance service to identify the mission;
    - c. The name of the air ambulance service;
    - d. The number or other identifier of the air ambulance used for the mission;
    - e. The following information about the patient:
      - i. The patient's name;
      - ii. The patient's date of birth or age, as available;
      - iii. The principal reason for requesting services for the patient;
      - iv. The patient's medical history, including any chronic medical illnesses, known allergies to medications, and medications currently being taken by the patient;
      - v. The patient's level of consciousness at initial contact and when reassessed;
      - vi. The patient's pulse rate, respiratory rate, oxygen saturation, and systolic blood pressure at initial contact and when reassessed;
      - vii. The results of an electrocardiograph, if available;

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- viii. The patient's glucose level at initial contact and when reassessed, if applicable;
  - ix. The patient's level of responsiveness score, as applicable, at initial contact and when reassessed;
  - x. The results of the patient's neurological assessment, if applicable; and
  - xi. The patient's pain level at initial contact and when reassessed; and
- f. Any procedures or other treatment provided to the patient at the scene or during transport, including any agents administered to the patient;
- 8. Creates a prehospital incident history report, in a Department-provided format, for each patient that includes the following information:
  - a. The name and identification number of the air ambulance service;
  - b. Information about the software for the storage and submission of the prehospital incident history report;
  - c. The unique number assigned to the mission;
  - d. The unique number assigned to the patient;
  - e. Information about the response to the call requesting service, including:
    - i. The mission level requested;
    - ii. Information obtained by the person providing direction for response to the request;
    - iii. Information about the air ambulance assigned to the mission;
    - iv. Information about the medical team responding to the call requesting service;
    - v. The priority assigned to the response; and
    - vi. Response delays, as applicable;
  - f. Whether patient care was transferred from another EMS provider or ambulance service and, if so, identification of the EMS provider or ambulance service;
  - g. The date and time that:
    - i. The call requesting service was received;
    - ii. The request was received by the person coordinating transport;
    - iii. The air ambulance service received the transport request;
    - iv. The air ambulance left for the patient's location;
    - v. The air ambulance arrived at the patient's location;
    - vi. The medical team in the air ambulance arrived at the patient's side;
    - vii. Transfer of the patient's care occurred at a location other than the destination, if applicable;
    - viii. The air ambulance departed the patient's location;
    - ix. The air ambulance arrived at the destination;
    - x. Transfer of the patient's care occurred at the destination;
    - xi. The air ambulance was available to take another mission;
  - h. Information about the patient, including:
    - i. The patient's first and last name;
    - ii. The address of the patient's residence;
    - iii. The county of the patient's residence;
    - iv. The country of the patient's residence;
    - v. The patient's gender, race, ethnicity, and age;
    - vi. The patient's estimated weight;
    - vii. The patient's date of birth; and
  - viii. If the patient has an alternate residence, the address of the alternate residence;
  - i. The primary method of payment for services and anticipated level of payment;
  - j. Information about the scene, including:
    - i. Specific information about the location of the scene;
    - ii. Whether the air ambulance was first on the scene;
    - iii. The number of patients at the scene;
    - iv. Whether the scene was the location of a mass casualty incident; and
    - v. If the scene was the location of a mass casualty incident, triage information;
  - k. Information about the reason for requesting service for the patient, including:
    - i. The date and time of onset of symptoms and when the patient was last well;
    - ii. Information about the complaint;
    - iii. The patient's symptoms;
    - iv. The results of the medical team's initial assessment of the patient;
    - v. If the patient was injured, information about the injury and the cause of the injury;
    - vi. If the patient experienced a cardiac arrest, information about the etiology of the cardiac arrest and subsequent treatment provided; and
    - vii. For an interfacility transport, the reason for the transport;
  - l. Information about any specific barriers to providing care to the patient;
  - m. Information about the patient's medical history, including:
    - i. Known allergies to medications,
    - ii. Surgical history,
    - iii. Current medications, and
    - iv. Alcohol or drug use;
  - n. Information about the patient's current medical condition, including the information in subsections (A)(7)(e)(v) through (xi) and the time and method of assessment;
  - o. Information about agents administered to the patient, including the dose and route of administration, time of administration, and the patient's response to the agent;
  - p. If not specifically included under subsection (A)(8)(k), (m)(iv), (n), or (o), the information required in A.A.C. R9-4-602(A);
  - q. Information about any procedures performed on the patient and the patient's response to the procedure;
  - r. Whether the patient was transported and, if so, information about the transport;
  - s. Information about the destination of the transport, including the reason for choosing the destination;
  - t. Whether patient care was transferred to another EMS provider or ambulance service and, if so, identification of the EMS provider or ambulance service;
  - u. Unless patient care was transferred to another EMS provider or ambulance service, information about:
    - i. Whether the destination facility was notified that the patient being transported has a time-sensitive condition and the time of notification;
    - ii. The disposition of the patient at the destination; and

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- iii. The disposition of the mission;
    - v. Any other narrative information about the patient, care receive by the patient, or transport; and
    - w. The name and certification level of the medical team member providing the information;
  - 9. Creates a record for each mission that includes:
    - a. Mission date;
    - b. Mission level;
    - c. Mission type;
    - d. Staffing of the mission;
    - e. Aircraft type—fixed-wing aircraft or rotor-wing aircraft;
    - f. Name of the person requesting the transport;
    - g. Time of receipt of the transport request;
    - h. The estimated time of arrival, as provided according to subsection (A)(4);
    - i. Departure time to the patient's location;
    - j. Address of the patient's location;
    - k. Arrival time at the patient's location;
    - l. Departure time to the destination health care institution;
    - m. Name and address of the destination health care institution;
    - n. Arrival time at the destination health care institution;
    - o. Either the:
      - i. Unique reference number used by the air ambulance service to identify the patient, or
      - ii. Unique call number used by the air ambulance service to identify the specific mission; and
    - p. Aircraft tail number for the air ambulance used on the mission;
  - 10. Establishes, documents, and, if necessary, implements a plan to address and minimize potential issues of patient health and safety due to the air ambulance service terminating operations at a physical address used for the air ambulance service that:
    - a. Is developed in conjunction with hospitals near the physical address used for the air ambulance service and other persons who may be adversely affected by the air ambulance service terminating operations;
    - b. Includes notification by the air ambulance service of the persons in subsection (A)(10)(a) of the intent to terminate operations, at least 30 calendar days before the termination of operations; and
    - c. Includes temporary measures that will be used until alternate methods may be arranged for patient transport that address patient health and safety;
  - 11. Establishes, documents, and implements a quality improvement program, as specified in policies and procedures, through which:
    - a. Data related to initial patient assessment, patient care, transport services provided, and patient status upon arrival at the destination are:
      - i. Collected continuously;
      - ii. For the information required in subsection (A)(8), submitted to the Department, in a Department-provided format and within 48 hours after the date of a mission, for quality improvement purposes; and
      - iii. If the air ambulance service is notified that the submission of information to the Department according to subsection (A)(11)(a)(ii) was unsuccessful, corrected and resubmitted within seven days after notification;
    - b. Continuous quality improvement processes are developed to identify, document, and evaluate issues related to the provision of services, including:
      - i. Care provided to patients with time-sensitive conditions;
      - ii. Transport or documentation, and
      - iii. Patient status upon arrival at the destination;
    - c. A committee consisting of the administrative medical director, the individual managing the air ambulance service or designee, and other employees as appropriate:
      - i. Review the data in subsection (A)(11)(a) and any issues identified in subsection (A)(11)(b) on at least a quarterly basis; and
      - ii. Implement activities to improve performance when deviations in patient care, transport, or documentation are identified; and
    - d. The activities in subsection (A)(11)(c) are documented, consistent with A.R.S. §§ 36-2401, 36-2402, and 36-2403; and
  - 12. Beginning within 12 months after the effective date of this Section, establish and maintain a method to electronically document patient information and treatment that is capable of being transferred.
- B.** An air ambulance service may transport a patient for whom the air ambulance does not have the resources to provide appropriate medical care:
- 1. In a rescue situation in which:
    - a. An individual's life, limb, or health is imminently threatened;
    - b. The threat may be reduced or eliminated by removing the individual from the situation to a location in which medical services may be provided; and
    - c. There is no other practical means of transport, including another air ambulance service, available; or
  - 2. For an interfacility transport of a patient if:
    - a. The sending health care institution provides medically appropriate life support measures, staff, and equipment to sustain the patient during the interfacility transport; and
    - b. Each staff member provided by the sending health care institution has completed training in the subject areas listed in R9-25-707(A) before participating in the interfacility transport.
- C.** If an air ambulance service completes a mission under subsection (B) for which the air ambulance service does not have the resources to provide appropriate medical care, the licensee shall ensure that the air ambulance service creates a record within five working days after the mission, including:
- 1. The information required under subsection (A)(8),
  - 2. The manner in which the air ambulance service deviated from subsection (A)(5), and
  - 3. The justification for operating under subsection (B).
- D.** If an air ambulance service uses a single-member medical team as authorized under R9-25-706(B) and (C), the licensee shall ensure that the air ambulance service creates a record within five working days after the mission, including:
- 1. The information required under subsection (A)(9),
  - 2. The name and qualifications of the individual comprising the single-member medical team, and
  - 3. The justification for using a single-member medical team.

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- E.** If an air ambulance service completes a critical care interfacility transport mission under conditions permitted in R9-25-802(F), the licensee shall ensure that the air ambulance service creates a record within five working days after the mission, including:
1. The information required under subsection (A)(9),
  2. A description of the life-support equipment used on the mission,
  3. A list of the equipment and supplies required in R9-25-802(C) that were removed from the air ambulance for the mission, and
  4. The justification for conducting the mission as permitted under R9-25-802(F).
- F.** A licensee shall ensure that an individual does not serve on the medical team for an interfacility maternal transport unless the air ambulance service's medical director has verified and attested in writing to the individual's having the proficiencies described in R9-25-706(A)(2).
- G.** A licensee shall ensure that an individual does not serve on the medical team for an interfacility neonatal transport unless the air ambulance service's medical director has verified and attested in writing to the individual's having the proficiencies described in R9-25-706(A)(3).
- H.** A licensee shall ensure that the air ambulance service:
1. Retains each document required to be created or maintained under this Article or Article 2 or 8 of this Chapter for at least three years after the last event recorded in the document, and
  2. Produces each document for Department review upon request.
- I.** A licensee shall ensure that, while on a mission, two-way voice communication is available:
1. Between and among personnel on the air ambulance, including the pilot; and
  2. Between personnel on the air ambulance and the following persons on the ground:
    - a. Personnel;
    - b. Physicians providing on-line medical direction or on-line medical guidance to medical team members; and
    - c. For a rotor-wing air ambulance mission:
      - i. Emergency medical services providers, and
      - ii. Law enforcement agencies.
- ii. Another physician, another registered nurse, a Paramedic, or a licensed respiratory care practitioner; and
- b. For a critical care mission that is an emergency medical services transport:
    - i. A physician or registered nurse; and
    - ii. A Paramedic or another registered nurse;
2. Each interfacility maternal transport mission is staffed by a medical team that:
    - a. Complies with the requirements for a critical care mission medical team in subsection (A)(1); and
    - b. Has the following additional qualifications:
      - i. Proficiency in advanced emergency cardiac life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association;
      - ii. Proficiency in neonatal resuscitation; and
      - iii. Proficiency in stabilization and transport of the pregnant patient;
  3. Each interfacility neonatal transport mission is staffed by a medical team that:
    - a. Complies with the requirements for a critical care mission medical team in subsection (A)(1); and
    - b. Has the following additional qualifications:
      - i. Proficiency in pediatric advanced emergency life support that includes didactic instruction and a practical skills test, consistent with training recognized by the American Heart Association; and
      - ii. Proficiency in neonatal resuscitation and stabilization of the neonatal patient; and
  4. Each advanced life support mission is staffed by a medical team of at least two individuals with the following qualifications:
    - a. For an advanced life support mission that is an emergency medical services transport:
      - i. A physician, registered nurse, or Paramedic; and
      - ii. Another Paramedic or another registered nurse;
    - b. For an advanced life support interfacility transport mission:
      - i. A physician, registered nurse, or Paramedic; and
      - ii. Another Paramedic, a licensed respiratory care practitioner, or another registered nurse.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-705 repealed; new Section R9-25-705 renumbered from R9-25-710 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-706. Minimum Standards for Mission Staffing (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), and 36-2213)**

- A.** A licensee shall ensure that, except as provided in subsection (B):
1. Each critical care mission is staffed by a medical team of at least two individuals with the following qualifications:
    - a. For a critical care interfacility transport mission:
      - i. A physician or registered nurse; and
- B.** If the pilot on a mission using a rotor-wing air ambulance determines, in accordance with the air ambulance service's written guidelines required under subsection (C)(1), that the weight of a second medical team member could potentially compromise the performance of the rotor-wing air ambulance and the safety of the mission, and the use of a single-member medical team is consistent with the on-line medical direction or on-line medical guidance received as required under subsection (C)(2), an air ambulance service may use a single-member medical team consisting of an individual with the following qualification:
1. For a critical care mission, a physician or registered nurse; and
  2. For an advanced life support mission, a physician, registered nurse, or Paramedic.
- C.** A licensee shall ensure that:
1. Each air ambulance service rotor-wing pilot is provided with written guidelines to use in determining when the weight of a second medical team member could poten-

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tially compromise the performance of a rotor-wing air ambulance and the safety of a mission, including the conditions of density altitude and weight that warrant the use of a single-member medical team;

2. The following are done, without delay, after an air ambulance service rotor-wing pilot determines that the weight of a second medical team member could potentially compromise the performance of a rotor-wing air ambulance and the safety of a mission:
  - a. The pilot communicates that information to the medical team,
  - b. The medical team obtains on-line medical direction or on-line medical guidance regarding the use of a single-member medical team, and
  - c. The medical team proceeds in compliance with the on-line medical direction or on-line medical guidance;
3. A single-member medical team has the knowledge and medical equipment to perform one-person cardiopulmonary resuscitation;
4. The patient care provided by each single-member medical team, including consideration of each patient's status upon arrival at the destination health care institution, is reviewed through the quality improvement processes in R9-25-705(A)(11)(b) and (c); and
5. A single-member medical team is used only when no other transport team is available that would be more appropriate for delivering the level of care that a patient requires.

- D. A licensee shall ensure that the air ambulance service creates and maintains for each personnel member a file containing documentation of the personnel member's qualifications, including, as applicable, licenses, certifications, and training records.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-706 renumbered to R9-25-710; new Section R9-25-706 renumbered from R9-25-711 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by exempt rulemaking at 28 A.A.R. 3681 (December 2, 2022), with an immediate effective date of November 8, 2022 (Supp. 22-4).

**R9-25-707. Minimum Standards for Training (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2213)**

- A. A licensee shall ensure that each medical team member completes training in the following subjects before serving on a mission:
  1. Aviation terminology;
  2. Physiological aspects of flight;
  3. Patient loading and unloading;
  4. Safety in and around the aircraft;
  5. In-flight communications;
  6. Use, removal, replacement, and storage of the medical equipment installed on the aircraft;
  7. In-flight emergency procedures;
  8. Emergency landing procedures; and
  9. Emergency evacuation procedures.
- B. A licensee shall ensure that the air ambulance service documents each medical team member's completion of the training required under subsection (A), including the name of the medical team member, each training component completed, and the date of completion.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-707 renumbered to R9-25-709; new Section R9-25-707 renumbered from R9-25-713 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-708. Minimum Standards for Medical Control (Authorized by A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), and 36-2213)**

- A. A licensee shall ensure that:
  1. The air ambulance service has an administrative medical director who:
    - a. Meets the qualifications in subsection (B);
    - b. Supervises and evaluates the quality of medical care provided by medical team members;
    - c. Ensures the competency and current qualifications of all medical team members;
    - d. Except as provided in subsections (A)(3) and (4), ensures that:
      - i. Each EMCT medical team member receives medical direction as required under Article 2 of this Chapter; and
      - ii. Each non-EMCT medical team member receives medical guidance through written treatment protocols and according to subsection (C); and
    - e. Approves, ensures implementation of, and annually reviews treatment protocols to be followed by medical team members;
  2. The administrative medical director reviews data related to patient care and transport services provided, documentation, and patient status upon arrival at destination that are collected through the quality management program in R9-25-705(A)(11);
  3. For an interfacility maternal transport mission, on-line medical direction or on-line medical guidance provided to medical team member is provided by a physician who meets the qualifications of subsection (B)(2)(b)(i);
  4. For an interfacility neonatal transport mission, on-line medical direction or on-line medical guidance provided to medical team member is provided by a physician who meets the qualifications of subsection (B)(2)(b)(ii);
- B. An administrative medical director shall:
  1. Be a physician; and
  2. Comply with one of the following:
    - a. If the air ambulance service provides emergency medical services transports, meet the qualifications of R9-25-201(A)(1); or
    - b. If the air ambulance service does not provide emergency medical services transports, meet the qualifications of R9-25-201(A)(1) or one of the following:
      - i. If the air ambulance service provides interfacility maternal transport missions, have board certification or have completed an accredited residency program in one of the following specialty areas:
        - (1) Obstetrics and gynecology, with subspecialization in critical care medicine or maternal and fetal medicine; or
        - (2) Pediatrics, with subspecialization in neonatal-perinatal medicine;
      - ii. If the air ambulance service provides interfacility neonatal transport missions, have board cer-

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tification or have completed an accredited residency program in one of the following specialization areas:

- (1) Obstetrics and gynecology, with subspecialization in maternal and fetal medicine; or
  - (2) Pediatrics, with subspecialization in neonatal-perinatal medicine, neonatology, pediatric critical care medicine, or pediatric intensive care; or
- iii. If neither subsection (B)(2)(b)(i) or (ii) applies, have board certification or have completed an accredited residency program in one of the following specialty areas:
- (1) Anesthesiology, with subspecialization in critical care medicine;
  - (2) Internal medicine, with subspecialization in critical care medicine;
  - (3) If the air ambulance service transports only pediatric patients, pediatrics, with subspecialization in pediatric critical care medicine or pediatric emergency medicine; or
  - (4) If the air ambulance service transports only surgical patients, surgery, with subspecialization in surgical critical care.
- C. An administrative medical director shall ensure that each non-EMCT medical team member receives on-line medical guidance provided by:
1. The administrative medical director;
  2. Another physician designated by the administrative medical director; or
  3. If the medical guidance needed exceeds the administrative medical director's area of expertise, a consulting specialty physician.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-708 renumbered to R9-25-711; new Section R9-25-708 renumbered from R9-25-715 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-709. Changes Affecting a License (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2213)**

- A. At least 30 days before the date of a change in an air ambulance service's name, the licensee shall send the Department written notice of the name change.
- B. At least 90 days before an air ambulance service ceases to operate, the licensee shall send the Department written notice of the intention to cease operating, effective on a specific date, and the licensee's intention to relinquish the air ambulance service's license as of that date.
- C. Within 30 days after the date of receipt of a notice described in subsection (A) or (B), the Department shall:
  1. For a notice described in subsection (A), issue an amended license that incorporates the name change but retains the expiration date of the current license; and
  2. For a notice described in subsection (B), send the licensee written confirmation of the voluntary relinquishment of the air ambulance service's license, with an effective date consistent with the written notice.
- D. A licensee shall notify the Department in writing at least 30 calendar days before:

1. Changing the physical address used for the air ambulance service, as provided according to R9-25-704(A)(1)(c); or
  2. Terminating operations at a physical address used for the air ambulance service, as provided according to R9-25-704(A)(1)(c).
- E. A licensee shall notify the Department in writing within one working day after:
1. A change in the air ambulance service's eligibility for licensure under R9-25-703(B) or (C);
  2. A change in the business organization information most recently submitted to the Department according to R9-25-704(A)(1)(f);
  3. A change in the air ambulance service's CAMTS accreditation status, including a copy of the air ambulance service's new CAMTS accreditation report, if applicable;
  4. A change in the air ambulance service's hours of operation, as specified according to R9-25-704(A)(1)(h);
  5. A change in the air ambulance service's schedule of rates, as specified according to R9-25-704(A)(1)(i); or
  6. A change in the mission types provided, as specified according to R9-25-704(A)(1)(j).
- F. If the Department receives a notice specified in subsection (E)(6), the Department:
1. Shall reissue a license for the air ambulance service reflecting the change, but retaining the expiration date on the original license; and
  2. May conduct an inspection according to R9-25-711.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-709 renumbered to R9-25-712; new Section R9-25-709 renumbered from R9-25-707 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-710. Term and Transferability of License (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), 36-2213, 36-2214, and 41-1092.11)**

- A. The Department shall issue an initial license:
  1. When based on current CAMTS accreditation, with a term beginning on the date of issuance of the initial license and ending on the expiration date of the CAMTS accreditation upon which licensure is based; and
  2. When based on Department inspection, with a term beginning on the date of issuance of the initial license and ending three years later.
- B. The Department shall issue a renewal license with a term beginning on the day after the expiration date shown on the previous license and ending:
  1. When based on current CAMTS accreditation, on the expiration date of the CAMTS accreditation upon which licensure is based; and
  2. When based on Department inspection, three years after the effective date of the renewal license.
- C. If a licensee submits an application packet for renewal as described in R9-25-704(B), the current license does not expire until the Department has made a final determination on the application for renewal, as provided in A.R.S. § 41-1092.11.
- D. At least 30 days before an anticipated change of ownership:
  1. A licensee wanting to transfer an air ambulance service license shall submit a letter to the Department that contains:
    - a. A request that the air ambulance service license be transferred,



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- b. The name and license number of the currently licensed air ambulance service, and
  - c. The name of the person to whom the air ambulance service license is to be transferred; and
- 2. The person to whom the license is to be transferred shall submit to the Department an application packet that complies with R9-25-704(A).
- E. A new owner shall not operate an air ambulance service in this state until:
  - 1. The new owner complies with requirements in Articles 7 and 8 of this Chapter, and
  - 2. The Department has issued an air ambulance service license to the new owner.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). R9-25-710 renumbered to R9-25-705; new Section R9-25-710 renumbered from R9-25-706 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-711. Inspections and Investigations (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), 36-2213, 36-2214, 36-2215, 41-1092.03, and 41-1092.11(B))**

- A. Except as provided in subsections (D) and (E), the Department shall inspect an air ambulance service, as required under A.R.S. § 36-2214(B), before issuing an initial or renewal license and as necessary to determine compliance with this Article, Articles 2 and 8 of this Chapter, and A.R.S. Title 36, Chapter 21.1.
- B. A Department inspection may include the air ambulance service's premises, records, and equipment, and each air ambulance used by the air ambulance service.
- C. If the Department receives written or verbal information alleging a violation of this Article, Article 2 or 8 of this Chapter, or A.R.S. Title 36, Chapter 21.1, the Department shall conduct an investigation.
  - 1. The Department may conduct an inspection as part of an investigation.
  - 2. A licensee shall allow the Department to inspect the air ambulance service's premises, records, and equipment, and each air ambulance and to interview personnel as part of an investigation.
- D. Except as provided in subsection (C), the Department shall not conduct an inspection of an air ambulance service before issuing an initial or renewal license if an applicant or licensee provides documentation of current CAMTS certification as part of the application packet according to R9-25-704(A)(8).
- E. When an application for an air ambulance service license is submitted along with a transfer request due to a change of ownership, the Department shall determine whether an inspection is necessary based upon the potential impact to public health, safety, and welfare.
- F. The Department shall conduct each inspection in compliance with A.R.S. § 41-1009.
- G. If the Department determines that an air ambulance service is not in compliance with the requirements in this Article, Article 2 or 8 of this Chapter, or A.R.S. Title 36, Chapter 21.1, the Department may:
  - 1. Take an enforcement action as described in R9-25-712; or
  - 2. Require that the air ambulance service submit to the Department, within 15 days after written notice from the Department, a corrective action plan to address issues of

compliance that do not directly affect the health or safety of a patient that:

- a. Describes how each identified instance of non-compliance will be corrected and reoccurrence prevented, and
- b. Includes a date for correcting each instance of non-compliance that is appropriate to the actions necessary to correct the instance of non-compliance.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). R9-25-711 renumbered to R9-25-706; new Section R9-25-711 renumbered from R9-25-708 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-712. Enforcement Actions (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), 36-2213, 36-2214, 36-2215, 41-1092.03, and 41-1092.11(B))**

- A. The Department may take an action listed in subsection (B) against an air ambulance service that:
  - 1. Fails to meet the eligibility requirements of R9-25-703;
  - 2. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
  - 3. Fails or has failed to comply with any provision in this Article or Article 2 or 8 of this Chapter;
  - 4. Does not submit a corrective action plan, as provided in R9-25-711(G)(2), that is acceptable to the Department;
  - 5. Does not complete a corrective action plan submitted according to R9-25-711(G)(2); or
  - 6. Knowingly or negligently provides false documentation or false or misleading information to the Department or to a patient, third-party payor, or other person billed for service.
- B. The Department may take the following actions against an air ambulance service:
  - 1. Except as provided in subsection (B)(3), after notice and an opportunity to be heard is provided under A.R.S. Title 41, Chapter 6, Article 10, suspend:
    - a. The air ambulance service license, or
    - b. The certificate of registration of an aircraft to be used as an air ambulance by the air ambulance service;
  - 2. After notice and an opportunity to be heard is provided under A.R.S. Title 41, Chapter 6, Article 10, revoke:
    - a. The air ambulance service license, or
    - b. The certificate of registration of an aircraft to be used as an air ambulance by the air ambulance service; and
  - 3. As permitted under A.R.S. § 41-1092.11(B), if the Department determines that the public health, safety, or welfare imperatively requires emergency action and incorporates a finding to that effect in the Department's order, immediately suspend:
    - a. The air ambulance service license pending proceedings for revocation or other action, or
    - b. The certificate of registration of an aircraft to be used as an air ambulance by the air ambulance service pending proceedings for revocation or other action.

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- C. In determining whether to take action under subsection (B), the Department shall consider:
1. The severity of each violation relative to public health and safety;
  2. The number of violations relative to the transport volume of the air ambulance service;
  3. The nature and circumstances of each violation;
  4. Whether each violation was corrected and, if so, the manner of correction; and
  5. The duration of each violation.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3). New Section R9-25-712 renumbered from R9-25-709 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-713. Renumbered****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-713 renumbered to R9-25-707 by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-714. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-715. Renumbered****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Section R9-25-715 renumbered to R9-25-708 by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-716. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-717. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-718. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final

rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**ARTICLE 8. AIR AMBULANCE REGISTRATION**

*Article 8, consisting of R9-25-801 through R9-25-808, recodified to Article 5 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).*

*Editor's Note: Article 8, consisting of Sections R9-25-801 through R9-25-803 and Exhibits, was recodified from A.A.C. R9-13-1501 through R9-13-1503. These recodified Sections were originally filed under an exemption from A.R.S. Title 41, Chapter 6. Refer to the historical notes in 9 A.A.C. 13 for adoption dates (Supp. 98-1).*

*Article 8, consisting of Section R9-25-805 and Exhibits 1 through 3, was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 36-2205(C). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Secretary of State's Office for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Section. Under A.R.S. § 36-2205(D) a person may petition the Director to amend an adopted protocol pursuant to A.R.S. § 41-1033 (Supp. 97-2).*

**R9-25-801. Requirement, Eligibility, and Application for an Initial or Renewal Certificate of Registration for an Air Ambulance (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, 36-2232(A)(11), and 36-2240(4))**

- A. To be eligible to obtain a certificate of registration for an air ambulance, an applicant shall:
1. Ensure that the aircraft is not currently registered with the Department by another air ambulance service;
  2. Hold a current and valid air ambulance service license issued under Article 7 of this Chapter;
  3. Possess a copy of a current and valid registration for the air ambulance, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4; and
  4. Comply with all applicable requirements of this Article, Articles 2 and 7 of this Chapter, and A.R.S. Title 36, Chapter 21.1.
- B. An applicant for an initial or renewal certificate of registration for an air ambulance shall submit an application packet to the Department, including:
1. The following information in a Department-provided format:
    - a. The applicant's name; mailing address; email address; fax number, if any; and telephone number;
    - b. The names of all other business organizations operated by the applicant related to the use of an air ambulance;
    - c. The physical address of the applicant, if different from the mailing address;
    - d. If applicable, the number of the applicant's air ambulance service license;
    - e. The name, title, address, email address, and telephone number of the individual acting on behalf of the applicant according to R9-25-102;
    - f. The name, address, telephone number, and email address of the owner of the air ambulance, if different from the applicant;

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- g. Whether the air ambulance is a fixed-wing or rotor-wing aircraft;
  - h. The number of engines on the air ambulance;
  - i. The manufacturer's name;
  - j. The model name of the air ambulance;
  - k. The year the air ambulance was manufactured;
  - l. The serial number of the air ambulance;
  - m. The tail number of the air ambulance;
  - n. The aircraft colors, including fuselage, stripe, and lettering;
  - o. A description of any insignia, monogram, or other distinguishing characteristics of the aircraft's appearance;
  - p. The address at which the air ambulance is usually based;
  - q. The address in Arizona at which the air ambulance will be available for inspection;
  - r. The name and telephone number of the individual to contact to arrange for inspection, if the inspection is preannounced;
  - s. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
  - t. Attestation that the information provided in the application packet, including the information in the accompanying documents, is accurate and complete; and
  - u. The dated signature of the applicant;
2. A copy of a current and valid registration for the air ambulance, issued by the Arizona Department of Transportation under A.R.S. Title 28, Chapter 25, Article 4; and
  3. Unless the applicant uses or intends to use the aircraft as an air ambulance only as a volunteer not-for-profit service, the following fees:
    - a. A \$50 registration fee, as required under A.R.S. § 36-2212(D); and
    - b. A \$200 annual regulatory fee, as required under A.R.S. § 36-2240(4).
- C.** The Department requires submission of a separate application and the fees in subsection (B)(3) for each air ambulance.
- D.** Except as provided in A.R.S. § 36-2232(A)(11), the Department shall inspect each air ambulance according to R9-25-805(A) and (B) to determine compliance with the provisions of A.R.S. Title 36, Chapter 21.1 and this Article:
1. Within 30 calendar days before issuing an initial certificate of registration; and
  2. At least every 12 months thereafter, before issuing a renewal certificate of registration.
- E.** The Department shall review and approve or deny each application as described in Article 12 of this Chapter.
- F.** If the Department approves the application and sends the applicant the written notice of approval, specified in R9-25-1201(C)(5), the Department shall issue the certificate of registration to the applicant:
1. For an applicant with a current and valid air ambulance service license issued under Article 7 of this Chapter, within five working days after the date on the written notice of approval; and
  2. For an applicant that does not have a current and valid air ambulance service license issued under Article 7 of this Chapter, when the air ambulance service license is issued.
- G.** The Department may deny a certificate of registration for an air ambulance if the applicant:
1. Fails to meet the eligibility requirements of subsection (A);
  2. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
  3. Fails or has failed to comply with any provision in this Article or Article 2 or 7 of this Chapter;
  4. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
  5. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).

**Historical Note**

R9-25-801 recodified from A.A.C. R9-13-1501 (Supp. 98-1). Amended by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-501 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-801 repealed; new Section R9-25-801 renumbered from R9-25-802 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**R9-25-802. Minimum Standards for an Air Ambulance (Authorized by A.R.S. §§ 36-2202(A)(3), (4), and (5); 36-2209(A)(2); and 36-2212)**

- A.** An applicant or certificate holder shall ensure that an air ambulance has:
1. A climate control system to prevent temperature extremes that would adversely affect patient care;
  2. If a fixed-wing air ambulance, pressurization capability;
  3. Interior lighting that allows for patient care and monitoring without interfering with the pilot's vision;
  4. For each place where a patient may be positioned, at least one electrical power outlet or other power source that is capable of operating all electrically powered medical equipment without compromising the operation of any electrical aircraft equipment;
  5. A back-up source of electrical power or batteries capable of operating all electrically powered life-support equipment for at least one hour;
  6. An entry that allows for patient loading and unloading without rotating a patient and stretcher more than 30 degrees about the longitudinal axis or 45 degrees about the lateral axis and without compromising the operation of monitoring systems, intravenous lines, or manual or mechanical ventilation;
  7. A configuration that allows each medical team member sufficient access to each patient to begin and maintain treatment modalities, including complete access to the patient's head and upper body for effective airway management;
  8. A configuration that allows for rapid exit of personnel and patients, without obstruction from stretchers and medical equipment;
  9. A configuration that protects the aircraft's flight controls, throttles, and communications equipment from any intentional or accidental interference from a patient or equipment and supplies;

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10. A padded interior or an interior that is clear of objects or projections in the head strike envelope;
  11. An installed self-activating emergency locator transmitter;
  12. A voice communications system that:
    - a. Is capable of air-to-ground communication, and
    - b. Allows the flight crew and medical team members to communicate with each other during flight;
  13. Interior patient compartment wall and floor coverings that are:
    - a. Free of cuts or tears,
    - b. Made from non-absorbent material,
    - c. Capable of being disinfected, and
    - d. Maintained in a sanitary manner; and
  14. If a rotor-wing air ambulance, the following:
    - a. A searchlight that:
      - i. Has a range of motion of at least 90 degrees vertically and 180 degrees horizontally,
      - ii. Is capable of illuminating a landing site, and
      - iii. Is located so that the pilot can operate the searchlight without removing the pilot's hands from the aircraft's flight controls;
    - b. Restraining devices that can be used to prevent a patient from interfering with the pilot or the aircraft's flight controls; and
    - c. A light to illuminate the tail rotor.
- B.** An applicant or certificate holder shall ensure that:
1. Except as provided in subsections (D), (E), and (F), each air ambulance has the equipment and supplies required in subsection (C) for each mission for which the air ambulance is used; and
  2. The equipment and supplies on an air ambulance are secured, stored, and maintained in a manner that prevents hazards to personnel and patients.
- C.** An applicant or certificate holder shall ensure that an air ambulance used for an advanced life support mission or critical care mission has the following equipment and supplies:
1. The following ventilation and airway equipment and supplies:
    - a. Portable and fixed suction apparatus, with wide-bore tubing, rigid pharyngeal curved suction tip, tonsillar and flexible suction catheters, 5F-14F;
    - b. Portable and fixed oxygen equipment, with variable flow regulators;
    - c. Oxygen administration equipment, including: tubing; non-rebreathing masks (adult and pediatric sizes); and nasal cannulas (adult and pediatric sizes);
    - d. Bag-valve mask, with hand-operated, self-reexpanding bag (adult size), with oxygen reservoir/accumulator; mask (adult, pediatric, infant, and neonate sizes); and valve;
    - e. Airways, oropharyngeal (adult, pediatric, and infant sizes);
    - f. Laryngoscope handle, adult and pediatric, with, if applicable, extra batteries and bulbs;
    - g. Laryngoscope blades, sizes 0, 1, and 2, straight; sizes 3 and 4, straight and curved;
    - h. Endotracheal tube cuff pressure manometer;
    - i. Endotracheal tubes, sizes 2.5-5.0 mm cuffed or uncuffed and 6.0-8.0 mm cuffed;
    - j. Stylettes for Endotracheal tubes, adult and pediatric;
    - k. Airways, nasal (adult, pediatric, and infant sizes), one each in French sizes 16 to 34;
  - l. One type of supraglottic airway device, adult and pediatric;
  - m. 10 mL straight-tip syringes;
  - n. Small volume nebulizer or nebulizers and aerosol masks, adult and pediatric;
  - o. Magill forceps, adult and pediatric;
  - p. Nasogastric tubes, sizes 5F and 8F, Salem sump sizes 14F and 18F;
  - q. End-tidal CO<sub>2</sub> detectors, quantitative;
  - r. Portable automatic ventilator with positive end expiratory pressure; and
  - s. In-line viral/bacterial filter;
2. The following monitoring and defibrillation equipment and supplies:
- a. Portable, battery-operated monitor/defibrillator, with:
    - i. Tape write-out/recorder,
    - ii. Defibrillator pads,
    - iii. Adult and pediatric paddles or hands-free patches,
    - iv. ECG leads,
    - v. Adult and pediatric chest attachment electrodes, and
    - vi. Capability to provide electrical discharge below 25 watt-seconds; and
  - b. Transcutaneous cardiac pacemaker, either stand-alone unit or integrated into monitor/defibrillator;
3. For rotor wing aircraft only, the following immobilization devices and supplies:
- a. Cervical collars, rigid, adjustable or in an assortment of adult and pediatric sizes;
  - b. Head immobilization device, either firm padding or another commercial device;
  - c. Lower extremity (femur) traction device, including lower extremity, limb support slings, padded ankle hitch, padded pelvic support, and traction strap; and
  - d. Upper and lower extremity immobilization splints;
4. The following bandages:
- a. Burn pack, including standard package, clean burn sheets;
  - b. Dressings, including:
    - i. Sterile multi-trauma dressings (various large and small sizes);
    - ii. Abdominal pads, 10" x 12" or larger; and
    - iii. 4" x 4" gauze sponges;
  - c. Gauze rolls, sterile (4" or larger);
  - d. Elastic bandages, non-sterile (4" or larger);
  - e. Occlusive dressing, sterile, 3" x 8" or larger; and
  - f. Adhesive or self-adhesive tape, including various sizes (1" or larger) hypoallergenic and various sizes (1" or larger) adhesive or self-adhesive;
5. The following obstetrical equipment and supplies:
- a. Separate sterile obstetrical kit, including:
    - i. Towels,
    - ii. 4" x 4" dressing,
    - iii. Umbilical tape,
    - iv. Sterile scissors or other cutting utensil,
    - v. Bulb suction,
    - vi. Clamps for cord,
    - vii. Sterile gloves,
    - viii. Blankets, and
    - ix. A head cover; and
  - b. An alternate portable patient heat source or two heat packs;

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6. The following infection control equipment and supplies, including the availability of latex-free:
    - a. Eye protection (full peripheral glasses or goggles, face shield);
    - b. Masks, at least as protective as a National Institute for Occupational Safety and Health-approved N-95 respirator, which are fit-tested;
    - c. Gloves, non-sterile;
    - d. Jumpsuits or gowns;
    - e. Shoe covers;
    - f. Disinfectant hand wash, commercial antimicrobial (towelette, spray, or liquid);
    - g. Disinfectant solution for cleaning equipment;
    - h. Standard sharps containers;
    - i. Disposable red trash bags; and
    - j. Protective facemasks or cloth face coverings for patients;
  7. The following injury prevention equipment:
    - a. Appropriate restraints, such as seat belts or, if applicable, child safety restraints, for patient, personnel, and family members;
    - b. For rotor wing aircraft only, safety vest or other garment with reflective material for each personnel member;
    - c. Fire extinguisher, either disposable with an indicator of a full charge or with a current inspection tag;
    - d. Hazardous material reference guide; and
    - e. Hearing protection for patient and personnel;
  8. The following vascular access equipment and supplies:
    - a. Intravenous administration equipment, with fluid in bags;
    - b. Antiseptic solution (alcohol wipes and povidone-iodine wipes);
    - c. Intravenous pole or roof hook;
    - d. Intravenous catheters 14G-24G;
    - e. Intraosseous needles, adult and pediatric sizes;
    - f. Venous tourniquet;
    - g. One of each of the following types of intravenous solution administration sets:
      - i. A set with blood tubing,
      - ii. A set capable of delivering 60 drops per cc, and
      - iii. A set capable of delivering 10 or 15 drops per cc;
    - h. Intravenous arm boards, adult and pediatric;
    - i. IV pump or pumps (minimum of 3 infusion lines); and
    - j. IV pressure bag;
  9. The agents, specified in a table of agents established according to A.R.S. § 36-2204 and available through the Department at [www.azdhs.gov/ems-regulatory-references](http://www.azdhs.gov/ems-regulatory-references), that an administrative medical director has authorized for use, based on the EMCT classification of the medical team; and
  10. The following miscellaneous equipment and supplies:
    - a. Sphygmomanometer (infant, pediatric, and adult regular and large sizes);
    - b. Stethoscope;
    - c. Pediatric equipment sizing reference guide;
    - d. Thermometer with low temperature capability;
    - e. Heavy bandage or paramedic scissors for cutting clothing, belts, and boots;
    - f. Cold packs;
    - g. Flashlight (1) with extra batteries or recharger, as applicable;
    - h. Blankets;
    - i. Sheets;
    - j. Disposable emesis bags or basins;
    - k. For fixed wing aircraft only, a disposable bedpan;
    - l. For fixed wing aircraft only, a disposable urinal;
    - m. Properly secured patient transport system;
    - n. Lubricating jelly (water soluble);
    - o. Glucometer or blood glucose measuring device with reagent strips;
    - p. Pulse oximeter with pediatric and adult probes;
    - q. Automatic blood pressure monitor; and
    - r. A commercially available trauma arterial tourniquet.
- D.** An applicant or certificate holder shall ensure that an air ambulance used for an interfacility maternal transport mission has:
1. The equipment and supplies in subsection (C); and
  2. The following:
    - a. A Doppler fetal heart monitor;
    - b. Unless use is not indicated for the patient as determined through on-line medical direction or on-line medical guidance provided as described in R9-25-708(A)(3), an external fetal heart and tocographic monitor with printer capability;
    - c. Tocolytic and anti-hypertensive medications;
    - d. Advanced emergency cardiac life support equipment and supplies; and
    - e. Neonatal resuscitation equipment and supplies.
- E.** An applicant or certificate holder shall ensure that an air ambulance used for an interfacility neonatal transport mission has:
1. The equipment and supplies in subsection (C); and
  2. The following:
    - a. A transport incubator with:
      - i. Battery and inverter capabilities,
      - ii. An infant safety restraint system, and
      - iii. An integrated neonatal-capable pressure ventilator with oxygen-air supply and blender;
    - b. An invasive automatic blood pressure monitor;
    - c. A neonatal monitor or monitors with heart rate, respiratory rate, temperature, non-invasive blood pressure, and pulse oximetry capabilities;
    - d. Neonatal-specific drug concentrations and doses;
    - e. Thoracostomy supplies;
    - f. Neonatal resuscitation equipment and supplies;
    - g. A neonatal size cuff (size 2, 3, or 4) for use with an automatic blood pressure monitor; and
    - h. A neonatal probe for use with a pulse oximeter.
- F.** A certificate holder may conduct a critical care interfacility transport mission using an air ambulance that does not have all of the equipment and supplies required in subsection (C) if:
1. Care of the patient to be transported necessitates use of life-support equipment that, because of its size or weight or both, makes it unsafe or impossible for the air ambulance to carry all of the equipment and supplies required in subsection (C), as determined by the certificate holder based upon:
    - a. The individual aircraft's capabilities,
    - b. The size and weight of the equipment and supplies required in subsection (C) and of the additional life-support equipment,
    - c. The composition of the required medical team, and
    - d. Environmental factors such as density altitude;
  2. The certificate holder ensures that, during the mission, the air ambulance has the equipment and supplies neces-

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sary to provide an appropriate level of medical care for the patient and to protect the health and safety of the personnel on the mission; and

3. The certificate holder ensures that the air ambulance is not used for another mission until the air ambulance has all of the equipment and supplies required in subsection (C).

**Historical Note**

R9-25-802 recodified from A.A.C. R9-13-1502 (Supp. 98-1). Section repealed; new Section made by exempt rulemaking at 7 A.A.R. 4092, effective September 1, 2001 (Supp. 01-3). Amended by exempt rulemaking at 8 A.A.R. 931, effective February 15, 2002 (Supp. 02-1). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-502 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-802 renumbered to R9-25-801; new Section R9-25-802 renumbered from R9-25-807 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**Exhibit 1. Repealed****Historical Note**

Section R9-25-802, Exhibit 1 recodified from A.A.C. R9-13-1502, Exhibit 1 (Supp. 98-1). Exhibit 1 repealed by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

**Exhibit 2. Repealed****Historical Note**

Section R9-25-802, Exhibit 2 recodified from A.A.C. R9-13-1502, Exhibit 2 (Supp. 98-1). Exhibit 2 repealed by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

**Exhibit 3. Repealed****Historical Note**

Section R9-25-802, Exhibit 3 recodified from A.A.C. R9-13-1502, Exhibit 3 (Supp. 98-1). Exhibit 3 repealed by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

**Exhibit 4. Repealed****Historical Note**

Section R9-25-802, Exhibit 4 recodified from A.A.C. R9-13-1502, Exhibit 4 (Supp. 98-1). Exhibit 4 repealed by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4).

**R9-25-803. Changes Affecting Registration (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), and 36-2212)**

- A. At least 30 days before the date of a change in a certificate holder's name, the certificate holder shall send the Department written notice of the name change.
- B. No later than 10 days after a certificate holder ceases to use an aircraft as an air ambulance, the certificate holder shall send the Department written notice of the date that the certificate holder ceased to use the aircraft as an air ambulance and of the certificate holder's intention to relinquish the certificate of registration for the use as an air ambulance as of that date.
- C. Within 30 days after the date of receipt of a notice described in subsection (A) or (B), the Department shall:

1. For a notice described in subsection (A), issue an amended certificate of registration that incorporates the name change but retains the expiration date of the current certificate of registration; and
  2. For a notice described in subsection (B):
    - a. Void the certificate of registration for the air ambulance; and
    - b. Send the certificate holder written confirmation of the voluntary relinquishment of the certificate of registration, with an effective date that corresponds to the written notice.
- D. A certificate holder shall notify the Department in writing within one working day after a change in the certificate holder's eligibility to hold a certificate of registration for an air ambulance under R9-25-801(A).
- E. Upon receiving a notification required in subsection (D), the Department:
1. Shall revoke the certificate for the aircraft used as an air ambulance; and
  2. If the air ambulance is the only aircraft used as an air ambulance by an air ambulance service, may revoke the license of the air ambulance service.

**Historical Note**

Section R9-25-803 recodified from A.A.C. R9-13-1503, (Supp. 98-1). Section repealed; new Section adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 8 A.A.R. 2625, effective June 1, 2002 (Supp. 02-2). Section recodified to R9-25-503 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-803 renumbered to R9-25-804; new Section R9-25-803 renumbered from R9-25-804 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023 (Supp. 23-2).

**Exhibit 1. Recodified****Historical Note**

Section R9-25-803, Exhibit 1 "EMT-P Drug List" and "EMT-I Drug List" recodified from A.A.C. R9-13-1503, Exhibit 1 "EMT-P Drug List" and "EMT-I Drug List" (Supp. 98-1). Exhibit 1 repealed; new Exhibit 1 adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 1507, effective May 1, 2000 (Supp. 00-1). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 3762, effective October 1, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 1654, effective March 30, 2001 (Supp. 01-1). Amended by exempt rulemaking at 8 A.A.R. 2625, effective June 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 9 A.A.R. 1703, effective May 15, 2003

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(Supp. 03-2). Exhibit 1 recodified to Article 5, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

**Exhibit 2. Recodified****Historical Note**

Exhibit 2 adopted effective November 30, 1998; filed in the Office of the Secretary of State November 24, 1998, under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) (Supp. 98-4). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 1507, effective May 1, 2000 (Supp. 00-1). Amended under an exemption from the provisions of the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C) at 6 A.A.R. 3762, effective October 1, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 1199, effective February 13, 2001 (Supp. 01-1). Amended by exempt rulemaking at 8 A.A.R. 2625, effective June 1, 2002 (Supp. 02-2). Exhibit 2 recodified to Article 5, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

**R9-25-804. Term and Transferability of Certificate of Registration (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, and 41-1092.11)**

- A. The Department shall issue an initial certificate of registration:
  1. With a term of one year from date of issuance of the initial certificate of registration; or
  2. If requested by the applicant, with a term shorter than one year that allows for the Department to conduct annual inspections of all of the applicant's air ambulances at one time.
- B. The Department shall issue a renewal certificate of registration with a term of one year from the expiration date on the previous certificate of registration.
- C. If a certificate holder submits an application for renewal as described in R9-25-801 before the expiration date of the current certificate of registration, the current certificate of registration does not expire until the Department has made a final determination on the application for renewal, as provided in A.R.S. § 41-1092.11.
- D. A certificate of registration is not transferable from one person to another.
- E. If there is a change in the ownership of an aircraft used as an air ambulance or the person who can legally use the aircraft as an air ambulance, the new owner or person who can legally use the aircraft as an air ambulance shall apply for and obtain a new certificate of registration before using the aircraft as an air ambulance in this state.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-504 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-804 renumbered to R9-25-803; new Section R9-25-804 renumbered from R9-25-803 and amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final expedited rulemaking 29 A.A.R. 1461 (June 30, 2023), with an immediate effective date of June 6, 2023

(Supp. 23-2).

**R9-25-805. Inspections (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, and 36-2232(A)(11))**

- A. Except as provided in R9-25-711(C), an applicant or a certificate holder shall make an air ambulance available for inspection within Arizona within 10 working days after a request by the Department.
- B. The Department shall conduct each inspection in compliance with A.R.S. § 41-1009.
- C. As permitted under A.R.S. § 36-2232(A)(11), upon a certificate holder's request and at the certificate holder's expense, the annual inspection of an air ambulance required for renewal of a certificate of registration may be conducted by a Department-approved inspection facility.

**Historical Note**

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-505 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**Exhibit 1. Recodified****Historical Note**

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Exhibit 1 recodified to Article 5, Exhibit 1 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

**Exhibit 2. Recodified****Historical Note**

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Exhibit 2 recodified to Article 5, Exhibit 2 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

**Exhibit 3. Repealed****Historical Note**

Adopted under an exemption from the Administrative Procedure Act pursuant to A.R.S. § 36-2205(C), effective May 19, 1997; filed in the Office of the Secretary of State May 21, 1997 (Supp. 97-2). Exhibit repealed by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4).

**R9-25-806. Repealed****Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 4895, effective October 5, 2001 (Supp. 01-4). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4).

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ary 3, 2004 (Supp. 03-4). Section recodified to R9-25-506 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**R9-25-807. Renumbered****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 2633, effective June 1, 2002 (Supp. 02-2). Amended by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-507 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3). New Section made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Section R9-25-807 renumbered to R9-25-802 by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**Table 8.1. Repealed****Historical Note**

New Table 8.1 renumbered from Table 1 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Table 8.1 amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4). Table 8.1, Minimum Equipment and Supplies Required on Air Ambulances, by Mission Level and Aircraft Type, repealed by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2).

**Table 1. Renumbered****Historical Note**

New Table 1 made by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Table 1 renumbered to Table 8.1 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**R9-25-808. Recodified****Historical Note**

New Section made by exempt rulemaking at 10 A.A.R. 239, effective January 3, 2004 (Supp. 03-4). Section recodified to R9-25-508 at 10 A.A.R. 4192, effective September 21, 2004 (Supp. 04-3).

**ARTICLE 9. GROUND AMBULANCE CERTIFICATE OF NECESSITY****R9-25-901. Definitions (Authorized by A.R.S. § 36-2202 (A))**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in Articles 9, 10, 11, and 12 unless otherwise specified:

1. "Accounting period" means a continuous 12-month span of time used by an applicant or a certificate holder for purposes of planning, budgeting, or annual financial reporting to the Department.
2. "Adjustment" means a modification, correction, or alteration to a rate or charge.
3. "ALS base rate" means the monetary amount set by the Department for a certificate holder to bill a patient according to A.R.S. § 36-2239(F).
4. "Ambulance response" means EMS provided by a ground ambulance service.

5. "Ambulance Revenue and Cost Report" means the information required in R9-25-909, which records and reports the financial activities of an applicant or a certificate holder.
6. "Application packet" means the information, applicable fees, and documents required by the Department when making a decision for certification, licensure, or approval of a request.
7. "Back-up agreement" means a written arrangement, which may include one of the following, between a certificate holder and a neighboring or overlapping certificate holder to allow one of the certificate holders to provide ambulance response or transport within the other certificate holder's service area on a limited basis when the certificate holder's ambulances are temporarily not able to provide needed services in the certificate holder's service area:
  - a. A mutual aid agreement, or
  - b. A Memorandum of Understanding.
8. "BLS base rate" means the monetary amount set by the Department for a certificate holder to bill a patient according to A.R.S. § 36-2239(G).
9. "Certificate holder" means a person to whom the Department issues a certificate of necessity.
10. "Certificate of registration" means an authorization issued by the Department to a certificate holder to operate a ground ambulance vehicle.
11. "Change of ownership" means a transfer of controlling legal or controlling financial interest and authority in a ground ambulance service, as demonstrated according to R9-25-904(A)(1).
12. "Charge" means the monetary amount billed for disposable supplies, medical supplies, medication, and oxygen-related costs used in providing care to a patient.
13. "Chassis" means the part of a ground ambulance vehicle consisting of all base components, including front and rear suspension, exhaust system, brakes, engine, engine hood or cover, transmission, front and rear axles, front fenders, drive train and shaft, fuel system, engine air intake and filter, accelerator pedal, steering wheel, tires, heating and cooling system, battery, and operating controls and instruments.
14. "Controlling person" means an individual who:
  - a. Owns at least a 20% interest in the business organization that operates or is applying to operate as a ground ambulance service;
  - b. If an applicant or certificate holder is a partnership, is a general partner or is a limited partner who holds at least 20% of the voting rights of the partnership;
  - c. If an applicant or certificate holder is a corporation, association, or limited liability company, is the president, chief executive officer, or incorporator, or an individual who owns or controls at least 20% of the voting securities; or
  - d. Is responsible for the overall day-to-day management and operation of the ground ambulance service.
15. "Contract rate or range of rates" means the monetary amount established by the Department according to R9-25-1103.
16. "Convalescent transport" means a ground ambulance service's response to a request for ambulance response or transport that is:
  - a. Not an interfacility transport, and



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- b. Pre-arranged to occur at a specific time.
17. "Critical care rate" means the monetary amount that is set by the Department for a certificate holder to bill a patient for critical care services.
18. "Critical care services" means care provided during an interfacility transport to a patient who has an illness or injury acutely or chronically impairing one or more organ systems, such that the conditions are life-threatening and require constant monitoring to avoid deterioration of the patient's condition.
19. "Dispatch" means the direction to a certificate holder or an emergency medical services provider to respond to a call for ambulance response or transport.
20. "Driver's compartment" means the part of a ground ambulance vehicle that contains the controls and instruments for operation of the ground ambulance vehicle.
21. "Financial statements" means an applicant's balance sheet, annual income statement, and annual cash flow statement, or corresponding documents if applicable to the type of business organization, prepared according to the conventions, and rules and procedures for accounting, including broad and specific guidelines, established by the Financial Accounting Standards Board or the Governmental Accounting Standards Board.
22. "Frame" means the structural foundation on which a ground ambulance vehicle chassis is constructed.
23. "General public rate" means the monetary amount set by the Department for a certificate holder to bill a patient for critical care services, ALS services, BLS services, mileage, standby waiting, or according to a subscription service contract.
24. "Generally accepted accounting principles" means the conventions, and rules and procedures for accounting, including broad and specific guidelines, established by the Financial Accounting Standards Board.
25. "Gross revenue" means the total monetary amount billed by a certificate holder during an accounting period, prior to any deductions, for providing ambulance response or transport.
26. "Ground ambulance service" means an ambulance service that operates on land.
27. "Ground ambulance service contract" means a written agreement between a certificate holder and a person for the provision of ambulance response or transport.
28. "Ground ambulance vehicle" means a motor vehicle, defined in A.R.S. § 28-101, specifically designed to carry ambulance attendants and patients on land.
29. "Level of service" means critical care services, ALS services, or BLS services, based on the type of ambulance attendants and the services provided by the ground ambulance service.
30. "Major defect" means a condition that exists on a ground ambulance vehicle that makes the ground ambulance vehicle unsafe to use for providing transport.
31. "Mileage rate" means the monetary amount set by the Department for a certificate holder to bill for transport of a patient for each mile traveled during the transport.
32. "Minor defect" means a condition that exists on a ground ambulance vehicle that may cause the ground ambulance vehicle to become unsafe to use for providing transport if allowed to continue.
33. "Out-of-service" means a ground ambulance vehicle cannot be operated for transport.
34. "Patient compartment" means the part of a ground ambulance vehicle that is intended to hold a patient during transport.
35. "Priority" means whether a response mode to a dispatch, on the basis of the information available to the certificate holder, is:
- Emergent, that is, an immediate response is required due to a patient's perceived condition; or
  - Non-emergent, that is, a response is required at a time appropriate to a patient's perceived condition.
36. "Public necessity" means that a need exists within an identified population and service area for all or part of the services proposed by an applicant or determined by the Department.
37. "Response time" means the difference between the time a certificate holder receives:
- A 9-1-1 or similar system dispatch and the time the certificate holder's first ground ambulance vehicle arrives at the scene; or
  - A request for an interfacility transport of a patient with a time-critical condition and the time the certificate holder's ground ambulance vehicle arrives at the health care institution to provide transport.
38. "Scene locality" means:
- An urban area, a geographic region delineated as an urbanized area by the United States Department of Commerce, Bureau of the Census;
  - A suburban area, a geographic region within a 10-mile radius of an urban area that has a population density equal to or greater than 1,000 residents per square mile;
  - A rural area, a geographic region with a population of less than 40,000 residents that is not a suburban area; or
  - A wilderness area, a geographic region that has a population density of less than one resident per square mile.
39. "Scheduled transport" means to convey a patient at a pre-arranged time by a ground ambulance vehicle for which an immediate dispatch and response is not necessary.
40. "Service area" means the geographical boundary designated on a certificate of necessity using the criteria in A.R.S. § 36-2233(I).
41. "Standby waiting rate" means the monetary amount set by the Department for a certificate holder to bill a patient when a ground ambulance vehicle is required to wait in excess of 15 minutes to load or unload the patient, unless the excess delay is caused by the ground ambulance vehicle or the ambulance attendants on the ground ambulance vehicle.
42. "Subscription service" means the provision of ambulance response or transport by a certificate holder to a group of individuals within the certificate holder's service area who contracted with the certificate holder for coverage to provide ambulance response or transport and the allocation of annual costs among the group of individuals.
43. "Subscription service contract" means a written agreement for subscription service.
44. "Subscription service rate" means the monetary amount set by the Department for a certificate holder to bill to a person for coverage under a subscription service contract.
45. "Third-party payor" means a person, other than a patient, who is financially responsible for the payment, in whole or in part, of a patient's billed general public rates and

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charges for ambulance response or transport provided to the patient by a ground ambulance service.

46. "Time-critical condition" means a patient's illness or injury, such as ST Elevated Myocardial Infarction, stroke, trauma that meets the criteria in R9-25-1308(H)(6)(b)(i), or hemodynamic instability, for which research has shown that a transport to a specialized health care institution or a higher level of care improves patient outcomes.
47. "Time-sensitive condition" means a patient's illness or injury for which, in the opinion of one of the following, a delay in the patient receiving appropriate medical services may result in harm to the patient:
  - a. For an interfacility transport, a physician, physician assistant, or registered nurse practitioner providing medical services to the patient; and
  - b. For a transport that results from a 9-1-1 or similar system dispatch, an EMCT or the physician providing on-line medical direction for the patient.
48. "Transport" means the conveyance of one or more patients in a ground ambulance vehicle from the point of patient pick-up to a specified destination.
49. "Type of service" means an interfacility transport, a convalescent transport, or a transport that results from a 9-1-1 or similar system dispatch, which is provided by a ground ambulance service.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).

Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-902. Application for an Initial Certificate of Necessity (Authorized by A.R.S. §§ 36-2201(11)(h), 36-2204, 36-2232, 36-2233, 36-2234, 36-2236(A), 36-2240)**

A. An applicant for an initial certificate of necessity shall submit to the Department an application packet that includes:

1. The following information in a Department-provided format:
  - a. The legal business or corporate name, mailing address, physical address if different from the mailing address, telephone number, facsimile number if any, and email address of the ground ambulance service;
  - b. Any other names by which the applicant is known;
  - c. If the applicant is a:
    - i. Governmental entity, the type of governmental entity; or
    - ii. Business organization:
      - (1) The type of business organization, and
      - (2) Whether the business organization is proprietary or non-profit;
  - d. A list of all business organizations or governmental entities affiliated with the applicant, if applicable, including for each:
    - i. The legal name;
    - ii. The type of business organization, if applicable; and
    - iii. Whether the relationship to the applicant is as:
      - (1) Parent organization,
      - (2) Subordinate organization,

- (3) Subsidiary organization,
  - (4) Member organization, or
  - (5) Business organization related to an ambulance service, ambulance response, or transport for which a controlling person of the applicant is also a controlling person of the business organization;
- e. The name, title, address, email address, and telephone number of the following:
  - i. Each applicant and individual responsible for managing the ground ambulance service,
  - ii. The individual acting for the applicant according to R9-25-102,
  - iii. The individual to contact to access the ground ambulance service's records required in R9-25-908(B), and
  - iv. The statutory agent for the ground ambulance service or the individual designated by the applicant to accept service of process and subpoenas for the ground ambulance service;
- f. The name, address, email address, and telephone number of the person providing dispatch for the ground ambulance service;
- g. The address, hours of operation, and, if available, telephone number of each suboperation station located within the proposed service area;
- h. Whether the applicant has a proposed deployment plan for the ground ambulance vehicles in subsection (A)(1)(m), including:
  - i. Whether the purchase and deployment of additional ground ambulance vehicles are planned for the first 12 months following the applicant receiving a certificate of necessity;
  - ii. Whether additional purchases and further deployment of additional ground ambulance vehicles are planned for the second 12-month period following the applicant receiving a certificate of necessity; and
  - iii. Whether ground ambulance vehicles will be deployed based on knowledge of the level of service, types of service provided, and locations of calls;
- i. Whether the applicant has a plan for participating in the implementation of a political subdivision's emergency preparedness plan;
- j. A list of EMS providers in surrounding service areas with whom the applicant has a back-up agreement or from whom the applicant has a letter of support;
- k. A description of the communication equipment to be used in each ground ambulance vehicle and suboperation station;
- l. If applicable, a description of traffic preemption equipment that the applicant plans to use to facilitate movement of a ground ambulance vehicle through traffic;
- m. For each ground ambulance vehicle proposed to be used by the ground ambulance service, the manufacturer's name, the year the ground ambulance vehicle was manufactured, and, if available, the current mileage;
- n. The number of ambulance attendants and the type of licensure, certification, or registration for each attendant;

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- o. The proposed hours of operation for the ground ambulance service;
  - p. The type of service;
  - q. The level of service;
  - r. If the applicant plans to provide ALS services or critical care services, a description of how the applicant plans to provide administrative medical direction according to R9-25-201 and on-line medical direction according to R9-25-202, including, as applicable:
    - i. The name, address, and telephone number of the base hospital or centralized medical direction communications center for the ground ambulance service;
    - ii. The name, address, professional license number, and telephone number of the physician providing administrative medical direction; and
    - iii. The name, address, professional license number, and telephone number of the physician or group of physicians providing on-line medical direction;
  - s. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
  - t. Attestation that the applicant is familiar with the requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter and will comply with applicable statutes and rules in any matter relating to or affecting the ground ambulance service;
  - u. Attestation that any information or documents submitted to the Department are true and correct; and
  - v. The signature of the individual acting for the applicant according to R9-25-102 and the date signed;
2. The following information about the proposed service area:
- a. The square miles within the proposed service area;
  - b. Whether a ground ambulance service currently operates in all or part of the proposed service area and, if so, a list of the ground ambulance services currently operating in the proposed service area;
  - c. The population demographics within the proposed service area;
  - d. Any changes in the population since the last national census;
  - e. Any change in the population demographics since the last national census;
  - f. The medical needs of the population within the proposed service area;
  - g. The number of anticipated requests for each type of service and level of service in the proposed service area, including the basis for the estimate;
  - h. The available routes of travel within the proposed service area;
  - i. The anticipated average mileage per transport within the proposed service area, including the basis for the estimate;
  - j. The geographic features and environmental conditions within the proposed service area;
  - k. The available medical and emergency medical resources within the proposed service area;
  - l. The geographic distribution of health care institutions within and surrounding the service area to which and from which the ground ambulance service may be transporting patients;
  - m. A statement of the proposed general public rates for services provided within the proposed service area;
  - n. A statement of the proposed charges;
  - o. The proposed response times and a compliance percentage, for each scene locality in the proposed service area and priority that will be assigned by the applicant to a response; and
  - p. If planning to provide interfacility transports within the proposed service area:
    - i. The response times and compliance percentages for the interfacility transport of a patient with a time-critical condition for each scene locality; and
    - ii. Either:
      - (1) A plan for complying with the requirements in R9-25-908(E)(3)(c) that demonstrates how quality patient care will be provided, including to patients with a time-sensitive condition; or
      - (2) A plan and justification for a standard different from that in R9-25-908(E)(3)(c);
3. A plan to provide temporary ambulance response or transport service to the proposed service area for a limited time when the applicant is unable to provide ambulance response or transport service to the proposed service area, including the criteria for the person providing dispatch to implement the plan;
4. Copies of the back-up agreements supporting the plan in subsection (A)(3) or letters of support specified according to subsection (A)(1)(j);
5. A plan for orientation and on-going training of employees;
6. If applicable, a copy of a plan for implementing deployment of ground ambulance vehicles as specified in subsection (A)(1)(h), including the timeframe, if applicable, for the purchase and deployment of additional ground ambulance vehicles during the first 12 months after receiving a certificate of necessity;
7. Whether the applicant or the individual acting for the applicant according to R9-25-102:
- a. Has ever been convicted of a felony or a misdemeanor involving moral turpitude;
  - b. Has ever had a license or certificate of necessity for a ground ambulance service suspended or revoked by any state or political subdivision, or
  - c. Has ever operated a ground ambulance service without the required certification or licensure in this or any other state;
8. A description of the proposed service area by any method specified in A.R.S. § 36-2233(E) and global positioning system data, in a Department-specified format, that would allow a map to be created that illustrates the proposed service area;
9. Documentation for the individual specified according to subsection (A)(1)(e)(ii) that complies with A.R.S. § 41-1080;
10. A copy of the business organization's articles of incorporation, articles of organization, or partnership documents, if applicable;
11. A copy of an organizational chart, illustrating both:
- a. The relationships in subsection (A)(1)(d) with two levels of supervision; and
  - b. At least three levels of supervision of key individuals operating the ground ambulance service, includ-

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- ing the individuals listed in subsection (A)(1)(e)(i) through (iii);
12. A projected Ambulance Revenue and Cost Report covering the first consecutive 12 months of operation, as specified in R9-25-909(A);
  13. A written explanation of why the applicant believes there is a public need for the applicant to receive an initial certificate of necessity, including:
    - a. A summary of how the applicant plans to address the factors in subsection (A)(2) to ensure the provision of quality patient care,
    - b. Justification for the proposed level of service,
    - c. Justification for proposed response times or compliance percentage, and
    - d. Supporting documentation;
  14. If available, any study or statistical analysis that examines the need for ground ambulance service within a service area or proposed service area that:
    - a. Considers the current or proposed service area's medical, fire, and police services; and
    - b. Was created for or adopted by:
      - i. A political subdivision, or
      - ii. A local emergency medical services coordinating system under A.R.S. § 36-2210(1);
  15. A summary of the applicant's financial history, including:
    - a. Documentation of capital resources and financial reserves, if applicable, that is available for the establishment and operation of the ground ambulance service; and
    - b. A plan for coverage of expected and unexpected expenses, including the source and amount of funding for cash flow from the date the ground ambulance service commences operation until the date cash flow covers monthly expenses, with supporting documentation;
  16. If the applicant is intending to bill for services, the method and plan for the applicant to bill for services;
  17. A list of all actual or anticipated purchase agreements or lease agreements to be used in connection with the ground ambulance service, including the monetary amount and duration of each agreement, for:
    - a. Real estate,
    - b. Ground ambulance vehicles, or
    - c. Equipment exceeding \$10,000;
  18. Documentation supporting the estimate of the number of transports to be provided, as shown in the Ambulance Revenue and Cost Report, including any proposed ground ambulance service contract under A.R.S. § 36-2232(A)(1) or 36-2234(M);
  19. If the applicant is requesting to establish general public rates, the information and documents specified in R9-25-1101(A);
  20. If the applicant is proposing charges to patients under R9-25-1109, the information required in R9-25-1109(A);
  21. Any subscription service contract under A.R.S. § 36-2232(A)(1) and R9-25-1105;
  22. If using a contracted person to provide dispatch, a copy of the contract;
  23. If the applicant is planning to provide ALS services or critical care services:
    - a. A copy of each current written contract for providing administrative medical direction,
    - b. A copy of each current written contract for providing on-line medical direction, and
    - c. Proof of professional liability insurance for personnel providing ALS services or critical care services required in R9-25-908(A)(1)(a)(iii);
  24. A certificate of insurance or documentation of self-insurance required in A.R.S. § 36-2237(A) and R9-25-908(A)(1)(a)(i) and (ii);
  25. A surety bond if required under A.R.S. § 36-2237(B);
  26. The resume or other description of experience and qualification to operate a ground ambulance service of the individuals specified according to subsection (A)(11)(b);
  27. If applicable, a copy of the applicant's plan for participating in the implementation of a political subdivision's emergency preparedness plan according to subsection (A)(1)(h), including as applicable:
    - a. Mass casualty protocols;
    - b. The provision of ambulance response and transport in the event of a local, state-wide, or national emergency;
    - c. Description of the applicant's experience in disaster response command and control structure; and
    - d. Special situations in the proposed service area that need to be taken into consideration; and
  28. Any other documents, exhibits, or statements that the applicant believes may assist the Director in evaluating the application or any other information or documents needed by the Director to clarify incomplete or ambiguous information or documents, such as:
    - a. The quality improvement process, as required in R9-25-908(K)(2);
    - b. A plan to collect and submit electronic patient care reports consistent with R9-25-908(K)(2)(a);
    - c. A plan to adopt clinical guidelines and operating procedures, consistent with national and state guidelines;
    - d. If applicable, a plan to initiate guideline-based pre-arrival instructions for all callers accessing 9-1-1 or a similar system for assistance;
    - e. Evidence of regular attendance and participation in meetings of the emergency medical services council, established according to A.R.S. § 36-2203, or a regional emergency medical and trauma services system, established according to A.R.S. § 36-2210;
    - f. Evidence of participation in a community-level injury prevention program; or
    - g. Documentation demonstrating that the service model will be cost effective.
- B.** In addition to the information and documents specified in subsection (A), applicant for an initial certificate of necessity shall submit the \$100 application filing fee for an initial certificate of necessity.
- C.** The Department shall approve or deny an application under this Section according to A.R.S. § 36-2233 and Article 12 of this Chapter.
- D.** The Department may approve an application with special limitations or conditions, based on the best interest of the public.
- E.** If the Department approves an application and sends the applicant the written notice of approval, specified in R9-25-1201(C)(5), the Department shall issue the certificate of necessity to the applicant, consistent with A.R.S. §§ 36-2233(E) and 36-2234(A):
1. After the applicant has submitted to the Department for each ground ambulance vehicle to be operated by the ground ambulance service:

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- a. An application for registration of the ground ambulance vehicle that includes all of the information required according to R9-25-1001(B)(1);
  - b. A copy of a current and valid motor vehicle registration for the ground ambulance vehicle, issued according to A.R.S. Title 28, Chapter 7, Article 2, or similar statutes in another state; and
  - c. Unless the applicant intends to operate the ground ambulance vehicle only as a volunteer not-for-profit service, the following fees for each ground ambulance vehicle to be registered:
    - i. A \$50 registration fee, as required under A.R.S. § 36-2212(D); and
    - ii. A \$200 ambulance operation fee, as required under A.R.S. § 36-2240(3); and
  - 2. When the certificate of registration for the first ground ambulance vehicle to be operated by the ground ambulance service is issued.
  - F. The Department may deny an application according to A.R.S. § 36-2233 if an applicant:
    - 1. Fails to comply with any provision in A.R.S. Title 36, Chapter 21.1;
    - 2. Fails to comply with any provision in this Article or Article 2, 10, or 11 of this Chapter;
    - 3. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
    - 4. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).
- Historical Note**
- New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).
- R9-25-903. Application for Renewal of a Certificate of Necessity (Authorized by A.R.S. §§ 36-2233, 36-2235, 36-2238, 36-2240, 36-2242)**
- A. An applicant for a renewal of a certificate of necessity shall submit to the Department, not less than 30 days before the expiration date of the certificate of necessity, an application packet that includes:
    - 1. The following information in a Department-provided format:
      - a. The identifying number on the applicant's current certificate of necessity;
      - b. The legal business or corporate name, address, telephone number, and facsimile number of the ground ambulance service;
      - c. Any other names by which the applicant is known;
      - d. The names of all other business organizations operated by the applicant related to the ground ambulance service;
      - e. The name, title, address, email address, and telephone number of the following:
        - i. Each applicant and individual responsible for managing the ground ambulance service,
        - ii. The individual acting for the applicant according to R9-25-102,
        - iii. The individual to contact to access the ground ambulance service's records required in R9-25-908(B), and
        - iv. The statutory agent for the ground ambulance service or the individual designated by the applicant to accept service of process and subpoenas for the ground ambulance service;
    - f. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
    - g. Attestation that the applicant has analyzed response times according to R9-25-908(G)(2) and, if applicable, performance of interfacility transports of patients with no time-critical condition according to R9-25-908(H)(1);
    - h. Attestation that the applicant is familiar with the requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter and will comply with applicable statutes and rules in any matter relating to or affecting the ground ambulance service;
    - i. Attestation that the certificate holder, except as provided in R9-25-908(G)(4), R9-25-908(H)(3), or R9-25-908(K)(1)(c), has and is continuing to meet the conditions of the certificate of necessity;
    - j. Attestation that any information or documents submitted to the Department are true and correct; and
    - k. The signature of the applicant or the applicant's designated representative and the date signed;
  - 2. Proof of continuous insurance coverage or a statement of continuing self-insurance, including a copy of the current certificate of insurance or current statement of self-insurance required in R9-25-908(A);
  - 3. Proof of continued coverage by a surety bond if required under A.R.S. § 36-2237(B);
  - 4. A copy of the list of current charges required in R9-25-1109;
  - 5. A list of all certificate holders with which the applicant has back-up agreements;
  - 6. If an instance of noncompliance has been identified, a corrective action plan or documentation specified in R9-25-908(G)(4), R9-25-908(H)(3), or R9-25-908(K)(1)(c), as applicable, if not already submitted to the Department; and
  - 7. \$50 application filing fee.
- B. A certificate holder who fails to file a timely application for renewal of the certificate of necessity according to A.R.S. § 36-2235 and this Section, shall:
  - 1. Cease operations at 12:01 a.m. on the date the certificate of necessity expires;
  - 2. If planning to continue operating as a ground ambulance service, file an initial certificate of necessity application according to R9-25-902; and
  - 3. Not resume operations without receiving a new certificate of necessity from the Department.
- C. The Department shall review an application packet under this Section according to A.R.S. §§ 36-2233 and 36-2235 and Article 12 of this Chapter, and:
  - 1. Approve the application;
  - 2. Approve the application with a corrective action plan, as specified in subsection (A)(6);
  - 3. Approve the application with special limitations or conditions; or
  - 4. Deny the application.

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- D. The Department may deny an application according to A.R.S. § 36-2235 if an applicant:
1. Fails to comply with any provision in A.R.S. Title 36, Chapter 21.1;
  2. Fails to comply with any provision in this Article or Article 2, 10, or 11 of this Chapter;
  3. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
  4. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).
- E. If a certificate holder submits an application for renewal according to subsection (A), the current certificate of necessity does not expire until the Department has made a final determination on the application for renewal, as provided in A.R.S. § 41-1092.11.
- F. If a certificate holder does not intend to apply for renewal of a certificate of necessity, the certificate holder shall:
1. At least 90 days before the expiration date of the certificate of necessity, send the Department written notice of the certificate holder's intention to cease operating, effective on the expiration date; and
  2. Not discontinue service, except as provided in A.R.S. § 36-2238.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section R9-25-903 renumbered to R9-25-906; new Section R9-25-903 renumbered from R9-25-904 and amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-904. Transfer of a Certificate of Necessity (Authorized by A.R.S. §§ 36-2232, 36-2233, 36-2236(A) and (B), 36-2238)**

- A. A certificate holder shall request that a certificate of necessity be transferred if:
1. There is an anticipated change of ownership, which is considered to occur when:
    - a. In the case of ownership by a sole proprietor, 20% or more interest or a beneficial interest is sold or transferred;
    - b. In the case of ownership by a partnership or a private corporation, 20% or more of the stock, interest, or beneficial interest is sold or transferred; or
    - c. The controlling influence changes to the extent that the management and control of the ground ambulance service is significantly altered, as determined according to subsection (B);
  2. The certificate holder and another certificate holder plan to execute a ground ambulance service contract for the provision of ambulance response or transport by one of the certificate holder's ground ambulance service in a portion of the other certificate holder's service area, except as part of a backup agreement; or
  3. There is a change in the type of business organization.
- B. The Department shall consider the following when determining whether a controlling influence in the ground ambulance service is changing to the extent that the management and control of the ground ambulance service has altered significantly:
1. Whether there has been or will be a change in who manages or controls the day-to-day operations of one or more ground ambulance vehicles operated by the ground

ambulance service, including whether the certificate holder has entered into or intends to enter into a contract or an agreement with another person or entity to supervise or manage all or a part of the ground ambulance service;

2. Whether there has been or will be a change in who manages or controls staffing and personnel decisions for one or more ground ambulance vehicles operated by the ground ambulance service;
  3. Whether there has been or will be a change in the operating policies and procedures for one or more ground ambulance vehicles operated by the ground ambulance service;
  4. Whether there has been or will be a change in who pays the operating expenses or who receives the operating revenue;
  5. Whether there has been or will be a change in the policy holder on the insurance coverage of one or more ground ambulance vehicles operated by the ground ambulance service;
  6. Whether there has been or will be a change in ownership, management, or control of the supplies, equipment, and materials for one or more ground ambulance vehicles operated by the ground ambulance service;
  7. Whether there has been or will be a change in the risk or liability attendant to the operation of one or more ground ambulance vehicles operated by the ground ambulance service;
  8. Whether there has been or will be a change in who manages or controls the strategic or long-term planning of the ground ambulance service;
  9. Whether the certificate holder has changed or intends to change affiliations, such as a parent company or a subsidiary owned or operated by the certificate holder, from that specified according to R9-25-902(A)(1)(d); and
  10. Other information related to the management and control of the ground ambulance service that the Department deems relevant.
- C. When requesting a transfer of a certificate of necessity:
1. A certificate holder wanting to transfer the certificate of necessity shall submit the following information to the Department in a written format:
    - a. The name and certificate of necessity number of the certificate holder;
    - b. A request that the certificate of necessity be transferred, including the rationale for the transfer;
    - c. Whether the transfer is due to a change of ownership or to a change in the type of business organization; and
    - d. If the transfer is due to a change of ownership, the name of the person to whom the certificate of necessity is to be transferred; and
  2. The person identified in subsection (C)(1)(d) or the individual acting according to R9-25-102 for the new type of business organization shall submit to the Department:
    - a. The information and documents specified in R9-25-902(A)(1), (3) through (7), (9) through (12), (15) through (18), and (22) through (29);
    - b. The \$50 application filing fee for a transfer of a certificate of necessity, as required under A.R.S. § 36-2240(3); and
    - c. A description of any planned amendments to the certificate of necessity during the next 12 months.

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- D.** In deciding whether to transfer a certificate of necessity is in the public's best interest, the Director shall consider the following:
1. The information required in subsections (C)(2)(a) and (c);
  2. Whether the person specified according to subsection (C)(1)(d) is fit and proper;
  3. Whether there is a public need for the transfer to take place:
    - a. Based on a possible gap in service or unmet needs in the service area; and
    - b. To ensure consistent service provision, efficiency, cost-effectiveness, and the health and safety of individuals in the service area;
  4. Whether the person specified according to subsection (C)(1)(d) demonstrates the ability to provide quality patient care; and
  5. Other matters determined by the Director or the applicant to be relevant to the determination of public necessity.
- E.** The Department shall approve or deny an application under this Section according to A.R.S. § 36-2233 and Article 12 of this Chapter.
- F.** If the Department approves an application for a transfer and sends the person in subsection (C)(1)(d) the written notice of approval, specified in R9-25-1201(C)(5), the Department shall issue the certificate of necessity to the person in subsection (C)(1)(d):
1. After the person in subsection (C)(1)(d) has submitted to the Department for each ground ambulance vehicle to be operated by the ground ambulance service:
    - a. An application for registration of the ground ambulance vehicle that includes all of the information required according to R9-25-1001(B)(1);
    - b. A copy of a current and valid motor vehicle registration for the ground ambulance vehicle, issued according to A.R.S. Title 28, Chapter 7, Article 2, or similar statutes in another state; and
    - c. Unless the person in subsection (C)(1)(d) intends to operate the ground ambulance vehicle only as a volunteer not-for-profit service, the following fees for each ground ambulance vehicle to be registered:
      - i. A \$50 registration fee, as required under A.R.S. § 36-2212(D); and
      - ii. A \$200 ambulance operation fee, as required under A.R.S. § 36-2240(3); and
  2. When the certificate of registration for the first ground ambulance vehicle to be operated by the ground ambulance service is issued.
- G.** The Department may deny an application under this Section if an applicant:
1. Fails to comply with any provision in A.R.S. Title 36, Chapter 21.1;
  2. Fails to comply with any provision in this Article or Article 2, 10, or 11 of this Chapter;
  3. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
  4. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).
- H.** If the Department denies the transfer of a certificate of necessity, the certificate holder shall not discontinue service, except as provided in A.R.S. § 36-2238.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). R9-25-

904 renumbered to R9-25-903; new Section R9-25-904 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-905. Application for Amendment of a Certificate of Necessity (Authorized by A.R.S. §§ 36-2232, 36-2240, 36-2247)**

- A.** A certificate holder requesting to amend the certificate of necessity due to a change in the legal name of the ground ambulance service shall submit to the Department:
1. The certificate of necessity number for the ground ambulance service;
  2. The name of the ground ambulance services on the certificate of necessity;
  3. The new legal name of the ground ambulance service;
  4. The name, title, address, email address, and telephone number of an individual whom the Department may contact about the requested amendment;
  5. Documentation demonstrating that the change in the name of the ground ambulance service does not constitute a change of ownership; and
  6. If applicable, documentation showing the new legal name of the ground ambulance service on:
    - a. Documentation of insurance coverage required according to R9-25-908(A), and
    - b. Coverage by a surety bond if required under A.R.S. § 36-2237(B).
- B.** A certificate holder requesting to amend the certificate of necessity for a reason other than a change in subsection (A) shall submit to the Department:
1. The following information in a Department-provided format:
    - a. The certificate of necessity number for the ground ambulance service;
    - b. The name and address of the ground ambulance service on the certificate of necessity;
    - c. The name, title, address, email address, and telephone number of an individual whom the Department may contact about the requested amendment;
    - d. A description of the requested change and the rationale for the change;
    - e. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
    - f. Attestation that the applicant is familiar with the requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter and will comply with applicable statutes and rules in any matter relating to or affecting the ground ambulance service;
    - g. Attestation that the certificate holder will meet the conditions of a modified certificate of necessity, including billing only those rates and charges approved and set by the Director;
    - h. Attestation that any information or documents submitted to the Department are true and correct; and
    - i. The signature of the applicant or the applicant's designated representative and the date signed;
  2. For a change in the legal address of the ground ambulance service:
    - a. The new legal address of the ground ambulance service; and
    - b. If applicable, documentation showing the new legal address of the ground ambulance service on documentation of insurance coverage required according to R9-25-908(A);

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3. For a change in the hours of service:
  - a. The current and proposed new hours of service,
  - b. The date on which the applicant plans to implement the change,
  - c. Information about the effect the requested change is expected to have on patients,
  - d. Information about the effect the requested change is expected to have on other EMS providers or ground ambulance services in or around the service area, and
  - e. Information about the financial effect the requested change is expected to have on the ground ambulance service;
4. For a change in the level of service to be provided:
  - a. If planning to begin providing critical care services or ALS services:
    - i. A description of how the certificate holder plans to provide administrative medical direction according to R9-25-201 and on-line medical direction according to R9-25-202,
    - ii. A copy of a current written contract for providing administrative medical direction,
    - iii. A copy of a current written contract for providing on-line medical direction, and
    - iv. Proof of professional liability insurance for personnel providing ALS services or critical care services as required in R9-25-908(A)(1)(a)(iii);
  - b. If planning to begin providing only BLS services:
    - i. A description of the rationale for stopping the provision of ALS services or critical care services,
    - ii. An acknowledgement that another emergency medical services provider may be granted a certificate of necessity to provide ALS services or critical care services in the service area to meet the needs of patients, and
    - iii. A plan for rendezvousing with another ground ambulance service providing ALS services or critical care services, if applicable, for patients requiring more than BLS services, including the identification of the other ground ambulance service;
  - c. Information about the effect the requested change is expected to have on patients, including how the requested change will result in quality patient care;
  - d. Information about the effect the requested change is expected to have on other EMS providers or ground ambulance services in or around the service area; and
  - e. Information about the financial effect the requested change is expected to have on the ground ambulance service;
5. For a change in the type of service to be provided:
  - a. If planning to begin providing interfacility transports of patients with a time-critical condition:
    - i. An estimate of the number of transports to be provided;
    - ii. The names of the health care institutions anticipated to be the source or destination of the transports;
    - iii. The proposed response times and compliance percentages for the interfacility transport of a patient with a time-critical condition;
  - iv. A justification for the response time or compliance percentage that demonstrates how quality patient care will be provided; and
  - v. Whether another ground ambulance service is currently providing interfacility transports of patients with a time-critical condition in the service area and, if so, the name of the other ground ambulance service and the anticipated financial impact on the other ground ambulance service if the change is approved;
- b. If planning to begin providing interfacility transports of patients who do not have a time-critical condition or convalescent transports:
  - i. An estimate of the number of transports to be provided;
  - ii. The names of the health care institutions anticipated to be the source or destination of the transports;
  - iii. Either:
    - (1) A plan for complying with the requirements in R9-25-908(E)(3)(c) that demonstrates how quality patient care will be provided, including to patients with a time-sensitive condition; or
    - (2) A plan and justification for a standard different from that in R9-25-908(E)(3)(c);
  - iv. If the certificate holder is requesting to amend the certificate of necessity according to A.R.S. § 36-2234.01, the information required according to A.R.S. § 36-2234.01(B)(1) and (2); and
  - v. Whether another ground ambulance service is currently providing interfacility transports or convalescent transports in the service area and, if so, the name of the other ground ambulance service and the anticipated financial impact on the other ground ambulance service if the change is approved;
- c. If planning to begin providing ambulance response or transport requested through 9-1-1 or a similar system:
  - i. An estimate of the number of transports to be provided;
  - ii. The names of the health care institutions anticipated to be the destination of the transports;
  - iii. The proposed response times or compliance percentage;
  - iv. A justification for the response times or compliance percentage that demonstrates how quality patient care will be provided; and
  - v. Whether another ground ambulance service is currently providing ambulance response or transport requested through 9-1-1 or a similar system in the service area and, if so, the name of the other ground ambulance service and the anticipated financial impact on the other ground ambulance service if the change is approved;
- d. Information about the effect the requested change is expected to have on patients, including how the requested change will result in quality patient care;
- e. Information about the effect the requested change is expected to have on health care institutions within and surrounding the service area to which and from



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- which the ground ambulance service would be transporting patients;
- f. Information about the effect the requested change is expected to have on other EMS providers or ground ambulance service in or around the service area;
  - g. Information about the financial effect the requested change is expected to have on the ground ambulance service; and
  - h. If the planned change will result in new or revised back-up agreements, a copy of the new or revised back-up agreement;
6. Except as specified in subsection (D), for a change in the service area:
    - a. A description of the current service area and the proposed service area by any method specified in A.R.S. § 36-2233(E) and global positioning system data that would allow a map to be created that illustrates the current service area and the proposed service area;
    - b. The following information about the proposed service area to be used by the Director in assessing the need for the proposed change:
      - i. The square miles within the proposed service area;
      - ii. The population demographics within the proposed service area;
      - iii. The change in the population demographics since the last national census;
      - iv. The medical needs of the population within the proposed service area;
      - v. The number of anticipated requests for each type of service and level of service in the proposed service area;
      - vi. The available routes of travel within the proposed service area;
      - vii. The geographic features and environmental conditions within the proposed service area;
      - viii. Whether a ground ambulance service currently operates in all or part of the proposed service area and if so, where;
      - ix. The available medical and emergency medical resources within the proposed service area;
      - x. The geographic distribution of health care institutions within and surrounding the proposed service area to which and from which the ground ambulance service would be transporting patients; and
      - xi. The proposed response times and compliance percentage, for each scene locality and priority that will be assigned by the applicant to a response;
    - c. Information about the effect the requested change is expected to have on patients, including how the requested change will result in quality patient care;
    - d. Information about the effect the requested change is expected to have on health care institutions within and surrounding the proposed service area to which and from which the ground ambulance service would be transporting patients;
    - e. Information about the effect the requested change is expected to have on EMS providers in the proposed service area that do not provide transport;
    - f. Information about the financial effect the requested change is expected to have on the ground ambulance service;
    - g. Whether the applicant has a proposed deployment plan for the ground ambulance vehicles registered under Article 10 of this Chapter to the applicant, including:
      - i. Whether suboperation stations will be used or whether ground ambulance vehicles will be deployed based on experience with the level and types of calls; and
      - ii. If suboperation stations will be used, where the applicant plans to locate suboperation stations within the applicant's proposed service area;
    - h. Whether the applicant has a plan for participating in the implementation of a political subdivision's emergency preparedness plan;
    - i. A list of EMS providers in surrounding service areas with whom the applicant has a back-up agreement or from whom the applicant has a letter of support; and
    - j. Any other information specified in R9-25-906 that the applicant believes relevant to a determination of the public necessity for the change in the service area;
  7. For a change in the ground ambulance service's response times for ambulance response or transport requested through 9-1-1 or a similar system or for an interfacility transport of a patient with a time-critical condition:
    - a. A description of the ground ambulance service's current response times and compliance percentage;
    - b. The results of the analysis of response time performance required in R9-25-908(G)(2);
    - c. The requested response times or compliance percentage, including a justification for each response time;
    - d. Information about the effect the requested change is expected to have on patients, including applicable information in subsections (B)(6)(b) and (c);
    - e. Information about the effect the requested change is expected to have on health care institutions within and surrounding the service area to which and from which the ground ambulance service would be transporting patients;
    - f. Information about the effect the requested change is expected to have on EMS providers in the service area that do not provide transport; and
    - g. Information about the financial effect the requested change is expected to have on the ground ambulance service;
  8. For a change in the plan for complying with the requirements in R9-25-908(E)(3)(c), or with a standard different from that in R9-25-908(E)(3)(c), that demonstrates how quality patient care will be provided, including to patients with a time-sensitive condition:
    - a. A description of the ground ambulance service's current plan;
    - b. The results of the analysis of the performance required in R9-25-908(H)(2);
    - c. The requested standard if different from that in R9-25-908(E)(3)(c);
    - d. Information about the effect the requested change is expected to have on patients, including applicable information in subsections (B)(6)(b) and (c);

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- e. Information about the effect the requested change is expected to have on health care institutions within and surrounding the service area to which and from which the ground ambulance service would be transporting patients; and
    - f. Information about the financial effect the requested change is expected to have on the ground ambulance service;
  - 9. For a change in the special limitations or conditions on the ground ambulance service's certificate of necessity:
    - a. A description of the special limitations or conditions on the ground ambulance service's certificate of necessity;
    - b. The requested change to the special limitations or conditions on the ground ambulance service's certificate of necessity, including a justification for each change and how the change is in the best interest of the public;
    - c. Information about the effect the requested change is expected to have on patients, including how the requested change will result in quality patient care;
    - d. Information about the effect the requested change is expected to have on health care institutions within and surrounding the service area to which and from which the ground ambulance service would be transporting patients;
    - e. Information about the effect the requested change is expected to have on EMS providers in the service area that do not provide transport; and
    - f. Information about the financial effect the requested change is expected to have on the ground ambulance service;
  - 10. Information required in R9-25-1102 and R9-25-1109(B), as applicable, related to the change, including any change in:
    - a. The proposed general public rates for services provided, or
    - b. The proposed charges;
  - 11. If applicable, letters of support for the change;
  - 12. Any other information or documentation demonstrating the public necessity for the change or otherwise justifying the change;
  - 13. Any other information or documents requested by the Director to clarify incomplete or ambiguous information or documents;
  - 14. Any documents, exhibits, or statements that the amending certificate holder wishes to submit to assist the Director in evaluating the proposed amendment; and
  - 15. The \$50 application filing fee.
- C.** A certificate holder subject to special limitations or conditions that are not displayed on the certificate holder's certificate of necessity may request, according to subsections (B)(1) and (9), to have the special limitations or conditions modified if the special limitations or conditions were the result of a final decision of the Director, established according to A.R.S. § 41-1092.08(F), issued before January 1, 2024.
- D.** If a certificate of necessity was granted to a certificate holder under A.R.S. § 36-2233(I)(2), the certificate holder shall notify the Department of a change in the service area within 30 calendar days after the change is finalized and include:
- 1. The following information in a Department-provided format:
    - a. The certificate of necessity number for the ground ambulance service,
    - b. The name and address of the ground ambulance service on the certificate of necessity,
    - c. A description of the change and the reason for the change,
    - d. The effective date of the change,
    - e. Attestation that the information or documents submitted to the Department are true and correct, and
    - f. The signature of the certificate holder's designated representative and the date signed;
  - 2. A description of the current service area and the proposed service area by any method specified in A.R.S. § 36-2233(E) and global positioning system data that would allow a map to be created that illustrates the current service area and the proposed service area; and
  - 3. Documentation establishing that the change in service area is under A.R.S. § 36-2233(E)(2).
- E.** The Department shall approve or deny an application under subsection (B) or (C) according to A.R.S. § 36-2233, Article 12 of this Chapter, and, if applicable, R9-25-1106 and R9-25-1107.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-906. Determining Public Necessity (Authorized by A.R.S. § 36-2233(F))**

- A.** In determining public necessity for an initial or amended certificate of necessity, the Director shall consider the following to ensure quality patient care:
- 1. The following information, as proposed by the applicant for the service area:
    - a. Proposed response times or compliance percentage,
    - b. The priority that may be assigned by an applicant or a certificate holder to a response, and
    - c. The percentage of time the actual response time for a run is or is anticipated to be compliant with the proposed response times during a 12-month period;
  - 2. Whether issuing the certificate of necessity is in the public's best interest:
    - a. Based on a possible gap in service or unmet needs in the service area; and
    - b. To ensure consistent service provision, efficiency, cost-effectiveness, and the health and safety of individuals in the service area;
  - 3. The information in R9-25-902(A)(1) through (4), (6), (8), (12) through (14), and (19) through (22);
  - 4. If applicable, the information in subsection (B); and
  - 5. Other matters determined by the Director or the applicant to be relevant to the determination of public necessity.
- B.** In deciding whether issuing a certificate of necessity to more than one ground ambulance service for the same service area or overlapping service areas is in the public's best interest, the Director shall consider the following in addition to the information in subsections (A)(1) through (3):
- 1. The existence of another ground ambulance service providing ambulance response or transport to all or part of the service area, including the level of service and type of service being provided;
  - 2. The current response times and compliance percentages achieved for requests made through 9-1-1 or a similar system in all or part of the service area;

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3. If applicable, the current response times and compliance percentages achieved for interfacility transports for patients with a time-critical condition in all or part of the service area;
  4. If applicable, the applicant's plans to provide interfacility transports for patients with no time-critical condition in all or part of the service area in compliance with R9-25-908(E)(3);
  5. The applicant's plans for implementation, taking into consideration the stability and consistency of service provision;
  6. If available, information or data that demonstrates the inability of the other certificate holder to provide services in all or part of the service area;
  7. How the applicant plans to interact with the ground ambulance service currently providing services in all or part of the service area, including the information in R9-25-908(E)(1)(a), (b), and (c);
  8. The availability of emergency medical services in all or part of the service area;
  9. The financial impact on certificate holders whose service area includes all or part of the service area in the requested certificate of necessity;
  10. The demonstrated need for additional 9-1-1 or similarly dispatched transport, convalescent transport, or interfacility transport, as applicable, including:
    - a. Whether a study or statistical analysis demonstrating need has been created for or adopted by the applicant, a political subdivision within the current or proposed service area, or a local emergency medical services coordinating system under A.R.S. § 36-2210 that:
      - i. Examines whether another ground ambulance service is necessary within the service area or proposed service area to provide ambulance response or transport; and
      - ii. Takes into account the current or proposed service area's medical, fire, and police services and the other ground ambulance service;
    - b. If a study or statistical analysis in subsection (B)(11)(a) exists, the content of the study or statistical analysis demonstrating need; and
    - c. Information received by the Department from a political subdivision, a health care institution, an elected official, or another interested party, as described in A.R.S. § 36-2233(D), indicating a need;
  11. For an application for additional 9-1-1 or similarly dispatched transport, the difference between the current response times in the service area for 90% compliance and the response times for 90% compliance proposed by the applicant; and
  12. Whether a certificate holder for the service area has demonstrated noncompliance with requirements in this Article, Articles 2, 10, or 11 of this Chapter, or A.R.S. Title 36, Chapter 21.1.
- C. The Department may periodically assess whether there have been changes in public necessity associated with a certificate of necessity, to include ensuring quality patient care.
- Historical Note**
- New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). R9-25-906 renumbered to R9-25-907; new Section R9-25-906 renumbered from R9-25-903 and amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).
- R9-25-907. Determining Response Times, Priority for Responses, and Compliance with Specified Times (Authorized by A.R.S. §§ 36-2232, 36-2233, 36-2236)**
- A. The Department may periodically assess whether the following parameters, as associated with a certificate of necessity, are appropriate to ensure quality patient care:
1. Response times, consistent with A.R.S. §§ 36-2232(A)(4) and 36-2236(E);
  2. The priority to be assigned by a certificate holder to a response;
  3. The percentage of time that the actual response time for a run is compliant with the response times for the certificate of necessity during a 12-month period;
  4. If applicable, the plan for complying with the requirements in R9-25-908(E)(3)(c), or with a standard different from that in R9-25-908(E)(3)(c), that demonstrates how quality patient care will be provided, including to patients with a time-sensitive condition; and
  5. If applicable, the percentage of time that the certificate holder is compliant with the standards in the plan in subsection (A)(4) during a 12-month period.
- B. In determining response times, the priority to be assigned by a certificate holder to a response, and the percentage of time the actual response time for a run is compliant with the proposed response times during a 12-month period for all or part of a service area or proposed service area, the Director may consider the following:
1. Differences in scene locality, if applicable;
  2. The response times and compliance percentages of other ground ambulance services in similar scene localities, as determined by historical response time data;
  3. The population density and demographics in the service area or proposed service area;
  4. The geographic features and environmental conditions within the service area or proposed service area;
  5. The geographic distribution of health care institutions within and surrounding the service area or proposed service area to which and from which the ground ambulance service would be transporting patients;
  6. Requirements of a 9-1-1 or similar dispatch system for all or part of the service area;
  7. Requirements in a contract approved by the Department between a ground ambulance service and a political subdivision or health care institution;
  8. Whether the certificate holder provides interfacility transports of patients with a time-critical condition and, if so:
    - a. The geographic distribution of health care institutions in the service area, and
    - b. The anticipated volumes of 9-1-1 dispatches and of interfacility transports;
  9. The basis for prioritization for the dispatch of a ground ambulance vehicle or an emergency medical services provider;
  10. Information from a political subdivision, a health care institution, an elected official, or another interested party, as described in A.R.S. § 36-2233(D), in the service area that was received by the Department about the request; and
  11. Other information submitted according to R9-25-902(A)(2) and (14) or R9-25-905(B), as applicable; and
  12. Other matters determined by the Director to be relevant to a determination of response times and compliance per-

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centage, for each scene locality and priority that will be assigned by the applicant to a response.

C. The Department may:

1. Develop a set of uniform standards for response times based on historical response time data:
  - a. By using the scene locality of a service area or proposed service area, and
  - b. Considering the response time for 90 percent of runs;
2. Compare the actual performance of a ground ambulance service to the applicable uniform standard developed according to subsection (C)(1);
3. Establish response times based on the applicable uniform standard and the factors specified in subsection (B); and
4. Take enforcement action, if appropriate, against a certificate holder based on response-time performance compared with the uniform standard, taking into consideration the factors in subsection (B).

D. In determining compliance with the standards in the plan in subsection (A)(4) during a 12-month period, the Director may consider the following:

1. The information submitted according to R9-25-902(A)(2) and (14) or R9-25-905(B), as applicable;
2. The geographic distribution of health care institutions in the service area and the anticipated volumes of interfacility transports and 9-1-1 dispatches;
3. Requirements in a contract approved by the Department between a ground ambulance service and health care institution;
4. The basis for prioritization for the dispatch of a ground ambulance vehicle according to procedures established by the certificate holder's medical direction authority;
5. Information from a political subdivision, a health care institution, an elected official, or another interested party, as described in A.R.S. § 36-2233(D), in the service area that was received by the Department about the request; and
6. Other matters determined by the Director to be relevant to a determination of compliance with the standards in the plan in subsection (A)(4).

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section R9-25-907 repealed; new Section R9-25-907 renumbered from R9-25-906 and amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-908. Operations (Authorized by A.R.S. §§ 36-2204.02, 36-2211, 36-2224, 36-2232, 36-2233, 36-2237, 36-2241)**

A. Insurance: A certificate holder shall:

1. Either:
  - a. Maintain with an insurance company authorized to transact business in this state:
    - i. A minimum single occurrence automobile liability insurance coverage of \$1,000,000 for ground ambulance vehicles;
    - ii. A minimum single occurrence professional liability insurance coverage for the ground ambulance service of \$1,000,000; and
    - iii. If the certificate holder provides ALS services or critical care services, a minimum single occurrence professional liability insurance coverage for personnel of the ground ambulance

service providing ALS services or critical care services of \$1,000,000; or

- b. Be self-insured for the amounts in subsection (A)(1)(a); and

2. Submit to the Department within seven days after renewal of the insurance coverage in subsection (A)(1)(a) or a change in how the insurance coverage in subsection (A)(1)(a) or (b) is obtained:

- a. A copy of the certificate of insurance in subsection (A)(1)(a); or
- b. Documentation of self-insurance according to subsection (A)(1)(b).

B. Record Retention: According to A.R.S. § 36-2241, a certificate holder shall maintain the following records for the Department's review and inspection:

1. The certificate holder's financial statements;
2. All federal and state income tax records;
3. All employee-related expense reports and payroll records;
4. All bank statements and documents used to reconcile accounts;
5. All documents establishing the depreciation of assets, such as schedules or accounting records on ground ambulance vehicles, equipment, office furniture, and other plant and equipment assets subject to depreciation;
6. All prehospital history incident reports, as specified in subsection (J)(1);
7. All patient billing and reimbursement records;
8. All dispatch records, as specified in subsection (J)(2);
9. All policies and procedures required by this Article or Article 2, 10, or 11 of this Chapter;
10. All plans required by this Article or Article 2, 10, or 11 of this Chapter;
11. Documentation of the analysis of response time performance according to subsection (G)(2);
12. Documentation of the analysis of performance of interfacility transports of patients with no time-critical condition, including patients with a time-sensitive condition, according to subsection (H)(1);
13. Documentation of notification to the Department of instances of noncompliance according to subsection (K)(1)(c);
14. All back-up agreements, contracts, grants, and financial assistance records related to ground ambulance vehicles, ambulance response, and transport;
15. All written complaints about the ground ambulance service; and
16. Information about destroyed or otherwise irretrievable records in a file including:
  - a. A list of each record destroyed or otherwise irretrievable,
  - b. A description of the circumstances under which each record became destroyed or otherwise irretrievable, and
  - c. The date each record was destroyed or became otherwise irretrievable.

C. Staffing: A certificate holder shall ensure that:

1. If a ground ambulance vehicle is marked with a level of service, the ground ambulance vehicle is staffed to provide the level of service identified;
2. An administrative medical director for the ground ambulance service complies with requirements in R9-25-201(F) and R9-25-502(B);

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3. Policies and procedures are established, implemented, and maintained that cover:
    - a. Job descriptions, duties, and qualifications, including required skills and knowledge for EMCTs and other employees; and
    - b. Orientation and in-service education for EMCTs and other employees;
  4. An EMCT employed by the ground ambulance service:
    - a. Is assigned patient care duties consistent with the EMCT's scope of practice and the administrative medical director's evaluation of the EMCT's skills and capabilities;
    - b. Complies with the protocols required in R9-25-201(E)(2);
    - c. Receives training on the policies and procedures required in R9-25-201(E)(3)(b); and
    - d. Receives ongoing education, training, or remediation consistent with the policies and procedures required in R9-25-201(E)(3)(b)(x); and
  5. Staffing of ground ambulance vehicles:
    - a. For the provision of BLS or ALS, is consistent with A.R.S. § 36-2239; and
    - b. For critical care services, includes at least one:
      - i. Paramedic with an additional endorsement, indicating additional training and authorization from the Department to provide critical care services; or
      - ii. Registered nurse.
  - D. Communications and Advertising:** A certificate holder shall ensure that the ground ambulance service:
    1. Makes a good faith effort to communicate information:
      - a. About its hours of operation to the general public through print media, broadcast media, the Internet, or other means; and
      - b. About resource availability and deployment to other EMS providers in overlapping and surrounding service areas;
    2. Does not advertise that the ground ambulance service:
      - a. Provides a type of service or level of service other than what is granted in the certificate of necessity,
      - b. Operates in the service area other than what is granted in the certificate of necessity, or
      - c. In a manner that circumvents the use of 9-1-1 or another similarly designated emergency telephone number;
    3. Establishes, implements, and maintains the protocol for providing information to emergency receiving facility staff concurrent with the transfer of care, required in R9-25-201(E)(2)(d)(i), which includes:
      - a. The date and time the dispatch was received by the ground ambulance service;
      - b. The unique number used by the ground ambulance service to identify the run;
      - c. The name of the ground ambulance service;
      - d. The number or other identifier of the ground ambulance vehicle used for the run;
      - e. The following information about the patient:
        - i. The patient's name;
        - ii. The patient's date of birth or age, as available;
        - iii. The principal reason for requesting services for the patient;
        - iv. The patient's medical history, including any chronic medical illnesses, known allergies to medications, and medications currently being taken by the patient;
  - v. The patient's level of consciousness at initial contact and when reassessed;
    - vi. The patient's pulse rate, respiratory rate, oxygen saturation, and systolic blood pressure at initial contact and when reassessed;
    - vii. The results of an electrocardiograph, if available;
    - viii. The patient's glucose level at initial contact and when reassessed, if applicable;
    - ix. The patient's level of responsiveness score, as applicable, at initial contact and when reassessed;
    - x. The results of the patient's neurological assessment, if applicable; and
    - xi. The patient's pain level at initial contact and when reassessed; and
  - f. Any procedures or other treatment provided to the patient at the scene or during transport, including any agents administered to the patient; and
4. Establishes, implements, and maintains a protocol for providing information to another certificate holder, ambulance service, EMS provider, or health care institution concurrent with the transfer of care, which includes the information in subsections (D)(3)(c), (d), (e), and (f).
- E. Dispatch and Scheduling:** A certificate holder shall ensure that:
  1. A contract or other agreement, including internal policies and procedures, to provide dispatch exists and includes:
    - a. Information about other certificate holders with which the certificate holder has a back-up agreement;
    - b. The process and parameters under which a ground ambulance vehicle of another certificate holder will be dispatched to respond to a call to which a ground ambulance vehicle of the certificate holder cannot respond;
    - c. Except as specified in subsection (E)(2), for an area within the certificate holder's service area that overlaps with another certificate holder's service area, that the nearest ground ambulance vehicle to the patient's location, under either certificate holder that can provide the necessary level of service, will be directed to respond to a call made through 9-1-1 or a similar dispatch system; and
    - d. If the entity providing dispatch is external to the ground ambulance service, a requirement that the certificate holder receive a copy of each dispatch made under the contract or other agreement;
  2. If a certificate holder has a ground ambulance service contract under R9-25-1104 with a political subdivision, the ground ambulance service contract contains requirements that specify a method for dispatch, which may differ from requirements in subsection (E)(1)(c); and
  3. For an interfacility transport of a patient with no time-critical condition:
    - a. Unless already specified in a written agreement between the certificate holder and the person requesting the interfacility transport, the entity receiving the request for the interfacility transport provides an estimated time of arrival to the person requesting the interfacility transport at the time that the interfacility transport is requested;

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- b. If the estimated time of arrival provided according to subsection (E)(3)(a) changes to a later time, the ground ambulance service, either directly or indirectly, does one of the following:
    - i. Contacts another ground ambulance service to respond to the dispatch, based on the ground ambulance service's back-up plan and back-up agreements;
    - ii. Provides to the contact at the requesting health care institution the name and telephone number of another ground ambulance service with which the ground ambulance service has a back-up agreement; or
    - iii. Provides an amended estimated time of arrival to the person requesting transport that takes into consideration:
      - (1) The patient's condition and needs, and
      - (2) Health and safety;
  - c. Unless otherwise specified on the certificate holder's certificate of necessity, the actual time of arrival of a ground ambulance vehicle at a health care institution for an interfacility transport of a patient who does not have a time-critical condition is within 60 minutes of the estimated time of arrival in subsection (E)(3)(a) or amended estimated time of arrival in subsection (E)(3)(b)(iii) for at least 90% of the interfacility transports; and
  - d. If the interfacility transport does not meet the standards in subsection (E)(3)(c), factors that may have contributed to not meeting the standards are considered through the quality improvement process in subsection (K)(2)(b).
- F. Transport:** A certificate holder:
- 1. Shall only provide ambulance response or transport within the service area identified in the certificate holder's certificate of necessity except:
    - a. When authorized by a service area's dispatch, before the service area's ground ambulance vehicle arrives at the scene;
    - b. According to a back-up agreement; or
    - c. If the area is not included in the service area of another certificate holder;
  - 2. Except as specified in subsection (F)(3), shall transport a patient in the certificate holder's service area who requests transport; and
  - 3. May deny transport to a patient in the certificate holder's service area:
    - a. As limited by A.R.S. § 36-2224;
    - b. If the patient is in a health care institution and the patient's medical condition requires a level of care or monitoring during transport that exceeds the scope of practice of the ambulance attendants' certification;
    - c. If the transport may result in an immediate threat to the ambulance attendant's safety, as determined by the ambulance attendant, the certificate holder, the administrative medical director, or a physician providing on-line medical direction and does not affect the ground ambulance service's hours of operation;
    - d. If the patient is 18 years or age or older, or meets the requirements in A.R.S. § 12-2451, 44-131, or 44-132, and refuses to be transported; or
    - e. If the patient is in a health care institution and does not meet the federal requirements for medically necessary ground vehicle ambulance transport as identified in 42 CFR 410.40.
- G. Response Time Performance:** A certificate holder shall ensure that:
- 1. Response times resulting from a 9-1-1 or similar system dispatch or, if applicable, a request for the interfacility transport of a patient with a time-critical condition comply with requirements of the certificate holder's certificate of necessity;
  - 2. Response time performance, based on the information in subsection (J)(2), is assessed at least every six months for compliance with requirements of the certificate holder's certificate of necessity;
  - 3. The following are reported to the Department annually, in a Department-provided format, concurrent with the submission of the information required in R9-25-909:
    - a. Response time data that complies with requirements in A.R.S. § 36-2232(A)(3), and
    - b. The results of the response time performance assessments in subsection (G)(2); and
  - 4. If response time performance does not comply with requirements of the certificate holder's certificate of necessity, either:
    - a. A corrective action plan, developed according to R9-25-910(E)(2)(a) through (d), is submitted to the Department with the information required in subsection (G)(3); or
    - b. The certificate holder submits to the Department with the information required in subsection (G)(3) documentation demonstrating that noncompliance was due to:
      - i. A situation specified in A.R.S. § 36-2232(G), or
      - ii. An external factor beyond the control of the certificate holder.
- H. Performance of Interfacility Transports of Patients with No Time-Critical Condition:** A certificate holder shall ensure that:
- 1. The performance of interfacility transports of patients with no time-critical condition:
    - a. Is based on the information in subsection (J)(2);
    - b. Is assessed at least every six months;
    - c. Includes the analysis of:
      - i. The number of calls received;
      - ii. The time a call was received;
      - iii. The initial estimated time of arrival, according to subsection (E)(3)(a); and
      - iv. The time of arrival at the patient's location; and
    - d. May include:
      - i. Any other information about cancelled calls, amended estimated times of arrival, or delays that may have factored into performance; and
      - ii. A description of any actions taken by the certificate holder to improve performance;
  - 2. The results of the performance assessments in subsection (H)(1) are reported to the Department annually in a Department-provided format, concurrent with the submission of the information required in R9-25-909; and
  - 3. If the performance of interfacility transports of patients with no time-critical condition does not comply with subsection (E)(3)(c) or requirements of the certificate holder's certificate of necessity, as applicable, either:
    - a. A corrective action plan, developed according to R9-25-910(E)(2)(a) through (d), is submitted to the

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Department with the information required in subsection (H)(2); or

- b. The certificate holder submits to the Department with the information required in subsection (H)(2) documentation demonstrating that noncompliance was due to an external factor beyond the control of the certificate holder.
- I. The Department may require that a certificate holder contract for third-party monitoring of response time performance as part of a:
  1. Political subdivision contract, unless both parties to the contract waive the requirement; or
  2. Corrective action plan.
- J. Records: A certificate holder shall ensure that:
  1. A prehospital incident history report, in a Department-provided format, is created for each patient that includes the following information, as available:
    - a. The name and identification number of the ground ambulance service;
    - b. Information about the software for the storage and submission of the prehospital incident history report;
    - c. The unique number assigned to the run;
    - d. The unique number assigned to the patient;
    - e. Information about the response to the dispatch, including:
      - i. The level of service requested;
      - ii. Information obtained by the person providing dispatch about the request;
      - iii. Information about the ground ambulance vehicle assigned to the dispatch;
      - iv. Information about the EMCTs responding to the dispatch;
      - v. The priority assigned to the dispatch; and
      - vi. Response delays, as applicable;
    - f. The date and time that:
      - i. The call requesting service was received through the 9-1-1 or similar dispatch system,
      - ii. The request was received by the person providing dispatch,
      - iii. The ground ambulance service received the dispatch,
      - iv. The ground ambulance vehicle left for the patient's location,
      - v. The ground ambulance vehicle arrived at the patient's location,
      - vi. The EMCTs in the ground ambulance vehicle arrived at the patient's side,
      - vii. Transfer of care for the patient occurred at a location other than the destination,
      - viii. The ground ambulance vehicle departed the patient's location,
      - ix. The ground ambulance vehicle arrived at the destination,
      - x. Transfer of care for the patient occurred at the destination, and
      - xi. The ground ambulance vehicle was available to take another call;
    - g. Information about the patient, including:
      - i. The patient's first and last name;
      - ii. The address of the patient's residence;
      - iii. The county of the patient's residence;
      - iv. The country of the patient's residence;
      - v. The patient's gender, race, ethnicity, and age;
      - vi. The patient's estimated weight;
      - vii. The patient's date of birth; and
      - viii. If the patient has an alternate residence, the address of the alternate residence;
  - h. The primary method of payment for services and anticipated level of payment;
  - i. Information about the scene, including:
    - i. Specific information about the location of the scene;
    - ii. Whether the ground ambulance vehicle was first on the scene;
    - iii. The number of patients at the scene;
    - iv. Whether the scene was the location of a mass casualty incident; and
    - v. If the scene was the location of a mass casualty incident, triage information;
  - j. Information about the reason for requesting service for the patient, including:
    - i. The date and time of onset of symptoms and when the patient was last well;
    - ii. Information about the principal reason the patient needs services;
    - iii. The patient's symptoms;
    - iv. The results of the EMCT's initial assessment of the patient;
    - v. If the patient was injured, information about the injury and the cause of the injury;
    - vi. If the patient experienced a cardiac arrest, information about the etiology of the cardiac arrest and subsequent treatment provided; and
    - vii. For an interfacility transport, the reason for the transport;
  - k. Information about any specific barriers to providing care to the patient;
  - l. Information about the patient's medical history, including:
    - i. Known allergies to medications,
    - ii. Surgical history,
    - iii. Current medications, and
    - iv. Alcohol or drug use;
  - m. Information about the patient's current medical condition, including the information in subsections (D)(2)(e)(v) through (xi) and the time and method of assessment;
  - n. Information about agents administered to the patient, including the dose and route of administration, time of administration, and the patient's response to the agent;
  - o. If not specifically included under subsection (J)(1)(l), (l)(iv), (m), or (n), the information required in A.A.C. R9-4-602(A);
  - p. Information about any procedures performed on the patient and the patient's response to the procedure;
  - q. Whether the patient was transported and, if so, information about the transport;
  - r. Information about the destination of the transport, including the reason for choosing the destination;
  - s. Whether transfer of care for the patient to another EMS provider or ambulance service occurred and, if so, identification of the EMS provider or ambulance service;
  - t. Unless transfer of care for the patient to another EMS provider or ambulance service occurred, information about:

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- i. Whether the destination facility was notified that the patient being transported has a time-critical condition and the time of notification;
      - ii. The disposition of the patient at the destination, and
      - iii. The disposition of the run;
    - u. Any other narrative information about the patient, care received by the patient, or transport; and
    - v. The name and certification level of the EMCT providing the information; and
  - 2. Dispatch records for each call or request for service, including all cancelled runs, contain the following information, in a Department-provided format:
    - a. The name of the ground ambulance service;
    - b. The date;
    - c. Level of service;
    - d. Type of service;
    - e. Staffing of the run;
    - f. Time of receipt of the call;
    - g. Time of the dispatch;
    - h. Departure time to the patient's location;
    - i. Address of the patient's location;
    - j. Time of arrival at the patient's location;
    - k. Departure time to the destination health care institution;
    - l. Name and address of the destination health care institution;
    - m. Time of arrival at the destination health care institution;
    - n. Any type of delay, if applicable;
    - o. The unique reference number used by the ground ambulance service to identify the patient, dispatch, or run;
    - p. The number assigned to the ground ambulance vehicle by the certificate holder;
    - q. The priority assigned by a certificate holder to the response;
    - r. The scene locality;
    - s. Whether the dispatch is a scheduled transport; and
    - t. The estimated time of arrival, as provided according to subsection (E)(3)(a), if applicable.
  - K.** Assuring Consistent, Compliant Performance: A certificate holder shall:
    - 1. Adopt, implement, and maintain policies and procedures for:
      - a. Complaint resolution;
      - b. Assessing the ground ambulance service's compliance with requirements in this Article, Articles 2, 10, or 11 of this Chapter, or A.R.S. Title 36, Chapter 21.1, including the review of:
        - i. The information provided to an emergency receiving facility for compliance with the protocol required in R9-25-201(E)(2)(d),
        - ii. Chain of custody for drugs,
        - iii. Compliance with minimum equipment requirements for a ground ambulance vehicle,
        - iv. Compliance with requirements in R9-25-201(E)(3), and
        - v. The quality improvement parameters in subsection (K)(2)(b) related to the provision of services;
      - c. Notifying the Department within 30 calendar days after completing an assessment in subsection (K)(1)(b), during which an instance of noncompliance was identified, and submitting a corrective action plan that complies with requirements in R9-25-910(E)(2)(a) through (d); and
    - d. A quality improvement process according to subsection (K)(2);
  - 2. Establish, document, and implement a quality improvement process, as specified in policies and procedures, through which:
    - a. Data related to initial patient assessment, patient care, transport services provided, and patient status upon arrival at the destination are:
      - i. Collected continuously;
      - ii. For the information required in subsection (J)(1), submitted to the Department, in a format specified by the Department and within 48 hours after the beginning of a run, for quality improvement purposes; and
      - iii. If notified that the submission of information to the Department according to subsection (K)(2)(a)(ii) was unsuccessful, corrected and resubmitted within seven days after notification;
    - b. Continuous quality improvement processes are developed and implemented to identify, document, and evaluate issues related to the provision of services to ensure quality patient care, including:
      - i. Care provided to patients with time-critical conditions, including deviations from national treatment standards for a patient with a time-critical condition;
      - ii. Transport, including an interfacility transport of a patient that does not have a time-critical condition;
      - iii. Documentation; and
      - iv. Patient status upon arrival at the destination;
    - c. A committee consisting of the administrative medical director, the individual managing the ground ambulance service or designee, and other employees as appropriate:
      - i. Review the data in subsection (K)(2)(a) and any issues identified in subsection (K)(2)(b) on at least a quarterly basis; and
      - ii. Implement activities to improve performance when deviations in patient care, transport, or documentation are identified; and
    - d. The activities in subsection (K)(2)(c) are documented, consistent with A.R.S. §§ 36-2401, 36-2402, and 36-2403; and
  - 3. Ensure that the information required in subsections (J)(2)(a) through (s) is submitted to the Department, in a Department-provided format, and within 48 hours after the receipt of a call or request for service.
- L.** If a certificate holder has a reasonable basis to believe that a situation or circumstance specified according to A.R.S. § 36-2211(A) has occurred, the certificate holder shall:
  - 1. If applicable, take immediate action to prevent the recurrence of the situation or circumstance;
  - 2. Report the suspected situation or circumstance to the Department and, if applicable, according to A.R.S. § 13-3620 or 46-454;
  - 3. Document:
    - a. The suspected situation or circumstance;
    - b. Any action taken according to subsection (L)(1); and
    - c. The report in subsection (L)(2);



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4. Maintain the documentation in subsection (L)(3) for at least 12 months after the date of the report in subsection (L)(2);
  5. Initiate an investigation of the situation or circumstance and document the following information within five working days after the report required in subsection (L)(2):
    - a. The dates, times, and description of the situation or circumstance;
    - b. A description of any injury to a patient related to the suspected situation or circumstance and any change to the patient's physical, cognitive, functional, or emotional condition;
    - c. The names of witnesses to the suspected situation or circumstance; and
    - d. The actions taken by the certificate holder to prevent the suspected situation or circumstance from occurring in the future; and
  6. Maintain a copy of the documented information required in subsection (L)(5) and any other information obtained during the investigation for at least 12 months after the date the investigation was initiated.
- M.** A certificate holder shall notify the Department of a change in the number or location of suboperation stations in the certificate holder's service area, according to A.R.S. § 36-2232(C)(4), and include:
1. The certificate of necessity number for the ground ambulance service;
  2. The name of the ground ambulance services on the certificate of necessity;
  3. The name, title, address, email address, and telephone number of an individual whom the Department may contact about the notification; and
  4. Information about the change, including, as applicable:
    - a. How the number of suboperation stations is changed from the information on the certificate holder's certificate of necessity;
    - b. The address of each suboperation station that is being removed from service; and
    - c. The address, hours of operation, and telephone number of each new suboperation station located within the service area.
- N.** A certificate holder shall submit to the Department, no later than 180 days after the certificate holder's fiscal year end, the information in the Ambulance Revenue and Cost Report specified in R9-25-909(A) or (C), as appropriate to the certificate holder's business organization.
- Historical Note**
- New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section R9-25-908 repealed; new Section R9-25-908 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1). Amended by final expedited rulemaking at 31 A.A.R. 404 (January 24, 2025), with an immediate effective date of December 31, 2024 (Supp. 24-4).
- R9-25-909. Ambulance Revenue and Cost Reporting Requirements (Authorized by A.R.S. §§ 36-2232, 36-2246)**
- A.** Except as provided in subsection (C), a certificate holder shall ensure that an Ambulance Revenue and Cost Report for a ground ambulance service includes, in a Department-provided format:
1. The following information to identify the source and time period for the Ambulance Revenue and Cost Report:
    - a. The legal name of the ground ambulance service and any other names by which the ground ambulance service is known;
    - b. The identifying number on the certificate holder's current certificate of necessity, if applicable;
    - c. The physical address at which financial records on which the information in the Ambulance Service and Cost Report is based are maintained;
    - d. The mailing address for the ground ambulance service, if different from the address in subsection (A)(1)(c);
    - e. The name, title, email address, and telephone number of the following:
      - i. The individual responsible for managing the ground ambulance service; and
      - ii. The individual to contact regarding the information in the Ambulance Service and Cost Report;
    - f. The beginning date and ending date of the reporting period; and
    - g. Whether the method of valuing inventory is:
      - i. First-in-first-out;
      - ii. Last-in-first-out; or
      - iii. Another method, including a description of the method;
  2. The following information to provide data in support of information in other portions of the Ambulance Revenue and Cost Report:
    - a. Except as provided in subsection (B), for each of the following, for the reporting period, under the ground ambulance service's subscription service rate, contract rate, or general public rate, the number of:
      - i. Transports billed at the critical care rate,
      - ii. Transports billed at the ALS base rate,
      - iii. Transports billed at the BLS base rate,
      - iv. Miles billed at the mileage rate while a patient is being transported,
      - v. Hours and minutes billed according to R9-25-1108(E), and
      - vi. Canceled and non-billable runs;
    - b. For each of subsections (A)(2)(a)(i) through (vi), the total number for all three rates for the reporting period; and
    - c. If applicable, the number of hours different classifications of EMCT and other ambulance attendants volunteered for the ground ambulance service and the total number of volunteer hours for the reporting period;
  3. The following information about revenue generated for the reporting period from routine operations of the ground ambulance service:
    - a. Except as provided in subsection (B), the amount of revenue generated from the following sources of revenue:
      - i. Transports billed at the critical care rate;
      - ii. Transports billed at the ALS base rate;
      - iii. Transports billed at the BLS base rate;
      - iv. Miles billed at the mileage rate while a patient is being transported;
      - v. Hours and minutes billed according to R9-25-1108(E),

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- vi. Charges for disposable supplies, medical supplies, medications, and oxygen-related items;
- vii. Charges for nursing services;
- viii. Charges for positioning a staffed ground ambulance vehicle at a public or private event, such as a sporting event or car race; and
- ix. Other sources of routine operating revenue; and
- b. The total amount of revenue generated for the reporting period from routine operations of the ground ambulance service;
- 4. The costs of goods, such as disposable supplies, medical supplies, medications, and oxygen-related items, charged to patients for the reporting period, calculated as:
  - a. The cost of the beginning inventory of all such goods,
  - b. Plus the costs of purchased items,
  - c. Plus any other costs, and
  - d. Minus the cost of the ending inventory of all such goods;
- 5. The following information about revenue generated for the reporting period from sources other than routine operations of the ground ambulance service:
  - a. For each entity with which the ground ambulance service has a ground ambulance service contract:
    - i. The name of the entity with which the ground ambulance service has the contract,
    - ii. The total number of billable runs for the reporting period,
    - iii. The amount billed for the reporting period based on the general public rate,
    - iv. The percent discount under the contract, and
    - v. The resulting discount amount;
  - b. The total amount of the discount amount from all the entities listed according to subsection (A)(5)(a); and
  - c. For a ground ambulance service providing subscription service, subscription service revenue and direct expenses, including:
    - i. The amount billed for the reporting period at the general public rate established according to R9-25-1101 or R9-25-1102;
    - ii. Any reductions to the amount in subsection (A)(5)(c)(i) due to:
      - (1) The discount amount the ground ambulance service receives from AHCCCS as an allowable rate,
      - (2) The discount amount the ground ambulance service receives from Medicare as an allowable rate,
      - (3) The subscription service rate established according to R9-25-1105, and
      - (4) Uncollectable revenue associated with subscription service;
    - iii. The total of the amounts in subsections (A)(5)(c)(ii)(1) through (4);
    - iv. The difference between the amount in subsection (A)(5)(c)(i) and the amount in subsection (A)(5)(c)(iii);
    - v. The amount of revenue from the sales of subscription service contracts;
    - vi. A description of other revenue associated with subscription service and the amount of revenue;
    - vii. The total subscription service revenue, calculated as the sum of the amounts in subsections (A)(5)(c)(iv) through (vi); and
    - viii. Direct expenses incurred selling subscription service contracts, by type of expense and in total;
  - d. The amount of revenue generated for the reporting period, by type of source of revenue, including from any other sources of revenue besides routine operations of the ground ambulance service;
  - e. The total amount of revenue generated for the reporting period from sources other than routine operations of the ground ambulance service;
  - 6. Except as provided in subsection (B), the following information about discounts for all applicable patients for the reporting period, based on the difference between the general public rate a ground ambulance service assesses a patient and the discount amount the ground ambulance service receives for each of the following:
    - a. From AHCCCS reimbursement;
    - b. From Medicare reimbursement;
    - c. From a contact rate or range of rates established according to R9-25-1103; and
    - d. From the provision of subscription service established according to R9-25-1105;
    - e. From any other discount amount, including a description of the source and the amount; and
    - f. The totals of subsections (A)(6)(a) through (e);
  - 7. The total amount of revenue generated and allowances given by the ground ambulance service for the reporting period;
  - 8. The following information about personnel of the ground ambulance service:
    - a. Except as provided in subsection (B), the number of FTEs, calculated as the sum of all hours for which employee wages were paid for the reporting period divided by 2,080, for each of the following categories of personnel, for the reporting period:
      - i. Owners or officers of the ground ambulance service;
      - ii. Managers of the ground ambulance service;
      - iii. Each classification of ambulance attendants who provide services on a ground ambulance vehicle, not including personnel who were paid wages on a per run basis; and
      - iv. Other types of employees;
    - b. The total number of FTEs for the reporting period;
    - c. Except as provided in subsection (B), the following for each category of personnel in subsections (A)(8)(a)(i) through (iv), including personnel who were paid wages on a per run basis:
      - i. Gross wages,
      - ii. Payroll taxes,
      - iii. Employee fringe benefits, and
      - iv. The totals of subsections (A)(8)(c)(i) through (iii);
    - d. The total amount of personnel expenses in subsection (A)(8)(c) for all personnel;
    - e. Details of salaries and wages paid to officers or owners of the ground ambulance service, including:
      - i. The name, title, and percentage ownership of each officer or owner;
      - ii. The salary or wages paid and FTE equivalent for the time the officer or owner spent performing management duties, for each officer or owner;

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- iii. The salary or wages paid and FTE equivalent for the time the officer or owner spent performing duties as an EMCT, for each officer or owner;
- iv. The salary or wages paid and FTE equivalent for the time the officer or owner spent performing office or administrative duties, for each officer or owner;
- v. The salary or wages paid and FTE equivalent for the time the officer or owner spent performing other types of duties, for each officer or owner; and
- vi. The total salary or wages paid and FTE equivalent for the time all officers or owners spent performing the types of duties in subsections (A)(8)(e)(ii) through (v); and
- f. Details on scheduled shifts, hourly wages, annual salary, and amount per run or shift for each category of personnel in subsection (A)(8)(b)(ii) through (iv);
- 9. Except as provided in subsection (B), the operating expenses incurred by the ground ambulance service for the reporting period, for each type of operating expense;
- 10. The total operating expenses incurred by the ground ambulance service for the reporting period;
- 11. Ambulance service income, calculated as the difference between the amount identified in subsection (A)(7) and the amount identified in subsection (A)(10);
- 12. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the ground ambulance service for the reporting period;
- 13. The total income and expenses, other than revenue and operating expenses, for the reporting period;
- 14. The net income or loss for the reporting period, before taxes, calculated as the sum of the amounts identified in subsections (A)(11) and (A)(13);
- 15. The amounts of:
  - a. State income taxes,
  - b. Federal income taxes, and
  - c. The total of subsections (A)(15)(a) and (b);
- 16. The net income or loss for the reporting period, after taxes, calculated as the difference between the amounts in subsections (A)(14) and (A)(15)(c);
- 17. Information pertaining to depreciation of property or equipment;
- 18. The amount of assets, for each type of asset, of the ground ambulance service for the reporting period;
- 19. The total amount of assets of the ground ambulance service for the reporting period;
- 20. The amount of liabilities, for each type of liability, of the ground ambulance service for the reporting period;
- 21. The total amount of liabilities of the ground ambulance service for the reporting period;
- 22. The amount of long-term debt, for each type of long-term debt, of the ground ambulance service for the reporting period;
- 23. The total amount of long-term debt of the ground ambulance service for the reporting period;
- 24. The amount of equity, for each type of equity, of the ground ambulance service for the reporting period;
- 25. The total amount of equity of the ground ambulance service for the reporting period;
- 26. The total amount of liabilities and equity of the ground ambulance service for the reporting period;
- 27. The statement of cash flows for the reporting period;
- 28. A list of all business organizations or governmental entities affiliated with the certificate holder, if applicable, including for each:
  - a. The legal name;
  - b. The type of business organization, if applicable; and
  - c. Whether the relationship to the applicant is as a:
    - i. Parent organization,
    - ii. Subordinate organization,
    - iii. Subsidiary organization,
    - iv. Member organization, or
    - v. Business organization related to an ambulance service, EMS, or transport for which a controlling person of the applicant is also a controlling person of the business organization; and
- 29. An attestation including:
  - a. The signature of the individual specified in subsection (A)(1)(e)(i), including the individual's title and date of signature;
  - b. A statement that the individual in subsection (A)(29)(a) directed the preparation of the Ambulance Revenue and Cost Report in accordance with requirements in this Article and using an accrual basis of accounting; and
  - c. A statement that the information provided in the Ambulance Revenue and Cost Report is true and correct.
- B.** If a ground ambulance service applies local resident subsidization to reimbursement under the general public rate, a certificate holder shall ensure that the Ambulance Revenue and Cost Report for a ground ambulance service includes, in a Department-provided format:
  - 1. The following, in total and broken out for both subsidized patients and non-subsidized patients:
    - a. The information for subsections (A)(2)(a)(i) through (vi) under the ground ambulance service's general public rate;
    - b. The amount of revenue generated from the sources of revenue specified in subsections (A)(3)(a)(i) through (ix) from routine operations of the ground ambulance service; and
    - c. The amount of discount for all applicable patients for the reporting period, based on the difference between the general public rate a ground ambulance service assesses a patient and the discount amount the ground ambulance service receives:
      - i. From AHCCCS reimbursement,
      - ii. From Medicare reimbursement, and
      - iii. Due to the local resident subsidization;
  - 2. The number of FTEs, calculated as the sum of all hours for which employee wages were paid for the reporting period divided by 2,080, for each of the following categories of personnel, for the reporting period:
    - a. Managers of the ground ambulance service;
    - b. Ambulance attendants who provide services on a ground ambulance vehicle, not including personnel who were paid wages on a per run basis; and
    - c. Other types of employees;
  - 3. The following for each category of personnel in subsection (B)(2)(a) through (c):
    - a. Gross wages,
    - b. Payroll taxes,
    - c. Employee fringe benefits, and

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- d. The totals of subsections (B)(3)(a) through (c);
  4. If applicable, for each category of employee in subsection (B)(2)(a) through (c), the basis of allocation of gross wages, payroll taxes, employee fringe benefits, and the totals of the allocations; and
  5. If applicable, for each category of employee in subsection (B)(2)(a) through (c), the allocation percentage for gross wages, payroll taxes, and employee fringe benefits;
  6. The operating expenses incurred, for each type of operating expense, by the ground ambulance service for the reporting period in total and with the allocation percentage for each category of operating expense, including the basis of allocation.
- C. A certificate holder shall ensure that an Ambulance Revenue and Cost Report for a ground ambulance service under A.R.S. § 36-2246(C) includes, in a Department-provided format:
1. The following information to identify the source and time period for the Ambulance Revenue and Cost Report:
    - a. The legal name of the ground ambulance service and any other names by which the ground ambulance service is known; and
    - b. The beginning date and ending date of the reporting period; and
  2. The following information to provide data in support of information in other portions of the Ambulance Revenue and Cost Report:
    - a. For each of the following, for the reporting period, under the ground ambulance service's subscription service rate, contract rate, or general public rate, the number of:
      - i. Transports billed at the critical care rate,
      - ii. Transports billed at the ALS base rate,
      - iii. Transports billed at the BLS base rate,
      - iv. Miles billed at the mileage rate while a patient is being transported,
      - v. Hours and minutes billed according to R9-25-1108(E), and
      - vi. Canceled and non-billable runs;
    - b. For each of subsections (C)(2)(a)(i) through (vi), the total number for all three rates for the reporting period; and
    - c. If applicable, the number of hours different classifications of EMCT and other ambulance attendants volunteered for the ground ambulance service and the total number of volunteer hours for the reporting period;
  3. The following information about revenue generated for the reporting period from routine operations of the ground ambulance service:
    - a. The amount of revenue generated from the following sources of revenue:
      - i. Transports billed at the critical care rate;
      - ii. Transports billed at the ALS base rate;
      - iii. Transports billed at the BLS base rate;
      - iv. Miles billed at the mileage rate while a patient is being transported;
      - v. Hours and minutes billed according to R9-25-1108(E),
      - vi. Charges for disposable supplies, medical supplies, medications, and oxygen-related items;
      - vii. Charges for nursing services; and
      - viii. Charges for positioning a staffed ground ambulance vehicle at a public or private event, such as a sporting event or car race; and
    - b. The total amount of revenue generated for the reporting period from routine operations of the ground ambulance service;
  4. The following information about discounts for all applicable patients for the reporting period, based on the difference between the general public rate a ground ambulance service assesses a patient and the discount amount the ground ambulance service receives:
    - a. From AHCCCS reimbursement,
    - b. From Medicare reimbursement,
    - c. Due to a contact rate or range of rates established according to R9-25-1103,
    - d. Due to a subscription service rate established according to R9-25-1105,
    - e. Due to any other revenue reduction, and
    - f. From the totals of subsections (C)(4)(a) through (e);
  5. The total amount of revenue generated, less allowances given, by the ground ambulance service from routine operations for the reporting period;
  6. The following information about personnel of the ground ambulance service:
    - a. The total number of FTEs, calculated as the sum of all hours for which employee wages were paid for the reporting period divided by 2,080, for the reporting period;
    - b. The number of FTEs, for each of the following categories of personnel, for the reporting period, not including personnel who were paid wages on a per run basis:
      - i. Managers of the ground ambulance service,
      - ii. Ambulance attendants who provide services on a ground ambulance vehicle, and
      - iii. Other types of employees;
    - c. The gross wages for each category of personnel in subsection (C)(6)(b)(i) through (iii);
    - d. Payroll taxes and employee fringe benefits for each category of personnel; and
    - e. The total gross wages taxes and fringe benefits for all category of personnel in subsections (C)(6)(b)(i) through (iii);
  7. The operating expenses incurred by the ground ambulance service for the reporting period for each type of operating expense;
  8. The total operating expenses incurred by the ground ambulance service for the reporting period;
  9. The total operating income or loss, calculated as the difference between the amount identified in subsection (C)(5) and the amount identified in subsection (C)(8);
  10. The amount of revenue generated or income derived for the reporting period by type of source of revenue or income, from sources other than routine operations of the ground ambulance service, including from:
    - a. The sale of subscription service contracts under R9-25-1105;
    - b. Any other sources of operating revenue besides routine operations of the ground ambulance service, including a description of the sources and amount of revenue;
    - c. Local supportive funding; and
    - d. Any other sources of income besides routine operations of the ground ambulance service, including a description of the sources and amount of income;

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11. Any other expenses incurred by the ground ambulance service for the reporting period, including a description of the sources and amount of expenses;
12. The net income or loss for the reporting period, before taxes, from sources other than routine operations of the ground ambulance service, calculated as the sum of the amounts identified in subsections (C)(9) and (C)(10), minus the amount in subsection (C)(11);
13. The amounts of:
  - a. State income taxes,
  - b. Federal income taxes, and
  - c. The total of subsections (C)(13)(a) and (b);
14. The net income or loss for the reporting period, after taxes, calculated as the difference between the amounts in subsections (C)(12) and (C)(13)(c);
15. The amount of assets, for each type of asset, of the ground ambulance service for the reporting period;
16. The total amount of current assets of the ground ambulance service for the reporting period;
17. Information pertaining to depreciation of property or equipment;
18. The amount of liabilities, for each type of liability, of the ground ambulance service for the reporting period;
19. The total amount of liabilities of the ground ambulance service for the reporting period;
20. The amount of long-term debt, for each type of long-term debt, of the ground ambulance service for the reporting period;
21. The total amount of long-term debt of the ground ambulance service for the reporting period;
22. The amount of equity, for each type of equity, of the ground ambulance service for the reporting period;
23. The total amount of equity of the ground ambulance service for the reporting period;
24. The total amount of liabilities and equity of the ground ambulance service for the reporting period;
25. The statement of cash flows for the reporting period.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section R9-25-909 repealed; new Section R9-25-909 renumbered from R9-25-910 and amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-910. Inspections and Investigations (Authorized by A.R.S. §§ 36-2204, 36-2212, 36-2232, 36-2241, 36-2245)**

- A. The Department may conduct an inspection of a ground ambulance service, which may include the ground ambulance service's premises, records, and equipment, and each ground ambulance vehicle operated or to be operated by the ground ambulance service.
- B. If the Department receives written or verbal information alleging a violation of this Article; Article 2, 10, or 11 of this Chapter; or A.R.S. Title 36, Chapter 21.1, the Department may conduct an investigation.
  1. The Department may conduct an inspection as part of an investigation.
  2. A certificate holder shall allow the Department to inspect the ground ambulance service's premises, records, and equipment, and each ground ambulance vehicle and to interview personnel as part of an investigation.
- C. When an application for a certificate of necessity for a ground ambulance service is submitted along with a transfer request

due to a change of ownership, the Department shall determine whether an inspection is necessary based upon the potential impact to public health, safety, and welfare.

- D. The Department shall conduct each inspection in compliance with A.R.S. § 41-1009.
- E. If the Department determines that a ground ambulance service is not in compliance with the requirements in this Article; Article 2, 10, or 11 of this Chapter; or A.R.S. Title 36, Chapter 21.1, the Department may:
  1. Take an enforcement action as described in R9-25-911; or
  2. As part of a stipulated agreement under A.R.S. § 36-2245(I), require that the ground ambulance service submit to the Department, within 30 days after written notice from the Department, a corrective action plan acceptable to the Department to address issues of compliance that do not directly affect the health or safety of a patient that:
    - a. Describes how each identified instance of noncompliance will be corrected and reoccurrence prevented;
    - b. Includes a date for correcting each instance of noncompliance that is appropriate to the actions necessary to correct the instance of noncompliance;
    - c. Includes the signature of the individual acting for the certificate holder according to R9-25-102 and date signed; and
    - d. If noncompliance is associated with medical direction, EMCT skills or performance, or other issues related to compliance with Article 2 or Article 5 of this Chapter, includes the dated signature of the administrative medical director.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section R9-25-910 renumbered to R9-25-909; new Section R9-25-910 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-911. Enforcement Action (Authorized by A.R.S. §§ 36-2234(L), 36-2244, 36-2245, 41-1092.03, 41-1092.11(B))**

- A. The Department may take an action listed in subsection (B) against a ground ambulance service that:
  1. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
  2. Fails or has failed to comply with any provision in this Article or Article 2, 10, or 11 of this Chapter;
  3. Does not submit a corrective action plan, as provided in R9-25-903(A)(6), R9-25-908(G)(4)(a), R9-25-908(H)(3)(a), R9-25-908(K)(1)(c), or R9-25-910(E)(2), that is acceptable to the Department;
  4. Does not complete a corrective action plan submitted according to R9-25-903(A)(8) or R9-25-910(E)(2); or
  5. Knowingly or negligently provides false documentation or false or misleading information to the Department or to a patient, third-party payor, or other person billed for service.
- B. The Department may take the following actions against a ground ambulance service:
  1. Except as provided in subsection (B)(3), after notice and an opportunity to be heard is provided under A.R.S. Title 41, Chapter 6, Article 10, suspend:
    - a. The ground ambulance service's certificate of necessity, or

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- b. The certificate of registration of a ground ambulance vehicle operated by the ground ambulance service;
  2. After notice and an opportunity to be heard is provided under A.R.S. Title 41, Chapter 6, Article 10, revoke:
    - a. The ground ambulance service's certificate of necessity, or
    - b. The certificate of registration of a ground ambulance vehicle operated by the ground ambulance service;
  3. As permitted under A.R.S. §§ 36-2234(N) and 41-1092.11(B), if the Department determines that the public health, safety, or welfare imperatively requires emergency action and incorporates a finding to that effect in the Department's order, immediately suspend:
    - a. The ground ambulance service's certificate of necessity pending proceedings for revocation or other action, or
    - b. The certificate of registration of a ground ambulance vehicle operated by the ground ambulance service pending proceedings for revocation or other action; or
  4. Another enforcement action according to A.R.S. § 36-2245(I), (J), or (K).
- C. In determining the type of enforcement action to impose under A.R.S. § 36-2245, the Director shall consider:
  1. The severity of the violation relative to public health and safety;
  2. The number of violations relative to the annual transport volume of the certificate holder;
  3. The nature and circumstances of the violation;
  4. Whether the violation was corrected, the manner of correction, and the time-frame involved;
  5. The duration of each violation;
  6. The frequency and nature of complaints received by the Department about a certificate holder; and
  7. The impact of the penalty or assessment on the provision of ambulance response or transport in the certificate holder's service area.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). R9-25-911 repealed; new R9-25-911 renumbered from R9-25-912 and amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-912. Renumbered****Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section R9-25-912 renumbered to R9-25-911 by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**Exhibit 9A. Repealed****Historical Note**

Exhibit 9A renumbered from Exhibit A and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). The Department requested (file number R22-134) that two corrections be made to page 1 of Exhibit 9(A) as amended at 19 A.A.R. 4032 (December 13, 2013); missing form fields have also been added due to clerical errors when formatting this Exhibit (Supp. 22-3). Exhibit 9A repealed by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective

date of March 7, 2024 (Supp. 24-1).

**Exhibit A. Renumbered****Historical Note**

New Exhibit adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). New Exhibit A recodified from Article 12 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2). Exhibit A renumbered to Exhibit 9A by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**Exhibit 9B. Repealed****Historical Note**

Exhibit 9B renumbered from Exhibit B and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Exhibit 9B repealed by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**Exhibit B. Renumbered****Historical Note**

New Table adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). New Exhibit B recodified from Article 12 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2). Exhibit B renumbered to Exhibit 9B by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**ARTICLE 10. GROUND AMBULANCE VEHICLE REGISTRATION****R9-25-1001. Initial and Renewal Application for a Certificate of Registration (Authorized by A.R.S. §§ 36-2212, 36-2232, 36-2240)**

- A. To be eligible to obtain a certificate of registration for a ground ambulance vehicle, an applicant shall:
  1. Hold a current and valid certificate of necessity issued under Article 9 of this Chapter;
  2. Possess a copy of a current and valid motor vehicle registration for the ground ambulance vehicle, issued according to A.R.S. Title 28, Chapter 7, Article 2, or similar statutes in another state; and
  3. Comply with all applicable requirements of this Article; Articles 2, 9, and 11 of this Chapter; and A.R.S. Title 36, Chapter 21.1.
- B. An applicant for an initial or renewal certificate of registration of a ground ambulance vehicle shall submit an application packet to the Department that contains:
  1. The following information in a Department-provided format:
    - a. The applicant's legal business or corporate name, including all other business names used by the applicant related to the use of a ground ambulance vehicle;
    - b. The applicant's mailing address; email address; physical address of the business, if different from the mailing address; fax number, if any; and telephone number;
    - c. The following information about the ground ambulance vehicle:
      - i. The manufacturer's name;
      - ii. The year the ground ambulance vehicle was manufactured;
      - iii. The vehicle identification number of the ground ambulance vehicle;

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- iv. The unit number of the ground ambulance vehicle, assigned by the applicant;
- v. The ground ambulance vehicle's state license plate number; and
- vi. The location at which the ground ambulance vehicle will be available for inspection;
- d. If applicable, the identification number of the certificate of necessity under which the ground ambulance vehicle is registered;
- e. The name, email address, and telephone number of the individual to contact to arrange for inspection, if the inspection is preannounced;
- f. The name, title, address, email address, and telephone number of the individual acting on behalf of the applicant according to R9-25-102;
- g. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
- h. Attestation that the information provided in the application packet, including the information in the accompanying documents, is accurate and complete; and
- i. The signature of the applicant or applicant's designated representative and date signed;
- 2. A copy of documentation demonstrating compliance with subsection (A)(2); and
- 3. Unless the applicant operates or intends to operate the ground ambulance vehicle only as a volunteer not-for-profit service, the following fees:
  - a. A \$50 registration fee, as required under A.R.S. § 36-2212(D); and
  - b. A \$200 annual regulatory fee, as required under A.R.S. § 36-2240(4).
- C. Except as provided in A.R.S. § 36-2232(A)(11), the Department shall inspect each ground ambulance vehicle according to R9-25-1004(A) and (B) to determine compliance with the provisions of A.R.S. Title 36, Chapter 21.1 and this Article:
  - 1. Within 30 calendar days before an initial certificate of registration is issued by the Department; and
  - 2. At least every 12 months thereafter, before issuing a renewal certificate of registration.
- D. The Department shall review and approve or deny each application as described in Article 12 of this Chapter.
- E. If the Department approves the application and sends the applicant the written notice of approval, specified in R9-25-1201(C)(5), the Department shall issue the certificate of registration to the applicant:
  - 1. For an applicant with a current and valid certificate of necessity issued under Article 9 of this Chapter, within five working days after the date on the written notice of approval; and
  - 2. For an applicant that does not have a current and valid certificate of necessity issued under Article 9 of this Chapter, when the certificate of necessity is issued.
- F. The Department may deny a certificate of registration for a ground ambulance vehicle if the applicant:
  - 1. Fails to meet the eligibility requirements of subsection (A);
  - 2. Fails or has failed to comply with any provision in A.R.S. Title 36, Chapter 21.1;
  - 3. Fails or has failed to comply with any provision in this Article or Article 2, 9, or 11 of this Chapter;
  - 4. Knowingly or negligently provides false documentation or false or misleading information to the Department; or
  - 5. Fails to submit to the Department documents or information requested under R9-25-1201(B)(1) or (C)(3) and requests a denial as permitted under R9-25-1201(E).

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1002. Term and Transferability of Certificates of Registration (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, and 41-1092.11)**

- A. The Department shall issue an initial certificate of registration:
  - 1. With a term of one year from date of issuance of the initial certificate of registration; or
  - 2. If requested by the applicant, with a term shorter than one year that allows for the Department to conduct annual inspections of all of the applicant's ground ambulance vehicles at one time.
- B. The Department shall issue a renewal certificate of registration with a term of one year from the expiration date on the previous certificate of registration.
- C. If a certificate holder submits an application for renewal as described in R9-25-1001 before the expiration date of the current certificate of registration, the current certificate of registration does not expire until the Department has made a final determination on the application for renewal, as provided in A.R.S. § 41-1092.11.
- D. A certificate of registration is not transferable from one person to another.
- E. If there is a change in the ownership of a ground ambulance vehicle or the person who can legally possess and operate the ground ambulance vehicle, the new owner or person who can legally possess and operate the ground ambulance vehicle shall apply for and obtain a new certificate of registration before operating the ground ambulance vehicle in this state.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). R9-25-1002 renumbered to R9-25-1005; new R9-25-1002 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1003. Changes Affecting Registration (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2238, and 36-2247)**

- A. At least 30 days before the date of a change in a certificate holder's name, the certificate holder shall send the Department written notice of the name change.
- B. Within 30 days after the date of receipt of a notice described in subsection (A), the Department shall issue an amended certificate of registration that incorporates the name change but retains the expiration date of the current certificate of registration.
- C. No later than 10 days after a certificate holder ceases to operate a ground ambulance vehicle, the certificate holder shall send the Department written notice of the date that the certificate holder ceased to operate the ground ambulance vehicle and of the certificate holder's intention to relinquish the certifi-

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icate of registration for the ground ambulance vehicle as of that date.

- D.** Within 30 days after the date of receipt of a notice described in subsection (C), the Department:
1. Shall:
    - a. Void the certificate of registration for the ground ambulance vehicle; and
    - b. Send the certificate holder written confirmation of the voluntary relinquishment of the certificate of registration, with an effective date that corresponds to the written notice; and
  2. If the ground ambulance vehicle is the only ground ambulance vehicle operated by a ground ambulance service, may revoke the certificate of necessity of the ground ambulance service.
- E.** A certificate holder shall notify the Department in writing within one working day after a change in the certificate holder's eligibility to hold a certificate of registration for a ground ambulance vehicle under R9-25-1001(A)(2) or (3).
- F.** Upon receiving a notification required in subsection (E), the Department:
1. Shall revoke the certificate for the ground ambulance vehicle; and
  2. If the ground ambulance vehicle is the only ground ambulance vehicle operated by a ground ambulance service, may revoke the certificate of necessity of the ground ambulance service.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Amended by final rulemaking at 12 A.A.R. 4404, effective January 6, 2007 (Supp. 06-4). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 3487, with an immediate effective date of December 4, 2018 (Supp. 18-4). R9-25-1003 repealed; new R9-25-1003 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1004. Ground Ambulance Vehicle Inspections (Authorized by A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2232(A)(11), and 36-2241)**

- A.** Except as provided in R9-25-910(B) and subsection (B)(2), an applicant or a certificate holder shall:
1. Make a ground ambulance vehicle, equipment, and supplies available for inspection within Arizona within 10 working days after a request by the Department; and
  2. Upon the Department's request, provide the opportunity to ride in or operate the ground ambulance vehicle being inspected.
- B.** The Department:
1. Shall inspect:
    - a. Each ground ambulance vehicle according to R9-25-1005 and Table 10.1,
    - b. Supplies and equipment according to Table 10.2, and
    - c. For the level of service the ground ambulance vehicle is expected to be used to provide;
  2. May inspect, without prior notification, a ground ambulance vehicle or supplies and equipment, for the level of service a ground ambulance vehicle is being used to provide at the time of inspection; and

3. Shall conduct each inspection in compliance with A.R.S. § 41-1009.

- C.** As permitted under A.R.S. § 36-2232(A)(11), upon a certificate holder's request and at the certificate holder's expense, the annual inspection of a ground ambulance vehicle required for renewal of a certificate of registration may be conducted by a Department-approved inspection facility according to Table 10.1.
- D.** A certificate holder may request the Department to inspect all of the certificate holder's ground ambulance vehicles at the same date and location.
- E.** If, after inspection of a certificate holder's ground ambulance vehicle according to Table 10.1, the Department determines that the ground ambulance vehicle has:
1. A major defect, the certificate holder shall take the ground ambulance vehicle out-of-service until the major defect is corrected; or
  2. A minor defect, the certificate holder:
    - a. May allow the ground ambulance vehicle to be operated to transport patients for up to 15 calendar days while the minor defect is corrected; and
    - b. After 15 calendar days, shall take the ground ambulance vehicle out-of-service until the minor defect is corrected, unless granted an extension of time, according to subsection (F), to repair the minor defect.
- F.** The Department may grant an extension of time for a certificate holder to repair a minor defect upon a written request from the certificate holder, detailing the reasons for the need of an extension of time.
- G.** Within 15 calendar days after the date of repair of a major defect or minor defect, a certificate holder shall submit written notice and documentation of the repair to the Department.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). R9-25-1004 repealed; new R9-25-1004 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1005. Minimum Standards for Ground Ambulance Vehicles (Authorized by A.R.S. §§ 36-2202(A)(5), 36-2232(C)(5))**

- A.** An applicant for a certificate of registration or a certificate holder shall ensure that a ground ambulance vehicle is marked on the sides of the ground ambulance vehicle with the legal business or corporate name of the applicant or certificate holder, with letters not less than six inches in height.
- B.** An applicant for a certificate of registration or a certificate holder shall ensure a ground ambulance vehicle is equipped with the following:
1. An engine intake air cleaner that meets the ground ambulance vehicle manufacturer's engine specifications;
  2. A brake system that meets the requirements in A.R.S. § 28-952;
  3. A cooling system in the engine compartment that maintains the engine temperature operating range required to prevent damage to the ground ambulance vehicle engine;
  4. A battery:
    - a. With no leaks, corrosion, or other visible defects; and



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- b. As measured by a voltage meter, capable of generating:
    - i. 12.6 volts at rest, and
    - ii. 13.2 to 14.2 volts on high idle with all electrical equipment turned on;
- 5. A wiring system in the engine compartment designed to prevent the wire from being cut by or tangled in the engine or hood;
- 6. Hoses, belts, and wiring with no visible defects;
- 7. An electrical system capable of maintaining a positive amperage charge while the ground ambulance vehicle is stationary and operating at high idle with headlights, running lights, patient compartment lights, environmental systems, and all warning devices turned on;
- 8. An exhaust pipe, muffler, and tailpipe that meet the requirements in A.R.S. § 28-955 under the ground ambulance vehicle and securely attached to the chassis;
- 9. A frame capable of supporting the:
  - a. Gross vehicle weight of the ground ambulance vehicle; and
  - b. The anticipated weight of ambulance attendants, supplies and equipment, and patients;
- 10. A horn that meets the requirements in A.R.S. § 28-954(A);
- 11. A siren that meets the requirements in A.R.S. § 28-954(E);
- 12. A front bumper that is positioned at the forward-most part of the ground ambulance vehicle extending to the ground ambulance vehicle's outer edges;
- 13. A fuel cap of a type specified by the manufacturer for each fuel tank;
- 14. A steering system to include:
  - a. For a hydraulic power steering system:
    - i. Power-steering belts free from frays, cracks, or slippage;
    - ii. Power-steering system that is free from leaks; and
    - iii. Fluid in the power-steering system that fills the reservoir between the full level and the add level indicator on the dipstick;
  - b. For an electrical or other type of steering system that does not contain the components of a hydraulic power steering system, components that:
    - i. Provide the same functions as a hydraulic power steering system, and
    - ii. Meet manufacturer's specifications; and
  - c. Bracing extending from the center of the steering wheel to the steering wheel ring that is not cracked;
- 15. Front and rear shock absorbers that are free from leaks;
- 16. Tires on each axle that:
  - a. Are properly inflated;
  - b. Are of equal size, equal ply ratings, and equal type;
  - c. Are free of bumps, knots, or bulges;
  - d. Have no exposed ply or belting; and
  - e. Have tread groove depth equal to or more than 4/32 inch;
- 17. An air cooling system capable of achieving and maintaining a 20° F difference between the air intake and the cool air outlet;
- 18. Air cooling and heater hoses secured in all areas of the ground ambulance vehicle and chassis to prevent wear due to vibration;
- 19. Body free of damage or rust that interferes with the physical operation of the ground ambulance vehicle or creates a hole in the driver's compartment or the patient compartment;
- 20. Windshield defrosting and defogging equipment;
- 21. Emergency warning lights that provide 360° conspicuity;
- 22. At least one 5-lb. ABC dry, chemical, multi-purpose fire extinguisher in a quick release bracket, either disposable with an indicator of a full charge or with a current inspection tag;
- 23. A heating system capable of achieving and maintaining a temperature of not less than 68° F in the patient compartment within 30 minutes;
- 24. Sides of the ground ambulance vehicle insulated and sealed to prevent dust, dirt, water, carbon monoxide, and gas fumes from entering the interior of the patient compartment and to reduce noise;
- 25. Interior patient compartment wall and floor coverings that are:
  - a. In good repair and capable of being disinfected, and
  - b. Maintained in a sanitary manner;
- 26. Padding over exit areas from the patient compartment and over sharp edges in the patient compartment;
- 27. Secured interior equipment and other objects;
- 28. When present, hangers or supports for equipment mounted not to protrude more than 2 inches when not being used;
- 29. Functional lamps and signals, including:
  - a. Bright and dim headlamps,
  - b. Brake lamps,
  - c. Parking lamps,
  - d. Backup lamps,
  - e. Tail lamps,
  - f. Turn signal lamps,
  - g. Side marker lamps,
  - h. Hazard lamps,
  - i. Patient loading door lamps and side spot lamps,
  - j. Spot lamp in the driver's compartment and within reach of the ambulance attendant, and
  - k. Patient compartment interior lamps;
- 30. Side-mounted rear vision mirrors and wide vision mirror mounted on, or attached to, the side-mounted rear vision mirrors or other optical devices allowing monitoring of the area surrounding the ground ambulance vehicle;
- 31. A patient loading door that permits the safe loading and unloading of a patient occupying a stretcher in a supine position;
- 32. At least two means of egress from the patient compartment to the outside through a door;
- 33. Functional open door securing devices on a patient loading door;
- 34. Patient compartment upholstery free of cuts or tears and capable of being disinfected;
- 35. A three-point occupant restraint system installed for each seat in the driver's compartment;
- 36. A restraint system installed for each seat in the patient compartment:
  - a. For a ground ambulance vehicle manufactured before January 1, 2025, that consists of at least a seat belt; and
  - b. For a ground ambulance vehicle manufactured on or after January 1, 2025, with at least three-points of contact with the occupant of a seat;
- 37. A wheeled, multi-level stretcher that is:
  - a. Suitable for supporting a patient at each level;
  - b. At least 69 inches long and 20 inches wide;

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- c. Rated for use with a patient weighing either:
  - i. Up to 350 pounds, or
  - ii. For a ground ambulance vehicle capable of transporting a patient weighing over 350 pounds, up to the rated capability of the ground ambulance vehicle;
- d. Adjustable to allow a patient to recline and to elevate the patient's head and upper torso to an angle at least 70° from the horizontal plane;
- e. Equipped with a mattress that has a protective cover that is free of cracks, cuts, or tears and capable of being disinfected;
- f. Equipped with a five-point restraint system to secure a patient during transport; and
- g. Equipped to secure the stretcher to the interior of the vehicle during transport using the fastener required under subsection (B)(38);
- 38. A crash stable side or center mounting fastener of the quick release type to secure a stretcher to a ground ambulance vehicle;
- 39. Windshield and windows free of obstruction;
- 40. A windshield free from unrepaired starred cracks and line cracks that extend more than 1 inch from the bottom or sides of the windshield or that extend more than 2 inches from the top of the windshield;
- 41. A windshield-washer system that applies enough cleaning solution to clear the windshield;
- 42. Operable windshield wipers with a minimum of two speeds;
- 43. Functional hood latch for the engine compartment;
- 44. Fuel system with fuel tanks and lines that meets manufacturer's specifications;
- 45. Suspension system that meets the ground ambulance vehicle manufacturer's specifications;
- 46. Instrument panel that meets the ground ambulance vehicle manufacturer's specifications; and
- 47. Wheels that meet and are mounted according to manufacturer's specifications.
- C. An applicant for a certificate of registration or a certificate holder shall ensure that a ground ambulance vehicle is equipped:
  - 1. To provide, and capable of providing, voice communication between:
    - a. An ambulance attendant and the dispatch center; and
    - b. An ambulance attendant and a source from which the ambulance attendant may request and receive on-line medical direction, according to R9-25-201(E)(2)(a)(i); and
  - 2. Except as provided in subsection (E), with a global positioning monitoring device to enable the recording of times of arrival on-scene for determining response times.
- D. An applicant for a certificate of registration or a certificate holder shall ensure that a ground ambulance vehicle is equipped, as specified in Table 10.2, to provide the level of service for which the ground ambulance vehicle is to be used.
- E. An applicant for a certificate of registration or a certificate holder may request a waiver of the requirement in subsection (C)(2) by submitting to the Department, on an annual basis and in a Department-provided format, the following information:
  - 1. The applicant's or certificate holder's name;
  - 2. If applicable, the identification number of the certificate of necessity under which the ground ambulance vehicle is registered;
  - 3. The identifying information specified in R9-25-1001(B)(1)(c) for the ground ambulance vehicle to which the waiver would pertain;
  - 4. A reason and justification for the waiver;
  - 5. The name, title, address, email address, and telephone number of the individual acting on behalf of the applicant or certificate holder according to R9-25-102;
  - 6. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
  - 7. Attestation that the information provided is accurate and complete; and
  - 8. The signature of the specified according to subsection (E)(5) and date signed.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). R9-25-1005 repealed; new R9-25-1005 renumbered from R9-25-1002 and amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1006. Repealed****Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Repealed by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

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**Table 10.1. Major and Minor Defects (Authorized by A.R.S. §§ 36-2202(A)(5), 36-2212, 36-2232, 36-2234)**

The Department classifies defects on a ground ambulance vehicle as major or minor as follows:

INSPECTION ITEM	MAJOR DEFECT	MINOR DEFECT
<b>EXTERIOR:</b>		
Emergency warning lights	Lack of 360° of conspicuity	Cracked, broken, or missing lens Inoperative lamps
Ground ambulance vehicle body	Damage or rust to the exterior of the ground ambulance vehicle, which interferes with the operation of the ground ambulance vehicle Damage resulting in a hole in the driver's compartment or the patient compartment Holes that may allow exhaust or dust to enter the patient compartment Bolts attaching body to chassis loose, broken, or missing	Damage resulting in cuts or rips to the exterior of the ground ambulance vehicle
Marking		Missing company identification Incorrect size or location
Mirrors or other optical devices allowing monitoring of the area surrounding the ground ambulance vehicle	Exterior rear vision or wide vision mirrors missing or An optical device not functioning according to manufacturer's specifications	Cracked mirror glass Loose mounting bracket bolts or screws Broken mirrors Loose or broken mounting brackets Missing mounting bracket bolts or screws
Windshield		Unrepaired starred cracks or line cracks extending more than 1 inch from the bottom or side of the windshield Unrepaired starred cracks or line cracks extending more than 2 inches from the top of the windshield
Windows		Placement of nontransparent materials which obstruct view Cracked or broken
Fuel caps	Fuel caps missing or of a type not specified by the manufacturer	
Bumpers		Loose or missing bumper
Patient compartment doors	Completely or partially missing window panel Two means of egress missing or inoperative	Inoperative open door securing devices Cracked window panels
Padding over exit areas		Missing padding over exits in the patient compartment Deterioration of padding
Fire extinguisher	Absent or non-functional	Not at full charge Expired inspection tag
Exhaust system	Exhaust fumes in the patient or driver compartment	Muffler not securely attached to the chassis and tailpipe Exhaust pipe brackets not securely attached to the chassis and tailpipe End of tailpipe pinched or bent
Wheels	Loose or missing lug nuts Broken lugs Cracked or bent rims	
Tires	Tires on each axle are not of equal size, equal ply ratings, and equal type Bumps, knots, or bulges on any tire Exposed ply or belting on any tire Flat tire on any wheel	Tread groove depth less than 4/32" measured in a tread groove on any tire Not properly inflated
<b>EXTERIOR LIGHTING:</b>		
Head lamps	Inoperative	High beam inoperative Low beam inoperative Inoperative dimmer switch
Brake lamps	Both inoperative	One inoperative

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Parking lamps		Inoperative
Back-up lamps		Inoperative Cracked, broken, or missing lens
Tail lamps	Both inoperative	One inoperative Cracked, broken, or missing lens
Turn signal lamps		Any turn signal lamp inoperative Cracked, broken, or missing lens
Side marker lamps		Inoperative Cracked, broken, or missing lens
Hazard lamps		Inoperative
Loading lamps		Inoperative Cracked, broken, or missing lens
ENGINE COMPARTMENT AND BATTERY:		
Engine compartment		Inoperative hood latch Deterioration of hoses, belts, or wiring Air cooling and heater hoses not secured Fluid leaks other than engine cooling system
Battery	Not secured For a vehicle powered by an electric motor, not meeting manufacturer's guidelines for use	Deterioration of battery hold-down clamps Corrosive acid buildup on battery terminals Incapable of generating voltage in compliance with R9-25-1005(B)(4)(b)
Electrical system	Does not comply with R9-25-1005(B)(7)	
Engine compartment wiring system		Does not comply with R9-25-1005(B)(5)
Engine cooling system	Does not comply with R9-25-1005(B)(3)	Leaks in system Inadequate fluid in reservoir
Engine intake air cleaner		Does not comply with R9-25-1005(B)(1)
DRIVER'S COMPARTMENT:		
Air cooling system	Does not maintain temperature required according to R9-25-1005(B)(17)	Unsecured hoses
Instrument panel		Inoperative gauges, switches, or illumination
Global positioning monitoring device		Except if under a waiver granted under R9-25-1005(E), lack of operative equipment
Horn		Inoperative
Siren	Inoperative	
Steering wheel bracing	Steering wheel bracing cracked	
Windshield-washer system		Does not comply with R9-25-1005(B)(41)
Windshield defroster/defogger		Inoperative Ventilation system openings partially blocked
Windshield wipers	Inoperative wiper on driver's side	Inoperative speed control Split or cracked wiper blade Inoperative wiper on passenger's side
Windshield	Windshield that is obstructed Placement of nontransparent materials that obstruct view	
Equipment		Inability to secure equipment
Occupant restraint system	Absence of an occupant restraint system or inoperative occupant restraint system in the driver's compartment	Frayed material on the occupant restraint system
Spot lamp in driver's compartment		Inoperative
Exhaust system	Exhaust fumes in the driver's compartment	
PATIENT COMPARTMENT:		
Air cooling system	Does not maintain temperature required according to R9-25-1005(B)(17)	Unsecured hoses

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Heating system		Unsecured hoses Does not maintain minimum temperature required in R9-25-1005(B)(23)
Equipment	Inability to secure oxygen tanks Inability of fixed oxygen tank to hold pressure	Inability to secure other equipment Inability of portable oxygen tank to hold pressure
Interior wall and floor coverings and seat upholstery	Visible blood, body fluids, or tissue	Unrepaired cuts or holes in seats Missing pieces of floor covering Upholstery, floor, walls, or ceiling not capable of being disinfected
Occupant restraint systems and securing belts	More than one inoperative occupant restraint system in the patient compartment Absence of securing belts on a stretcher	Frayed material on the occupant restraint system or securing belt One inoperative occupant restraint system in the patient compartment
Stretcher fastener	Does not comply with R9-25-1005(B)(38)	
Hangers		Supports or hangers protruding more than 2" when not being used
Edges		Presence of exposed sharp edges
Patient Compartment interior lamps	All lamps inoperative	Inoperative individual lamps Missing lens
Stretcher	Does not comply with R9-25-1005(B)(37)	
Exhaust system	Exhaust fumes in the patient compartment	
COMMUNICATION EQUIPMENT:		
Communication capability between an ambulance attendant and the dispatch center	Lack of operative communication equipment	
Communication capability between an ambulance attendant and the physician providing on-line medical direction	Lack of operative communication equipment	
GENERAL SYSTEMS:		
Frame	Cracks in frame	
Suspension	Broken suspension parts U-bolts loose or missing	Bent suspension parts Leaking shock absorbers Cracks or breaks in shock absorber mounting brackets
Side insulation	Missing or settled insulation	Inadequate insulation
Parking brake		Inoperative
Vehicle brakes	Inoperative	Fluid leaks
Steering system	Inoperative	Power steering belts slipping Power steering belts cracked or frayed Fluid leaks Fluid does not fill the reservoir between the full level and the add level indicator on the dipstick

**Historical Note**

New Table 10.1 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

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**Table 10.2. Minimum Equipment and Supplies for Ground Ambulance Vehicles (Authorized by A.R.S. § 36-2202(A)(5))**

An applicant for a certificate of registration or a certificate holder shall ensure that a ground ambulance vehicle contains, at a minimum, the following operational equipment and supplies based on the level of service of use:

MINIMUM EQUIPMENT AND SUPPLIES	BLS	ALS
<b>A. Ventilation and Airway Equipment</b>		
1. Portable and fixed suction apparatus	X	X
2. Wide-bore tubing, rigid pharyngeal curved suction tip and flexible suction catheters in the following French sizes: a. Two in 6, 8, or 10; and b. Two in 12, 14, or 16	X	X
3. One fixed oxygen cylinder or equivalent with a minimum capacity of 106 cubic feet, a minimum pressure of 500 p.s.i., and a variable flow regulator	X	X
4. One portable oxygen cylinder with a minimum capacity of 13 cubic feet, a minimum pressure of 500 p.s.i., and a variable flow regulator	X	X
5. Oxygen administration equipment, including tubing; non-rebreathing masks (adult, pediatric, and infant sizes); and nasal cannulas (adult, Pediatric, and infant sizes)	X	X
6. Bag-valve mask, with hand-operated, self-reexpanding bag (adult size), with oxygen reservoir/accumulator; mask (adult, pediatric, infant, and neonate sizes); and valve	X	X
7. Airways, nasal (adult, pediatric, and infant sizes), one each in French sizes 16 to 34	X	X
8. Airways, oropharyngeal, two each in adult, pediatric, and infant sizes	X	X
9. Laryngoscope handle, adult and pediatric, with, if applicable, extra batteries and bulbs	-	X
10. Laryngoscope blades, one each in sizes 0, 1, and 2, straight; sizes 3 and 4, straight and curved	-	X
11. Endotracheal tubes, sizes 2.5-5.5 mm cuffed or uncuffed and 6.0-9.0 mm cuffed	-	X
12. Endotracheal tube cuff pressure manometer	-	X
13. Stylettes for Endotracheal tubes, one each in adult and pediatric sizes	-	X
14. One type of supraglottic airway device	-	X
15. Two 10 mL straight-tip syringes	-	X
16. Two long, large-bore needles for needle chest decompression, 2" to 3.25" long and 14-16G	-	X
17. Hand-held nebulizer(s)	-	X
18. Aerosol masks, one each adult and pediatric	-	X
19. Magill forceps, adult and pediatric	-	X
20. Nasogastric tubes, sizes 5F and 8F, Salem sump sizes 14F and 18F	-	X
21. End-tidal CO2 detectors, quantitative, with capability for adult and pediatric patients	-	X
22. Non-Invasive Positive Pressure Ventilation (NIPPV) device with one mask in each available size	-	X
23. In-line viral/bacterial filter	-	X
<b>B. Monitoring and Defibrillation</b>		
1. Automatic external defibrillator	X	-
2. One portable, battery-operated monitor/defibrillator, with tape write-out/recorder, defibrillator pads, adult and pediatric paddles or hands-free patches, ECG leads, and adult and pediatric chest attachment electrodes	-	X
3. Transcutaneous cardiac pacemaker, either stand-alone unit or integrated into monitor/defibrillator, including pediatric pads and cables	-	X
<b>C. Stretchers and Immobilization Devices</b>		
1. One stair chair or another mechanism for safely moving a patient in an upright sitting position	X	X
2. Cervical immobilization devices, rigid, adjustable or two each in small, medium, and large sizes	X	X
3. Head immobilization device, either firm padding or another commercial device	X	X
4. Lower extremity (femur) traction device, including lower extremity, limb support slings, padded ankle hitch, padded pelvic support, and traction strap (one adult-sized and one child-sized)	X	X
5. Two upper and two lower extremity immobilization splints in each of small, medium and large sizes	X	X
6. Two full-length spine boards	X	X
7. Supplies to secure a patient to a spine board, including at least three appropriate restraint straps (not using a single chin strap for head immobilization)	X	X
8. One cervical-thoracic spinal immobilization device for extrication	X	X
<b>D. Bandages</b>		
1. Burn pack, including standard package, two sterile burn sheets	X	X
2. Dressings, including sterile multi-trauma dressings (various large and small sizes, including three sized 10" x 12" or larger)	X	X
3. Two abdominal pads, 10" x 12" or larger	X	X
4. Fifty non-sterile 4" x 4" gauze sponges	X	X
5. Two triangular bandages	X	X
6. Four gauze rolls, sterile (4" or larger)	X	X

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7.	Ten soft roller bandages, non-sterile (4" or larger)	X	X
8.	Four occlusive dressing, sterile, 3" x 8" or larger	X	X
9.	Adhesive or self-adhesive tape, including various sizes (1" or larger) hypoallergenic adhesive and two various sizes (1" or larger) adhesive or self-adhesive	X	X
<b>E. Obstetrical</b>			
1.	Sterile obstetrical kit, including towels, 4" x 4" dressing, umbilical tape, sterile scissors or other cutting utensil, bulb suction, clamps for cord, sterile gloves, blankets, and a head cover	X	X
2.	An alternate portable patient heat source or 2 heat packs	X	X
<b>F. Miscellaneous</b>			
1.	Sphygmomanometer (infant, pediatric, and adult regular and large sizes)	X	X
2.	Stethoscope	X	X
3.	Pediatric equipment sizing reference guide	-	X
4.	Thermometer with low temperature capability	X	X
5.	Paramedic or trauma shears capable of cutting heavy bandages, clothing, belts, and boots	X	X
6.	Cold packs	X	X
7.	Two flashlights with extra batteries or recharger, as applicable	X	X
8.	Two blankets	X	X
9.	One blanket with head cover made of heat-reflective material	X	X
10.	Two sheets	X	X
11.	Two cloth towels, each at least 12" by 12" in size	X	X
12.	Five disposable emesis bags or basins	X	X
13.	Lubricating jelly (water soluble)	X	X
14.	Glucometer or blood glucose measuring device with reagent strips	X	X
15.	Pulse oximeter with pediatric and adult probes	X	X
16.	Automatic blood pressure monitor	-	X
17.	Trauma arterial tourniquet	X	X
18.	One scalpel	-	X
19.	Mass casualty triage sorting capability for at least 50 individuals (triage tags)	X	X
20.	Beginning April 2024, a method to electronically document patient information and treatment that is capable of being transferred	X	X
<b>G. Infection Control (Latex-free equipment shall be available)</b>			
1.	Two sets of eye protection (full peripheral glasses or goggles, face shield)	X	X
2.	Two masks, at least as protective as a National Institute for Occupational Safety and Health-approved N-95 respirator, which are fit-tested	X	X
3.	Two pairs of gloves, non-sterile, and three pairs of non-latex gloves	X	X
4.	Two jumpsuits or gowns	X	X
5.	Two pairs of shoe covers	X	X
6.	Disinfectant hand wash, commercial antimicrobial (towelette, spray, or liquid)	X	X
7.	Disinfectant solution for cleaning equipment	X	X
8.	Standard sharps containers	X	X
9.	Disposable red trash bags	X	X
10.	Ten protective facemasks or cloth face coverings for patients	X	X
<b>H. Injury Prevention Equipment</b>			
1.	Safety vest or other garment with reflective material for each personnel member	X	X
2.	Hazardous material reference guide	X	X
3.	Hearing protection for personnel	X	X
<b>I. Vascular Access</b>			
1.	The following intravenous solution administration sets:	-	X
a.	Four intravenous solution administration sets, capable of delivering 10 drops per cc		
b.	Four intravenous solution administration sets capable of delivering 60 drops per cc		
2.	Antiseptic solution (alcohol wipes and povidone-iodine wipes)	X	X
3.	Intravenous pressure infuser device or mechanical capability	-	X
4.	Intravenous catheters, one each of 14, 16, 18, 20, 22, and 24 G	-	X
5.	Two intraosseous needles, each capable of use in adult and pediatric patients	-	X
6.	Venous tourniquet	-	X

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7. The following syringes:	-	X
a. Two 1 mL tuberculin,		
b. Four 3 mL,		
c. Four 5 mL,		
d. Four 10-12 mL,		
e. Two 20 mL, and		
f. Two 50-60 mL		
8. Three 5 micron filter needles	-	X
9. Assorted sizes of non-filter needles	-	X
10. Intravenous arm boards, adult and pediatric	-	X
<b>J. Medications</b>		
1. Agents specified in a table of agents, established according to A.R.S. § 36-2204 and available through the Department at <a href="http://www.azdhs.gov/ems-regulatory-references">www.azdhs.gov/ems-regulatory-references</a> , that an administrative medical director may authorize for use based on the EMCT classification	X	X
2. Sterile saline for irrigation	X	X

**Historical Note**

New Table 10.2 made by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**ARTICLE 11. GROUND AMBULANCE SERVICE RATES AND CHARGES; CONTRACTS****R9-25-1101. Establishing Initial General Public Rates (Authorized by A.R.S. §§ 36-2232, 36-2239)**

A. As provided in R9-25-902(A)(19), an applicant wanting to establish initial general public rates as part of an application for an initial certificate of necessity shall include the following in the application packet submitted to the Department according to R9-25-902(A):

1. A copy of the applicant's financial statements, covering the most recent consecutive 12-month period;
2. A copy of the purchase agreements or lease agreements listed according to R9-25-902(A)(17), if not already submitted according to R9-25-902(A)(28);
3. For all business organizations or governmental entities affiliated with the applicant listed according to R9-25-902(A)(1)(d), the methodology and calculations used in allocating costs among the applicant and government entities or profit or not-for-profit businesses;
4. Other documents, exhibits, or statements that may assist the Department in setting the general public rates; and
5. Any other information or documents requested by the Director to clarify or complete the application.

B. A certificate holder applying for initial general public rates shall submit to the Department:

1. The following information, in a Department-provided format:
  - a. The identifying number on the certificate holder's current certificate of necessity;
  - b. The legal business or corporate name, address, telephone number, and facsimile number of the ground ambulance service;
  - c. Any other names by which the certificate holder is known;
  - d. The names of all other business organizations or governmental entities operated by the certificate holder related to the ground ambulance service;
  - e. The name, title, address, email address, and telephone number of the following:
    - i. Each certificate holder and individual responsible for managing the ground ambulance service,
    - ii. The individual acting for the certificate holder according to R9-25-102,

iii. The individual to contact to access the ground ambulance service's records required in R9-25-908(B), and

iv. The statutory agent for the ground ambulance service or the individual designated by the certificate holder to accept service of process and subpoenas for the ground ambulance service;

- f. The requested general public rates;
- g. Whether the certificate holder agrees to allow the Department to submit supplemental requests for information under R9-25-1201(C)(3);
- h. Attestation that the information or documents submitted to the Department are true and correct; and
- i. The signature of the individual acting for the certificate holder according to R9-25-102 and the date signed;

2. A copy of the certificate holder's financial statements, covering the most recent consecutive 12-month period;
3. A projected Ambulance Revenue and Cost Report covering the first consecutive 12 months of operation under the requested general public rates in subsection (B)(1)(f);
4. A copy of all actual or anticipated purchase agreements or lease agreements to be used in connection with the ground ambulance service, including the monetary amount and duration of each agreement, for:
  - a. Real estate,
  - b. Ground ambulance vehicles, or
  - c. Equipment exceeding \$10,000;
5. For all business organizations or governmental entities affiliated with the certificate holder listed according to subsection (B)(1)(d), the methodology and calculations used in allocating costs among the certificate holder and business organizations or governmental entities;
6. Other documents, exhibits, or statements that may assist the Department in setting the general public rates; and
7. Any other information or documents requested by the Director to clarify or complete the application.

C. Each certificate holder requesting to apply for a uniform general public rate under A.R.S. § 36-2232(E) shall submit to the Department:

1. The information required in subsection (B)(1);
2. The documents required in subsections (B)(4) through (7);
3. A copy of the certificate holder's financial statements, covering the most recent consecutive 24-month period;



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4. Projected Ambulance Revenue and Cost Reports covering the first consecutive 24 months of operation under the requested general public rates in subsection (B)(1)(f); and
  5. A document signed by each certificate holder requesting to apply for a uniform general public rate under A.R.S. § 36-2232(E).
- D.** The Department shall review an application under subsection (B) or (C) according to R9-25-1106, R9-25-1107, and R9-25-1201 and approve or deny the application according to A.R.S. § 36-2232 and Article 12 of this Chapter.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1102. Application for Adjustment of General Public Rates (Authorized by A.R.S. §§ 36-2234, 36-2239)**

- A.** A certificate holder applying for an adjustment of general public rates not exceeding the monetary amount calculated according to A.R.S. § 36-2234(G) shall submit to the Department, in a Department-provided format:
1. The name of the certificate holder,
  2. The identifying number on the certificate holder's current certificate of necessity,
  3. A statement that the certificate holder is making the request according to A.R.S. § 36-2234(G),
  4. A statement that the certificate holder has not applied for an adjustment to the certificate holder's general public rates within the previous six months,
  5. The amount of the requested general public rate,
  6. The effective date of the requested general public rate adjustment,
  7. An attestation that the information provided by the certificate holder is true and correct, and
  8. The signature of the individual acting for the certificate holder according to R9-25-102 and the date signed.
- B.** A certificate holder requesting an adjustment of general public rates exceeding the monetary amount calculated according to A.R.S. § 36-2234(G) shall submit to the Department:
1. The following information in a Department-provided format:
    - a. The identifying number on the certificate holder's current certificate of necessity;
    - b. The legal business or corporate name, address, telephone number, and facsimile number of the ground ambulance service;
    - c. Any other names by which the certificate holder is known;
    - d. The names of all other business organizations or governmental entities operated by the certificate holder related to the ground ambulance service;
    - e. The name, title, address, email address, and telephone number of the following:
      - i. Each entity and individual responsible for managing the ground ambulance service,
      - ii. The individual acting for the certificate holder according to R9-25-102,
      - iii. The individual to contact to access the ground ambulance service's records required in R9-25-908(B), and
      - iv. The statutory agent for the ground ambulance service or the individual designated by the certificate holder to accept service of process and subpoenas for the ground ambulance service;
  2. A copy of the certificate holder's financial statements, covering at least:
    - a. If applicable under A.R.S. § 36-2234(H), the most recent consecutive 24-month period; or
    - b. The most recent consecutive 12-month period;
  3. A copy of the certificate holder's most recent Ambulance Revenue and Cost Report;
  4. A projected Ambulance Revenue and Cost Report covering the first consecutive 12 months of operation under the requested general public rates in subsection (B)(1)(h);
  5. If the ground ambulance service has a contract with a federal or tribal entity, a copy of the certificate holder's contract with each federal or tribal entity unless the contract has been submitted to the Department and reviewed according to R9-25-1104;
  6. A copy of all actual or anticipated purchase agreements or lease agreements to be used in connection with the ground ambulance service, including the monetary amount and duration of each agreement, for:
    - a. Real estate,
    - b. Ground ambulance vehicles, or
    - c. Equipment exceeding \$10,000;
  7. For all business organizations or governmental entities affiliated with the certificate holder listed according to subsection (B)(1)(d), the methodology and calculations used in allocating costs among the certificate holder and business organizations or governmental entities;
  8. Other documents, exhibits, or statements that support the reason for the general public rate adjustment request as specified in subsection (B)(1)(g) and may assist the Department in setting the general public rates; and
  9. Any other information or documents requested by the Director to clarify or complete the application.
- C.** An applicant under R9-25-902, requesting to join a group of certificate holders, with a uniform general public rate established according to A.R.S. § 36-2232(E) and R9-25-1101(C), shall submit to the Department:
1. The information required in R9-25-902(A) and R9-25-1101(A)(1);
  2. The documents required in subsections (B)(5) through (9);
  3. A copy of the applicant's financial statements, covering the most recent consecutive 24-month period;

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4. Projected Ambulance Revenue and Cost Reports covering the first consecutive 24 months of operation under the uniform general public rate; and
  5. Documentation supporting the request, signed by each certificate holder with the uniform general public rate.
- D.** A certificate holder with a uniform general public rate, established according to A.R.S. § 36-2232(E) and R9-25-1101(C), that wants to establish a different general public rate shall submit to the Department:
1. A request according to subsection (A) or (B), as applicable; and
  2. Documentation that the certificate holder has notified the other certificate holders with the uniform public rate of the certificate holder's intention of establishing a different general public rate.
- E.** A certificate holder with a uniform general public rate, established according to A.R.S. § 36-2232(E) and R9-25-1101(C), that is notified according to subsection (D)(2) shall, within 60 calendar days after the date of notification of the Department's decision to grant the different general public rate:
1. Notify the Department of the intention to retain the rate currently on the certificate of necessity; or
  2. Submit to the Department the information and documentation required in subsection (B).
- F.** The Department shall review an application under this Section according to R9-25-1106, R9-25-1107, and R9-25-1201 and approve or deny the application according to A.R.S. §§ 36-2234 and 36-2239 and Article 12 of this Chapter.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).  
Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1103. Application for a Contract Rate or Range of Rates Less than General Public Rates (A.R.S. §§ 36-2234(I) and (K), 36-2239)**

- A.** A certificate holder applying for approval of a contract rate or range of rates under A.R.S. § 36-2234(I) shall submit to the Department:
1. The following information, in a Department-provided format:
    - a. The name of the certificate holder;
    - b. The identifying number on the certificate holder's current certificate of necessity;
    - c. A statement that the certificate holder is making the request under A.R.S. § 36-2234(I);
    - d. The contract rate or range of rates being requested;
    - e. The effective date of the requested contract rate or range of rates;
    - f. An attestation that the information and documents provided by the certificate holder are true and correct; and
    - g. The signature of the individual acting for the certificate holder according to R9-25-102 and the date signed; and
  2. Information demonstrating the cost and economics of providing the transports for the requested contract rate or range of rates, such as:
    - a. A copy of the certificate holder's most recent Ambulance Revenue and Cost Report; and
    - b. A projected Ambulance Revenue and Cost Report covering the first consecutive 12 months of opera-

tion under the requested contract rate or range of rates in subsection (A)(1)(d).

- B.** A certificate holder applying for approval of a contract rate or range of contract rates under A.R.S. § 36-2234(K) shall submit to the Department:
1. The information in subsection (A)(1), in a Department-provided format; and
  2. The documents required in R9-25-1102(B)(2) through (8).
- C.** The Department shall review an application under this Section according to R9-25-1106, R9-25-1107, and R9-25-1201 and approve or deny the application according to A.R.S. §§ 36-2234 and 36-2239 and Article 12 of this Chapter.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1).  
Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1104. Ground Ambulance Service Contracts (A.R.S. §§ 36-2232, 36-2234(M))**

- A.** A certificate holder shall not institute a new service contract between the ground ambulance service and a political subdivision of this state except as provided in A.R.S. § 36-2234(M).
- B.** Before implementing a ground ambulance service contract, a certificate holder shall submit to the Department:
1. A cover letter from the certificate holder, including:
    - a. The name of the certificate holder;
    - b. The identifying number on the certificate holder's current certificate of necessity;
    - c. A statement that the certificate holder is submitting a copy of a ground ambulance service contract according to A.R.S. § 36-2234(M);
    - d. The name of the other party to the ground ambulance service contract, including, if applicable, the name of a political subdivision;
    - e. The name, title, address, email address, and telephone number of an individual representing the other party, as specified according to subsection (B)(1)(d), who the Department may contact about the proposed ground ambulance service contract if necessary;
    - f. The total number of pages of the proposed ground ambulance service contract; and
    - g. The signature of the individual acting for the certificate holder according to R9-25-102 and the date signed; and
  2. A copy of the proposed ground ambulance service contract that:
    - a. Includes the certificate holder's legal name and any other name listed on the certificate holder's current certificate of necessity;
    - b. Includes the name of the other party to the ground ambulance service contract, as specified according to subsection (B)(1)(d);
    - c. Identifies each type of service and level of service to be provided under the proposed ground ambulance service contract;
    - d. Lists the general public rates or contract rate or range of rates approved by the Director according to R9-25-1101, R9-25-1102, or R9-25-1103;
    - e. Complies with A.R.S. §§ 36-2201 through 36-2246 and this Chapter; and

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- f. Does not preclude use of the 9-1-1 system or a similar system.
- C. Except as provided in R9-25-904(A)(2), the Department shall not approve a proposed ground ambulance service contract between two certificate holders.
- D. The Department shall review a proposed ground ambulance service contract under this Section according to A.R.S. §§ 36-2232 and, if applicable, 36-2234(M) and Article 12 of this Chapter.
- E. The Department shall not enforce the provisions of a ground ambulance service contract unless the executed ground ambulance service contract has been approved by the Department and contains language authorizing the Department to enforce the provisions of the ground ambulance service contract.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1105. Application for Provision of Subscription Service or to Establish a Subscription Service Rate (A.R.S. § 36-2232(A)(1))**

- A. An applicant for an initial certificate of necessity or a certificate holder applying to provide subscription service, establish a subscription service rate, or request approval of a subscription service contract shall submit an application packet to the Department that includes:
- The following information, in a Department-provided format:
    - The name of the applicant or certificate holder;
    - The identifying number on the certificate holder's current certificate of necessity, if applicable;
    - The number of estimated subscription service contracts;
    - An estimate of the number of annual subscription service transports for the service area;
    - The proposed subscription service rate;
    - An estimate of the cost of providing subscription service to the service area;
    - An attestation that the information and documents provided by the applicant or certificate holder are true and correct; and
    - The signature of the individual acting for the applicant or certificate holder according to R9-25-102 and the date signed;
  - A copy of the proposed subscription service contract;
  - Documents supporting the estimate in subsection (A)(1)(c), such as a survey of the service area;
  - Documents supporting the estimate in subsection (A)(1)(f); and
  - Any other information or documents that the certificate holder believes may assist the Department in setting a subscription service rate.
- B. The Department shall review an application under this Section according to R9-25-1106, R9-25-1107, and R9-25-1201 and approve or deny a subscription service rate according to Article 12 of this Chapter.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Section heading corrected at request of the Department, Office File No. M11-313, filed September 12, 2011 (Supp. 10-

4). Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1106. Rate of Return Setting Considerations (A.R.S. §§ 36-2232, 36-2239)**

- A. In determining the rate of return on gross revenue in A.R.S. § 36-2239(I)(4), the Director shall consider a ground ambulance service's:
- Direct costs for operating the ground ambulance service within its service area, including the costs of supplies and equipment;
  - Indirect costs for operating the ground ambulance service within its service area, such as costs that do not include the costs of supplies or equipment;
  - Financial statements;
  - Ratio between variable and fixed costs on the financial statements;
  - Method of indirect costs allocation to specific cost-center areas;
  - Return on equity;
  - Reimbursable and non-reimbursable charges;
  - Type of business entity;
  - Monetary amount and type of debt financing;
  - Replacement and expansion costs;
  - Number of calls, transports, and billable miles;
  - Costs associated with rules, inspections, and audits;
  - Substantiated prior reported losses;
  - Medicare and AHCCCS settlements, the difference between the general public rate a ground ambulance service assesses a patient and what a ground ambulance service receives from Medicare or AHCCCS as an allowable rate; and
  - Any other information or documents needed by the Director to clarify incomplete or ambiguous information or documents.
- B. In determining the rate of return on gross revenue in A.R.S. § 36-2239(I)(4), the Director shall not consider:
- Depreciation of the portion of ground ambulance vehicles and equipment obtained through Department funding;
  - The certificate holder's travel and entertainment expenses that do not directly relate to providing the EMS or transport;
  - The monetary value of any goodwill accumulated by the certificate holder, that is, the difference between the purchase price of a ground ambulance service and the fair market value of the ground ambulance service's identifiable net assets;
  - Any penalties or fines imposed on the certificate holder by a court or government agency; and
  - Any financial contributions received by the certificate holder.
- C. In determining just, reasonable, and sufficient rates in A.R.S. § 36-2232(A)(1), the Director shall establish rates to provide for a rate of return that is at least 7% of gross revenue, calculated using the accrual method of accounting according to generally accepted accounting principles, unless the certificate holder requests a lower rate of return.
- D. The Department shall calculate the rate of return on gross revenue by dividing net income, as specified according to R9-25-909(A)(16) or (C)(14) as applicable, by gross revenue, as specified according to R9-25-909((A)(3)(b) or (C)(3)(b) as applicable.

**Historical Note**

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New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1107. Rate Calculation Factors (A.R.S. § 36-2232)**

- A. When evaluating a proposed mileage rate, the Department shall consider the following factors:
1. The cost of licensure and registration of each ground ambulance vehicle;
  2. The cost of fuel;
  3. The cost of ground ambulance vehicle maintenance;
  4. The cost of ground ambulance vehicle repair;
  5. The cost of tires;
  6. The cost of ground ambulance vehicle insurance;
  7. The cost of mechanic wages, benefits, and payroll taxes;
  8. The cost of loan interest related to the ground ambulance vehicles;
  9. The cost of the weighted allocation of overhead;
  10. The cost of ground ambulance vehicle depreciation;
  11. The cost of reserves for replacement of ground ambulance vehicles and equipment; and
  12. Mileage reimbursement, as established by Medicare guidelines for EMS and transport provided by a ground ambulance service, including considerations to maximize Medicare reimbursement.
- B. When evaluating a proposed BLS base rate, the Department shall consider the costs associated with providing EMS and transport.
- C. When evaluating a proposed ALS base rate, the Department shall consider the factors in subsection (B) and the additional costs of ALS ambulance equipment, ALS personnel, and professional liability insurance for ALS personnel.
- D. When evaluating a proposed critical care rate, the Department shall:
1. Consider the factors in subsections (B) and (C) and the additional costs of providing critical care services; and
  2. Ensure that the critical care rate is:
    - a. Equivalent to at least the amount for specialty care transport, as used in federal Medicare guidelines; and
    - b. Greater than an ALS base rate.
- E. The Department shall determine the standby waiting rate as no higher than the BLS base rate divided by 4.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1108. Implementation of Rates and Charges (A.R.S. §§ 36-2232, 36-2239)**

- A. Except as provided in A.R.S. § 36-2239(B) and (E), a certificate holder shall not institute a new general public rate, new contract rate or range of rates, or subscription service rate before receiving from the Department an approval of the new general public rate, new contract rate or range of rates, or subscription service rate.
- B. Under A.R.S. § 36-2232(A)(1) and (4), the Department may periodically review and, if appropriate, adjust rates and charges for a ground ambulance service to ensure that the rates and charges are just, reasonable, and sufficient.
- C. A certificate holder shall assess rates and charges as follows:

1. When calculating a rate or charge:
    - a. Omit fractions of less than 1/2 of 1 cent; or
    - b. Increase to the next whole cent, fractions of 1/2 of 1 cent or greater;
  2. When calculating the number of miles for a transport, use one of the following, with the number of miles rounded as specified in subsection (C)(1):
    - a. The ground ambulance vehicle's odometer reading,
    - b. Software designed to calculate mileage, or
    - c. A regional map;
  3. When calculating the reimbursement amount for mileage of a transport, multiply the number of miles for the transport by the mileage rate;
  4. When transporting two or more patients in the same ground ambulance vehicle, assess to each patient:
    - a. Fifty percent of the mileage rate and one hundred percent of the ALS or BLS base rate; and
    - b. One hundred percent of:
      - i. The charge for each disposable supply, medical supply, medication, and oxygen-related cost used on the patient; and
      - ii. Waiting time assessed according to subsection (E); and
  5. When agreed upon by prior arrangement to transport a patient to one destination and return to the point of pick-up or to one destination and then to a subsequent destination, assess only the ALS or BLS base rate, mileage rate, and standby waiting rate for the transport.
- D. When a certificate holder transfers a patient to an air ambulance, the certificate holder shall assess the patient the rates and charges for EMS and transport provided to the patient before the transfer.
- E. A certificate holder shall assess a standby waiting rate in quarter-hour increments, except for:
1. The first 15 minutes after arrival to load the patient at the point of pick-up;
  2. The time, exceeding the first 15 minutes, required by ambulance attendants to provide necessary medical treatment and stabilization of the patient at the point of pick-up; and
  3. The first 15 minutes to unload the patient at the point of destination.
- F. When a certificate holder responds to a request outside the certificate holder's service area, the certificate holder shall assess the certificate holder's own rates and charges for EMS or transport provided to the patient.
- G. When the Department or the certificate holder determines that a refund of a rate or a charge is required, the certificate holder shall refund the rate or charge within 90 days after the date of the determination.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1109. Charges (A.R.S. §§ 36-2232, 36-2239(D))**

- A. A certificate holder that charges patients for disposable supplies, medical supplies, medications, and oxygen-related costs shall submit to the Department:
1. A list of the items and the proposed charges, and
  2. A non-retroactive effective date.

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- B.** A certificate holder shall submit to the Department a new list, containing the information required in subsection (A), each time the certificate holder proposes a change in the items or the amount charged.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**R9-25-1110. Invoices (A.R.S. §§ 36-2234, 36-2239)**

- A.** A certificate holder shall ensure that:
- Each invoice for rates and charges contains the following:
    - The patient's name;
    - The certificate holder's name, address, and telephone number;
    - The date of service;
    - An itemized list of the rates and charges assessed;
    - The total monetary amount owed the certificate holder; and
    - The payment due date; and
  - Any subsequent invoice to the same patient for the same EMS or transport contains all the information in subsection (A) except the information in subsection (A)(1)(d).
- B.** A certificate holder may combine into one line item the charges for multiple items if:
- The supplies are used together for a specific purpose, and
  - The name of the combined item is included in the certificate holder's list provided to the Department according to R9-25-1109.
- C.** A certificate holder may combine rates and charges into one line item if required by a third-party payor.

**Historical Note**

New Section adopted by final rulemaking at 7 A.A.R.

1098, effective February 13, 2001 (Supp. 01-1).

Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**ARTICLE 12. TIME-FRAMES FOR DEPARTMENT APPROVALS****R9-25-1201. Time-frames (Authorized by A.R.S. §§ 36-2235, 41-1072 through 41-1079)**

- A.** The overall time-frame described in A.R.S. § 41-1072 for each type of approval granted by the Department is listed in Table 12.1. The applicant and the Director may agree in writing to extend the overall time-frame. The substantive review time-frame shall not be extended by more than 25% of the overall time-frame.
- B.** The administrative completeness review time-frame described in A.R.S. § 41-1072 for each type of approval granted by the Department is listed in Table 12.1. The administrative completeness review time-frame begins on the date that the Department receives an application form or an application packet.
- If the application packet is incomplete, the Department shall send to the applicant a written notice specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the written request until the date the Department receives a complete application packet from the applicant.
  - When an application packet is complete, the Department shall send a written notice of administrative completeness.
  - If the Department grants an approval during the time provided to assess administrative completeness, the Department shall not issue a separate written notice of administrative completeness.
- C.** The substantive review time-frame described in A.R.S. § 41-1072 is listed in Table 12.1 and begins on the date of the notice of administrative completeness.
- As part of the substantive review time-frame for an application for an approval other than renewal of an ambulance registration, the Department shall conduct inspections, conduct investigations, or hold hearings required by law.
  - If required under R9-25-402, the Department shall fix the period and terms of probation as part of the substantive review.
  - During the substantive review time-frame, the Department may make one comprehensive written request for additional documents or information and may make supplemental requests for additional information with the applicant's written consent.
  - The substantive review time-frame and the overall time-frame are suspended from the date of the written request for additional information or documents until the Department receives the additional information or documents.
  - The Department shall send a written notice of approval to an applicant:
    - Who:**
      - Meets the qualifications in A.R.S. Title 36, Chapter 21.1 and this Chapter for the type of application submitted; or
      - Is not in compliance with requirements in A.R.S. Title 36, Chapter 21.1 and this Chapter, for the type of application submitted, that do not directly affect the health or safety of a patient and submits to the Department a corrective action plan that is acceptable to the Department to address issues of compliance; and
    - For an application under R9-25-902 or R9-25-903, which may include special conditions or limitations, including a shorter renewal term, according to A.R.S. § 36-2235.
  - The Department shall send a written notice of denial to an applicant who fails to meet the qualifications in A.R.S. Title 36, Chapter 21.1, and this Chapter for the type of application submitted.
- D.** If an applicant fails to supply the documents or information under subsections (B)(1) and (C)(3) within the number of days specified in Table 12.1 from the date of the written notice or comprehensive written request, the Department shall consider the application withdrawn.
- E.** An applicant that does not wish an application to be considered withdrawn may request a denial in writing within the number of days specified in Table 12.1 from the date of the written notice or comprehensive written request for documents or information under subsections (B)(1) and (C)(3).
- F.** If a time-frame's last day falls on a Saturday, Sunday, or an official state holiday, the Department shall consider the next business day as the time-frame's last day.
- G.** A person may appeal a decision according to A.R.S. § 36-2234 or Title 41, Chapter 6, Article 6.

**Historical Note**

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New Section adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 2352, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Amended by exempt

rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

Table 12.1. Time-frames (in days)

Type of Application	Statutory Authority	Overall Time-frame	Administrative Completeness Time-frame	Time to Respond to Written Notice	Substantive Review Time-frame	Time to Respond to Comprehensive Written Request
ALS Base Hospital Certification (R9-25-204)	A.R.S. §§ 36-2201, 36-2202(A)(3), and 36-2204(5)	45	15	60	30	60
Training Program Certification (R9-25-301)	A.R.S. §§ 36-2202(A)(3) and 36-2204(1) and (3)	120	30	60	90	60
Addition of a Course (R9-25-303)	A.R.S. §§ 36-2202(A)(3) and 36-2204(1) and (3)	90	30	60	60	60
EMCT Certification (R9-25-403)	A.R.S. §§ 36-2202(A)(2), (3), and (4), 36-2202(G), and 36-2204(1)	120	30	90	90	270
EMCT Recertification (R9-25-404)	A.R.S. §§ 36-2202(A)(2), (3), (4), and (6), 36-2202(G), and 36-2204(1) and (4)	120	30	60	90	60
Extension to File for EMCT Recertification (R9-25-405)	A.R.S. §§ 36-2202(A)(2), (3), (4), and (6), 36-2202(G), and 36-2204(1) and (7)	30	15	60	15	60
Downgrading of Certification (R9-25-406)	A.R.S. §§ 36-2202(A)(2), (3), and (4), 36-2202(G), and 36-2204(1) and (6)	30	15	60	15	60
Initial Air Ambulance Service License (R9-25-704)	A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2213, 36-2214, and 36-2215	150	30	60	120	60
Renewal of an Air Ambulance Service License (R9-25-704)	A.R.S. §§ 36-2202(A)(3) and (4), 36-2209(A)(2), 36-2213, 36-2214, and 36-2215	90	30	60	60	60
Initial Certificate of Registration for an Air Ambulance (R9-25-801)	A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2240(4)	90	30	60	60	60
Renewal of a Certificate of Registration for an Air Ambulance (R9-25-801)	A.R.S. §§ 36-2202(A)(4) and (5), 36-2209(A)(2), 36-2212, 36-2213, 36-2214, and 36-2240(4)	90	30	60	60	60
Initial Certificate of Necessity (R9-25-902)	A.R.S. §§ 36-2204, 36-2232, 36-2233, 36-2240	180	30	60	120	
Renewal of a Certificate of Necessity (R9-25-903)	A.R.S. §§ 36-2233, 36-2235, 36-2240	90	30	60	60	60
Transfer of a Certificate of Necessity (R9-25-904)	A.R.S. §§ 36-2236(A) and (B), 36-2240	180	30	60	120	60
Amendment of a Certificate of Necessity (R9-25-905)	A.R.S. §§ 36-2232(A)(4), 36-2240	180	30	60	120	60
Initial Registration of a Ground Ambulance Vehicle (R9-25-1001)	A.R.S. §§ 36-2212, 36-2232, 36-2240	90	30	60	60	60
Renewal of a Ground Ambulance Vehicle Registration (R9-25-1001)	A.R.S. §§ 36-2212, 36-2232, 36-2240	90	30	60	60	60
Establishment of Initial General Public Rates (R9-25-1101)	A.R.S. §§ 36-2232, 36-2239	180	30	60	120	60

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Adjustment of General Public Rates (R9-25-1102)	A.R.S. §§ 36-2234, 36-2239	450	30	60	420	60
Contract Rate or Range of Rates Less than General Public Rates (R9-25-1103)	A.R.S. §§ 36-2234, 36-2239	450	30	60	420	60
Ground Ambulance Service Contracts (R9-25-1104)	A.R.S. § 36-2232	450	30	60	420	60
Ground Ambulance Service Contracts with Political Subdivisions (R9-25-1104)	A.R.S. §§ 36-2232, 36-2234(K)	30	15	15	15	Not Applicable
Subscription Service Rate (R9-25-1105)	A.R.S. § 36-2232(A)(1)	450	30	60	420	60

**Historical Note**

Table 12.1 renumbered from Table 1 and amended by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4). Amended by final expedited rulemaking at 24 A.A.R. 268, with an immediate effective date of January 9, 2018 (Supp. 18-1). Amended by final rulemaking at 28 A.A.R. 842 (April 29, 2022), effective June 5, 2022 (Supp. 22-2). Amended by final rulemaking at 30 A.A.R. 581 (March 29, 2024), with an immediate effective date of March 7, 2024 (Supp. 24-1).

**Table 1. Renumbered****Historical Note**

New Table adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Amended by final rulemaking at 8 A.A.R. 2352, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4). Amended by final rulemaking at 12 A.A.R. 656, effective April 8, 2006 (Supp. 06-1). Table 1 renumbered to Table 12.1 by exempt rulemaking at 19 A.A.R. 4032, effective December 1, 2013 (Supp. 13-4).

**Exhibit A. Recodified****Historical Note**

New Exhibit adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Exhibit A recodified to Article 9 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2).

**Exhibit B. Recodified****Historical Note**

New Table adopted by final rulemaking at 7 A.A.R. 1098, effective February 13, 2001 (Supp. 01-1). Exhibit B recodified to Article 9 at 12 A.A.R. 2243, effective June 2, 2006 (Supp. 06-2).

**ARTICLE 13. TRAUMA CENTERS AND TRAUMA REGISTRIES****R9-25-1301. Definitions (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

In addition to the definitions in A.R.S. § 36-2201 and R9-25-101, the following definitions apply in this Article, unless otherwise specified:

1. "Admitted" means when a patient is either:
  - a. Held for observation of a trauma-related injury; or
  - b. Considered an inpatient, as defined in A.A.C. R9-10-201.
2. "Business day" means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday.
3. "Designation" means a formal determination by the Department that a health care institution complies with

requirements in A.R.S. § 36-2225 and this Article for providing a particular Level of trauma service.

4. "Emergency department" means a designated area of a hospital that provides emergency services, as defined in A.A.C. R9-10-101, as an organized service, 24 hours per day, seven days per week, to individuals who present for immediate medical services.
5. "ICD-code" means an International Classification of Diseases code, a set of numbers or letters or a combination of letters and numbers that specify a disease, condition, or injury; the location of the disease, condition, or injury; or the circumstances under which a patient may have incurred the disease, condition, or injury, which is used by a health care institution for billing purposes.
6. "Level I Pediatric trauma center" means a Level I trauma center that has a trauma service specifically intended to meet the needs of children requiring trauma care.
7. "Level II Pediatric trauma center" means a Level II trauma center that has a trauma service specifically intended to meet the needs of children requiring trauma care.
8. "Medical services" means the services pertaining to the "practice of medicine," as defined in A.R.S. § 32-1401, or "medicine," as defined in A.R.S. § 32-1800, performed at the direction of a physician.
9. "National verification organization" has the same meaning as in A.R.S. § 36-2225.
10. "Nursing services" means services that pertain to the curative, restorative, and preventive aspects of "registered nursing," as defined in A.R.S. § 32-1601, performed:
  - a. At the direction of a physician; and
  - b. By or under the supervision of a registered nurse licensed:
    - i. According to Title 32, Chapter 15; or
    - ii. When performed in a health care institution operating under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation, by a similar licensing board in another state.
11. "On-call" means assigned to respond and, if necessary, come to a health care institution when notified by a personnel member of the health care institution.

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12. "Organized service" has the same meaning as in A.A.C. R9-10-201.
13. "Owner" means one of the following:
  - a. For a health care institution licensed under 9 A.A.C. 10, the licensee;
  - b. For a health care institution operated under federal or tribal laws, the administrative unit of the U.S. government or sovereign tribal nation operating the health care institution.
14. "Personnel member" means an individual providing medical services, nursing services, or health-related services, as defined in A.R.S. § 36-401, to a patient.
15. "Physician" means an individual licensed:
  - a. According to A.R.S. Title 32, Chapter 13 or 17; or
  - b. When working in a health care institution operating under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation, by a similar licensing board in another state.
16. "Signature" means:
  - a. A handwritten or stamped representation of an individual's name or a symbol intended to represent an individual's name, or
  - b. An "electronic signature" as defined in A.R.S. § 44-7002.
17. "Substantial compliance" has the same meaning as in A.R.S. § 36-401.
18. "Transport" means the conveyance of a patient by ground ambulance or air ambulance from one location to another location.
19. "Trauma care" means medical services and nursing services provided to a patient suffering from a sudden physical injury.
20. "Trauma center" has the same meaning as in A.R.S. § 36-2225.
21. "Trauma critical care course" means a multidisciplinary class or series of classes consisting of interactive tutorials, skills teaching, and simulated patient management scenarios of trauma care, consistent with training recognized by the American College of Surgeons.
22. "Trauma facility" means a health care institution that provides trauma care to a patient as an organized trauma service.
23. "Trauma service" means designated personnel members, equipment, and area within a health care institution and the associated policies and procedures for the personnel members to follow when providing trauma care to a patient.
24. "Trauma team" means a group of personnel members with defined roles and responsibilities in providing trauma care to a patient.
25. "Trauma team activation" means a notification to respond that is sent to trauma team personnel members in reaction to triage information received concerning a patient with injury or suspected injury.
26. "Verification" means formal confirmation by a national verification organization that a health care institution meets the national verification organization's standards for providing trauma care at a specific Level of trauma service.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Amended by final expedited rulemaking at

29 A.A.R. 2321 (October 6, 2023), with an immediate effective date of September 18, 2023 (Supp. 23-3).

**R9-25-1302. Eligibility for Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

- A.** A health care institution is eligible for designation as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, Level II Pediatric trauma center, or Level III trauma center if the health care institution:
1. Is either:
    - a. Licensed by the Department under 9 A.A.C. 10 to operate as a hospital; or
    - b. Operating as a hospital under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation; and
  2. For designation as a:
    - a. Level I trauma center:
      - i. Holds verification, issued within the six months before the date of designation, as a Level I trauma facility;
      - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level I trauma center; or
      - iii. Meets the requirements in subsection (C);
    - b. Level I Pediatric trauma center:
      - i. Holds verification, issued within the six months before the date of designation, as a Level I Pediatric trauma facility;
      - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level I Pediatric trauma center; or
      - iii. Meets the requirements in subsection (C);
    - c. Level II trauma center:
      - i. Holds verification, issued within the six months before the date of designation, as a Level II trauma facility; or
      - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level II trauma center; or
      - iii. Meets the requirements in subsection (C);
    - d. Level II Pediatric trauma center:
      - i. Holds verification, issued within the six months before the date of designation, as a Level II Pediatric trauma facility;
      - ii. Has documentation issued by a national verification organization, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level II Pediatric trauma center; or
      - iii. Meets the requirements in subsection (C); or
    - e. Level III trauma center:
      - i. Holds verification, issued within the six months before the date of designation, as a Level III trauma facility; or



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- ii. Has documentation issued by a national verification organization or the Department, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level III trauma center.
- B. A health care institution is eligible for designation as a Level IV trauma center if the health care institution:
  - 1. Is either:
    - a. Licensed by the Department under 9 A.A.C. 10 to operate as:
      - i. A hospital; or
      - ii. An outpatient treatment center authorized to provide emergency room services, as defined in A.A.C. R9-10-1001, according to A.A.C. R9-10-1019; or
    - b. Operating as a hospital or an outpatient treatment center providing emergency services under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation; and
  - 2. Either:
    - a. Holds verification, issued within the six months before the date of designation, as a Level IV trauma facility; or
    - b. Has documentation issued by a national verification organization or the Department, within the six months before the date of designation, stating that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for a Level IV trauma center.
- C. A health care institution is eligible for designation as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center based on assessment by the Department that the health care institution meets the standards specified in R9-25-1308 and Table 13.1 for the Level of trauma center for which designation is requested if the health care institution:
  - 1. Applies for verification from a national verification organization;
  - 2. Informs the Department, at least 30 calendar days before, of the dates the national verification organization will be on the premises of the health care institution to assess the health care institution for compliance with the national verification organization's standards for verification;
  - 3. Invites the Department to review the facility and documentation of capabilities of the health care institution during the national verification organization's assessment in subsection (C)(2);
  - 4. Is not issued verification from the national verification organization at the Level of designation sought;
  - 5. Does not receive the documentation required in subsection (A)(2)(a)(ii), (b)(ii), (c)(ii), or (d)(ii), as applicable; and
  - 6. Receives the documentation specified in R9-25-1306(G) and, if applicable, submits to the Department a written plan in R9-25-1306(H), acceptable to the Department, to correct instances of non-compliance.
- D. A health care institution is eligible to retain designation as a specific Level of trauma center if the health care institution complies with the applicable requirements in this Article for the specific Level of trauma center.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Amended by final

rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1303. Application and Designation Process (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

- A. An owner applying for initial designation or to renew designation for a health care institution shall submit to the Department an application including:
  - 1. The following information, in a Department-provided format:
    - a. The name, address, and telephone number of the health care institution for which the owner is requesting designation;
    - b. The owner's name, address, email address, telephone number, and, if available, fax number;
    - c. The name, email address, telephone number, and, if available, fax number of the chief administrative officer, as defined in A.A.C. R9-10-101, for the health care institution for which the owner is requesting designation;
    - d. The designation Level for which the owner is applying;
    - e. Whether the owner is requesting designation for the health care institution based on:
      - i. Verification, or
      - ii. Meeting the applicable standards specified in R9-25-1308 and Table 13.1;
    - f. If the owner is requesting designation for the health care institution based on verification:
      - i. The name of the national verification organization;
      - ii. The name, telephone number, and email address for a representative of the national verification organization;
      - iii. The Level of verification held;
      - iv. The effective date of the verification, and
      - v. The expiration date of the verification;
    - g. If the owner is requesting designation for the health care institution based on the health care institution meeting the applicable standards specified in R9-25-1308 and Table 13.1:
      - i. Whether:
        - (1) A national verification organization has assessed the health care institution, or
        - (2) The Department will be assessing the health care institution;
      - ii. If a national verification organization has assessed the health care institution:
        - (1) The name of the national verification organization;
        - (2) The name, telephone number, and email address for a representative of the national verification organization; and
        - (3) The date the national verification organization assessed the health care institution; and
      - iii. If the Department will be assessing the health care institution, the date the health care institution will be ready for the Department to assess the health care institution;
    - h. Unless the owner is an administrative unit of the U.S. government or a sovereign tribal nation, the license number, issued by the Department, for the health care institution for which designation is being requested;

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- i. The name, email address, telephone number, and, if available, fax number of the health care institution's trauma program manager;
  - j. Whether the health care institution's trauma registry will be located at the health care institution or be part of a centralized trauma registry;
  - k. The name, email address, telephone number, and, if available, fax number of the health care institution's trauma registrar;
  - l. If applying for designation as a Level IV trauma center, whether the health care institution plans to submit, in addition to the information required in R9-25-1309(A), the information specified in R9-25-1309(B);
  - m. If not already submitting trauma registry information to the Department, the time period for which the health care institution plans to begin submitting trauma registry information;
  - n. Except for a health care institution applying for designation as a Level IV trauma center, the name, email address, telephone number, and, if available, fax number of the health care institution's trauma medical director;
  - o. The name, title, address, and telephone number of the owner's statutory agent or the individual designated by the owner to accept service of process and subpoenas;
  - p. Attestation that:
    - i. The owner will comply with all applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article; and
    - ii. The information and documents provided as part of the application are accurate and complete; and
  - q. The dated signature of the applicable individual according to R9-25-102;
2. If applicable, documentation demonstrating that the health care institution is operating as a hospital or an outpatient treatment center providing emergency services under federal or tribal law as an administrative unit of the U.S. government or a sovereign tribal nation; and
  3. One of the following:
    - a. Documentation from the national verification organization, identified according to subsection (A)(1)(f)(i), establishing that the owner holds verification for the health care institution at the Level of designation being requested and showing the effective date and expiration date of the verification;
    - b. Documentation from the national verification organization, identified according to subsection (A)(1)(g)(ii)(1), demonstrating that the health care institution meets the applicable standards specified in R9-25-1308 and Table 13.1; or
    - c. The information and documents required in R9-25-1307(C), (D), or (F), as applicable.
- B.** An owner applying to renew designation for a health care institution shall submit the application in subsection (A) to the Department at least 60 calendar days and no more than 90 calendar days before the expiration of the current designation.
- C.** Within 30 calendar days after receiving an application submitted according to subsection (A), the Department shall review the application submitted for completeness, and, if the application is:
1. Incomplete, provide to the owner a written notice listing each missing item and the information or items needed to complete the application; and
  2. Complete and based on:
    - a. Verification, comply with R9-25-1307(A);
    - b. A national verification organization assessing the health care institution's meeting the applicable standards specified in R9-25-1308 and Table 13.1, comply with R9-25-1307(B); or
    - c. The Department assessing the health care institution's meeting the applicable standards specified in R9-25-1308 and Table 13.1, assess compliance with applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article according to R9-25-1307(E) or (G).
- D.** The Department shall consider an application withdrawn if an owner:
1. Fails to submit to the Department all of the information or items listed in a notice of missing items within 60 calendar days after the date on the notice of missing items, unless the Department and the owner agree to an extension of this time; or
  2. Submits a written request withdrawing the application.
- E.** If an owner submits an application for renewal of designation for a health care institution according to subsection (A) before the expiration date of the current designation, the designation of the health care institution remains in effect until the:
1. Department has determined whether or not to issue a renewal of the designation, or
  2. Application is withdrawn.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3). New Section R9-25-1303 renumbered from R9-25-1304 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1303.01. Expired****Historical Note**

New Section made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Section expired under A.R.S. 41-1056(J) at 29 A.A.R. 421 (January 27, 2023), with an immediate effective date of January 4, 2023 (Supp. 23-1).

**R9-25-1304. Changes Affecting Designation Status (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))****A.** An owner of a trauma center shall:

1. Notify the Department, in writing or in a Department-provided format, no later than 60 calendar days after the date of a change in the health care institution's:
  - a. Name,
  - b. Trauma program manager, or
  - c. If applicable, trauma medical director; and
2. Provide the effective date of the change and, as applicable, the:
  - a. Current and new name of the health care institution, or
  - b. Name of the new trauma program manager or trauma medical director.

**B.** An owner of a trauma center shall notify the Department in writing within three business days after:

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1. The trauma center's health care institution license expires or is suspended or revoked;
  2. The trauma center's health care institution license is changed to a provisional license under A.R.S. § 36-425;
  3. The trauma center no longer holds verification; or
  4. A change, which is expected to last for more than seven consecutive calendar days, in the trauma center's ability to meet:
    - a. The applicable standards specified in R9-25-1308 and Table 13.1; or
    - b. If designation is based on verification, the national verification organization's standards for verification.
- C.** At least 90 calendar days before a trauma center ceases to provide a trauma service, the owner of the trauma center shall notify the Department, in writing or in a Department-provided format, of the owner's intention to cease providing the trauma service and to relinquish designation, including the effective date.
- D.** The Department shall, upon receiving a notice described in:
1. Subsection (A), issue an amended designation that incorporates the name change but retains the expiration date of the current designation;
  2. Subsection (B)(1), send the owner a written notice stating that the health care institution no longer meets the definition of a trauma center and that the Department intends to dedesignate the health care institution, according to R9-25-1307(J)(2);
  3. Subsection (B)(2), evaluate the restrictions on the provisional license to determine if the trauma service was affected and may send the owner a written notice of the Department's intention to:
    - a. Dedesignate the health care institution, according to R9-25-1307(J) through (M);
    - b. Require a modification of the health care institution's designation within 15 calendar days after the date of the notice, according to R9-25-1305; or
    - c. Require a corrective action plan to address issues of compliance with the applicable standards specified in R9-25-1308 and Table 13.1, according to R9-25-1306(E);
  4. Subsection (B)(3), send the owner written notice that the owner is required, within 15 calendar days after the date of the notice, to submit to the Department:
    - a. An application for designation at a specific Level of trauma center, according to R9-25-1303, based on meeting the applicable standards specified in R9-25-1308 and Table 13.1; or
    - b. Written notification of the owner's intention to relinquish designation;
  5. Subsection (B)(4), send the owner written notice that the owner is required, within 15 calendar days after the date of the notice, to submit to the Department:
    - a. An application for modification of the health care institution's designation, according to R9-25-1305;
    - b. A corrective action plan to address issues of compliance with the applicable standards specified in R9-25-1308 and Table 13.1, according to R9-25-1306(E); or
    - c. Written notification of the owner's intention to relinquish designation; or
  6. Subsection (C), (D)(4)(b), or (D)(5)(c), send the owner written confirmation of the voluntary relinquishment of designation.
- E.** An owner of a trauma center, who obtains verification for the trauma center during a term of designation that was based on the trauma center meeting the applicable standards specified in R9-25-1308 and Table 13.1, may obtain a new initial designation based on verification, with a designation term based on the dates of the verification, by submitting an application according to R9-25-1303.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1304 renumbered to R9-25-1303; new Section R9-25-1304 renumbered from R9-25-1308 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Amended by final expedited rulemaking at 29 A.A.R. 2321 (October 6, 2023), with an immediate effective date of September 18, 2023 (Supp. 23-3).

**R9-25-1305. Modification of Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

- A.** Except as provided in R9-25-1304(D)(3)(b) and (5)(a), at least 30 calendar days before ceasing to provide a trauma service consistent with a trauma center's current designation, an owner of a trauma center may request a designation that requires fewer resources and capabilities than the trauma center's current designation by submitting to the Department an application for modification of the trauma center's designation, in a Department-provided format, that includes:
1. The name and address of the trauma center for which the owner is requesting modification of designation;
  2. A list of the criteria for the current designation with which the owner no longer intends to comply;
  3. An explanation of the changes being made in the trauma center's resources or operations, related to each criterion specified according to subsection (A)(2), to ensure the health and safety of a patient;
  4. The Level of designation being requested;
  5. An attestation that:
    - a. The owner will be in compliance with all applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article for the Level of designation requested if modified designation is issued; and
    - b. The information provided in the application is accurate and complete; and
  6. The dated signature of the applicable individual according to R9-25-102.
- B.** The Department shall review the application submitted according to R9-25-1307(I) to determine whether, with the changes being made in the trauma center's resources and operations, the trauma center will be in substantial compliance based the applicable standards specified in R9-25-1308 and Table 13.1 for the Level of designation requested.
- C.** To retain trauma center designation for a health care institution, an owner who holds modified designation shall, before the expiration date of the modified designation:
1. Apply for renewal of designation according to R9-25-1303, based on the health care institution's meeting the applicable standards specified in R9-25-1308 and Table 13.1, for the Level of the modified designation; or
  2. Apply for initial designation according to R9-25-1303, based on the health care institution meeting the applicable standards specified in R9-25-1308 and Table 13.1, for a Level other than the Level of the modified designation.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363,

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effective October 6, 2005 (Supp. 05-4). Section R9-25-1305 repealed; new Section R9-25-1305 renumbered from R9-25-1309 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1306. Inspections (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

- A.** When the Department inspects a health care institution applying for a trauma center designation or a health care institution designated as a trauma center to determine compliance with the applicable requirements in this Article, the Department:
1. Shall use criteria for assessing compliance developed using recommendations from the State Trauma Advisory Board, according to A.R.S. § 36-2222(E)(1); and
  2. May:
    - a. Evaluate the health care institution's equipment and physical plant;
    - b. Interview the health care institution's personnel members, including any individuals providing trauma care; and
    - c. Review any of the following:
      - i. Medical records;
      - ii. Patient discharge summaries;
      - iii. Patient care logs;
      - iv. Rosters and schedules of personnel members and individuals who provide trauma care as part of the trauma service;
      - v. Performance-improvement-related documents, including quality management program documents required in A.A.C. R9-10-204 or R9-10-1004 as applicable; and
      - vi. Other documents relevant to the provision of trauma care as part of the trauma service.
- B.** The Department shall determine whether there is a need for an inspection of a health care institution and which components in subsection (A)(2) to include in an inspection, based on the health care institution's application; previous inspections, if applicable; and the operating history of the health care institution and may conduct an announced inspection of the identified components:
1. Before issuing an initial, renewal, or modified designation to an owner applying for designation of a health care institution as a trauma center;
  2. If an owner of a health care institution designated as a trauma center has submitted a corrective action plan under subsection (E); or
  3. A health care institution designated as a trauma center is randomly selected to receive an inspection.
- C.** If the Department has reason to believe that a trauma center is not complying with applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article, the Department may conduct an announced or unannounced inspection of the trauma center according to subsection (A).
- D.** Within 30 calendar days after completing an inspection, the Department shall send to an owner a written report of the Department's findings, including, if applicable, a list of any instances of non-compliance identified during the inspection and a request for a written corrective action plan.
- E.** Within 15 calendar days after receiving a request for a written corrective action plan, an owner shall submit to the Department a written corrective action plan that includes for each identified instance of non-compliance:
1. A description of how the instance of non-compliance will be corrected and reoccurrence prevented, and
  2. A date of correction for the instance of non-compliance.

- F.** The Department shall accept a written corrective action plan if the corrective action plan:
1. Describes how each identified instance of non-compliance will be corrected and reoccurrence prevented, and
  2. Includes a date for correcting each instance of non-compliance that is appropriate to the actions necessary to correct the instance of non-compliance.
- G.** If the Department reviews a health care institution's facility and documentation of capabilities during a national verification organization's assessment according to R9-25-1302(C)(3) and the health care institution is not issued verification from the national verification organization at the Level of designation sought, the Department shall send to an owner of the health care institution, within 30 calendar days after the review, a written report of the Department's findings, including, if applicable, a list of any instances of non-compliance with requirements in R9-25-1308 and Table 13.1 identified during the review.
- H.** A health care institution receiving a written report in subsection (G), containing a list of instances of non-compliance with requirements in R9-25-1308 and Table 13.1 identified during a review of the health care institution's facility and documentation of capabilities, may submit to the Department a written plan to correct instances of non-compliance that includes:
1. A description of how the health care institution will correct each instance of non-compliance and prevent the reoccurrence, and
  2. A date by which the health care institution plans to correct each instance of non-compliance.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1306 repealed; new Section R9-25-1306 made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Amended by final expedited rulemaking at 29 A.A.R. 2321 (October 6, 2023), with an immediate effective date of September 18, 2023 (Supp. 23-3).

**R9-25-1307. Designation and Dedicatation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

- A.** For initial designation or renewal of designation of a health care institution based on verification, the Department shall, within 45 calendar days after receiving a complete application from an owner:
1. Except as provided in subsection (H)(2), if the application complies with the applicable requirements in this Article, issue a designation for the health care institution that is valid for the duration of the verification; or
  2. If the application does not comply with the applicable requirements in this Article, provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10, that the Department intends to decline to issue a designation for the health care institution.
- B.** Except as provided in subsection (F) specifying requirements for renewal of a one-year designation, for initial designation or renewal of designation of a health care institution based on an assessment by a national verification organization, the Department shall, within 60 calendar days after receiving a complete application from an owner, review the application and, if the Department determines that:
1. The application and the health care institution comply with the applicable requirements in this Article, except as provided in subsection (H)(1), issue a designation for the

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- health care institution that is valid for three years from the issue date;
2. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article, and the Department has accepted a written corrective action plan submitted according to R9-25-1306(E), issue a designation for the health care institution that is valid for one year from the issue date; or
  3. The application or the health care institution does not comply with the applicable requirements in this Article, provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10, that the Department intends to decline to issue a designation for the health care institution.
- C. Except as provided in subsection (F) specifying requirements for renewal of a one-year designation, for initial designation or renewal of designation of a health care institution as a Level III trauma center or a Level IV trauma center based on an assessment by the Department, an owner shall include as part of the application required in R9-25-1303(A):
1. The following information in a Department-provided format:
    - a. The name of the health care institution for which the owner is requesting designation;
    - b. The services the health care institution is providing or plans to provide as part of the trauma service;
    - c. The name and title of the liaison to the trauma service from each of the services listed according to subsection (C)(1)(b);
    - d. If applicable, the name, email address, telephone number, and, if available, fax number of the health care institution's emergency department physician director;
    - e. If applicable, the name, email address, telephone number, and, if available, fax number of the health care institution's surgical director or co-director;
    - f. If a multidisciplinary peer review committee is required according to Table 13.1 for the Level of the trauma center, the name and title of each member of the multidisciplinary peer review committee;
    - g. If the health care institution's trauma registry will be part of a centralized trauma registry, a description of the training provided to the trauma program manager to enable the trauma program manager to comply with R9-25-1308(D)(2);
    - h. If applicable, for an application for initial designation, a description of the health care institution's plans for the continuing education activities related to trauma care, required in R9-25-1308(G)(4);
    - i. For renewal of designation, a description of the continuing education activities conducted during the term of the designation;
    - j. If applicable, the name, email address, telephone number, and, if available, fax number of the health care institution's injury prevention coordinator;
    - k. A description of the methods by which trauma team personnel members communicate with EMS personnel;
    - l. A description of the trauma-related training received by registered nurses in the intensive care unit;
    - m. An attestation that the owner of the health care institution will prohibit:
      - i. The trauma medical director from serving as trauma medical director for another health care institution; and
      - ii. A physician on-call for general surgery, neurosurgery, or orthopedic surgery to be on-call or on a back-up call list at another health care institution; and
    - n. The dated signature of the applicable individual according to R9-25-102;
  2. A copy of the policies and procedures required in R9-25-1308(B)(6) for the health care institution's trauma registry;
  3. A copy of the policies and procedures required in R9-25-1308(B)(7) for the health care institution's performance improvement program;
  4. A copy of the policies and procedures required in R9-25-1308(F)(2) for the health care institution's trauma service;
  5. If applicable, a copy of the policies and procedures required in R9-25-1308(F)(9) for operating rooms;
  6. A copy of the applicable policies and procedures required in R9-25-1308(H)(4);
  7. A copy of the health care institution's clinical practice guidelines, describing the health care institution's capability to resuscitate, stabilize, and transfer pediatric patients;
  8. If applicable, a copy of the bylaws of the health care institution's multidisciplinary peer review committee;
  9. Copies of the job descriptions for the health care institution's:
    - a. Trauma program manager;
    - b. Trauma registrar; and
    - c. If applicable, injury prevention coordinator;
  10. A list of the trauma care parameters the health care institution is or will be monitoring as part of the performance improvement program;
  11. A list of trauma team members, including:
    - a. Name,
    - b. Title, and
    - c. Role on the trauma team;
  12. If required for an individual listed according to subsection (C)(11), a copy of documentation of the individual's:
    - a. Board certification or board eligibility,
    - b. Most recent certification in a trauma critical care course,
    - c. Pediatric-specific credentials, and
    - d. Other trauma-related training; and
  13. If the trauma medical director is not a member of the trauma team, the applicable documentation required in subsection (C)(12) for the trauma medical director.
- D. Except as provided in subsection (F) specifying requirements for renewal of a one-year designation, for initial designation or renewal of designation of a health care institution as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center based on an assessment by the Department under R9-25-1302(C), an owner shall include as part of the application required in R9-25-1303(A):
1. A copy of the documentation submitted to the national verification organization as part of an application for verification;
  2. If not included in the documentation in subsection (D)(1):
    - a. Any information or documents required in subsection (C);

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- b. For an application for initial designation, a description of the health care institution's plans for:
      - i. Injury prevention activities, required in R9-25-1308(G)(5)(a); and
      - ii. Educational outreach activities, required in R9-25-1308(G)(5)(b); and
    - c. For an application for renewal of designation, a description of the injury prevention activities and educational outreach activities conducted during the term of the designation;
  - 3. A copy of the national verification's organization's written report to the health care institution describing the results of the national verification organization's assessment of the health care organization;
  - 4. A copy of the written report in R9-25-1306(G); and
  - 5. If applicable, the written plan to correct instances of non-compliance in R9-25-1306(H).
- E. Except for renewal of a one-year designation as provided in subsection (G), for initial designation or renewal of designation of a health care institution based on an assessment by the Department according to subsection (C) or (D), the Department shall, within 90 calendar days after receiving a complete application from an owner, review the application, inspect the health care institution, if applicable, and, if the Department determines that:
  - 1. The application and the health care institution comply with the applicable requirements in this Article, except as provided in subsection (H)(1), issue a designation for the health care institution that is valid for three years from the issue date;
  - 2. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article, and the Department has accepted the document submitted according to R9-25-1306(E) or subsection (D)(5), issue a designation for the health care institution that is valid for one year from the issue date; or
  - 3. The application or the health care institution does not comply with the applicable requirements in this Article, provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10, that the Department intends to decline to issue a designation for the health care institution.
- F. For renewal, at the same Level of trauma center, of a one-year designation issued according to subsection (B)(2) or (E)(2), an owner shall include, as part of the application required in R9-25-1303(A), documentation related to the completion of the plan specified in the document accepted by the Department in subsection (B)(2) or (E)(2).
- G. The Department shall, within 60 calendar days after receiving from an owner an application submitted according to subsection (F), review the information and documentation, inspect the health care institution if applicable, and:
  - 1. Issue a designation for the health care institution that is valid for two years from the issue date if the Department determines that:
    - a. The application and the health care institution comply with the applicable requirements in this Article; and
    - b. The owner has completed the plan specified in the document accepted by the Department in subsection (B)(2) or (E)(2), as applicable; or
  - 2. Provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10, that the Department intends to decline to issue a designation for the health care institution if the Department determines that:
    - a. The application or the health care institution do not comply with the applicable requirements in this Article; or
    - b. The owner has not completed all of the components of the plan specified in the document accepted by the Department in subsection (B)(2) or (E)(2), as applicable.
- H. The Department may:
  - 1. Issue or extend a designation to a health care institution that is longer than three years if:
    - a. The health care institution would be eligible for designation under R9-25-1302(A)(2)(a)(ii) or (iii), (A)(2)(b)(ii) or (iii), (A)(2)(c)(ii) or (iii), (A)(2)(d)(ii) or (iii), or (A)(2)(e)(ii) with assessment from a national verification organization;
    - b. The national verification organization either:
      - i. Will not allow the health care institution to apply for verification within the time-frame necessary to comply with R9-25-1302(C), or
      - ii. Does not schedule an assessment visit to the health care institution within six months after the date of the health care institution's request;
    - c. The health care institution and, if applicable, the application comply with the applicable requirements in this Article; and
    - d. The health care institution provides to the Department documentation supporting subsection (H)(1)(b); or
  - 2. Issue a designation based on verification to a health care institution, according to subsection (A)(1), that is shorter than the duration of the verification if the expiration of the verification is more than five years after the date of issuance.
- I. For modification of a designation according to R9-25-1305, the Department shall, within 30 calendar days after receiving a complete application for modification in R9-25-1305(A) from an owner, review the application, inspect the health care institution, if applicable, and:
  - 1. Issue a modified designation for the Level of designation requested for the health care institution that is valid for the duration of the original designation or one year from the issue date, whichever is longer, if the Department determines that:
    - a. The application and the health care institution comply with the applicable requirements in this Article for the Level of designation requested; or
    - b. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article for the Level of designation requested, and the Department has accepted a written corrective action plan submitted according to R9-25-1306(E);
  - 2. Issue a modified designation for a lower Level of designation than the Level of designation requested for the health care institution that is valid for the duration of the original designation or one year from the issue date, whichever is longer, if the Department determines that:
    - a. The application and the health care institution comply with the applicable requirements in this Article for the lower Level of designation and the health care institution:

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- i. Does not comply with the applicable requirements in this Article for the Level of designation requested; or
    - ii. Is in substantial compliance with the applicable requirements in this Article for the Level of designation requested, and the Department has not accepted a written corrective action plan submitted according to R9-25-1306(E); or
  - b. The application complies with the applicable requirements in this Article, the health care institution is in substantial compliance with the applicable requirements in this Article for the lower Level of designation, and the Department has accepted a written corrective action plan according to R9-25-1306(E); or
  - 3. Provide a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10 that the Department intends to decline to issue a modified designation for the health care institution if the Department determines that the application or the health care institution does not comply with the applicable requirements in this Article.
- J.** The Department may dedesignate a health care institution as a trauma center if an owner:
- 1. Has provided false or misleading information to the Department;
  - 2. Is not eligible for designation under R9-25-1302(A) or (B); or
  - 3. Fails to comply with an applicable requirement in A.R.S. Title 36, Chapter 21.1 or this Article.
- K.** In determining whether to dedesignate a health care institution as a trauma center, the Department shall consider:
- 1. The severity of each instance relative to public health and safety;
  - 2. The number of instances;
  - 3. The nature and circumstances of each instance;
  - 4. Whether each instance was corrected, the manner of correction, and the duration of the instance; and
  - 5. Whether the instances indicate a lack of commitment to having the trauma center meet the verification standards of a national verification organization or, if applicable, the standards specified in R9-25-1308 and Table 13.1.
- L.** If the Department intends to dedesignate a health care institution, the Department shall send to the owner a written notice that complies with A.R.S. Title 41, Chapter 6, Article 10.
- M.** An owner who receives a written notice in subsection (A)(2), (B)(3), (E)(3), (G)(2), (I)(3), or (J) may file a written notice of appeal with the Department that complies with A.R.S. Title 41, Chapter 6, Article 10.
- Historical Note**
- New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1307 repealed; new Section R9-25-1307 renumbered from R9-25-1312 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Amended by final expedited rulemaking at 29 A.A.R. 2321 (October 6, 2023), with an immediate effective date of September 18, 2023 (Supp. 23-3).
- R9-25-1308. Trauma Center Responsibilities (A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2221, and 36-2225(A)(4), (5), and (6))**
- A.** The owner of a trauma center shall ensure that:
- 1. If designation is based on:
    - a. Verification, the trauma center meets the applicable standards of the verifying national verification organization; or
    - b. Meeting the applicable standards specified in this Section and Table 13.1, the trauma center meets the applicable standards for the Level of trauma center for which designation has been issued;
  - 2. The trauma center complies with a written corrective action plan accepted by the Department according to R9-25-1306(F); and
  - 3. The Department has access to:
    - a. The trauma center and to personnel members present in the trauma center; and
    - b. Documents that are requested by the Department and not confidential under A.R.S. Title 36, Chapter 4, Article 4 or 5, within two hours after the Department's request.
- B.** The owner of a trauma center shall ensure that the trauma center:
- 1. Except as provided in subsection (D), establishes a trauma registry of patients receiving trauma care who meet the criteria specified in subsection (C)(1) that contains the information required in R9-25-1309, as applicable for the specific Level of the trauma center;
  - 2. Appoints an individual to act as trauma registrar to coordinate trauma registry activities;
  - 3. If necessary to comply with subsections (C)(2) and (3), provides sufficient additional individuals to assist with trauma registry activities;
  - 4. Establishes a performance improvement program for the trauma service to develop and implement processes to improve trauma care parameters;
  - 5. If required according to Table 13.1 for the Level of the trauma center, establishes as part of the performance improvement program, established according to subsection (B)(4), a multidisciplinary peer review committee to review the quality of trauma care provided by the trauma center, including information from the trauma registry, and suggest methods to improve the quality of trauma care;
  - 6. Establishes, documents, and implements policies and procedures for the trauma registry established according to subsection (B)(1) that include:
    - a. Ensuring that individuals responsible for collecting, entering, or reviewing information in the trauma registry have received training in gaining access to, and retrieving information from, the trauma registry;
    - b. Collection of the information required in R9-25-1309 about the patients specified in subsection (C)(1) receiving trauma care;
    - c. Submission to the Department of the information required in subsection (C)(2);
    - d. Review of information in the trauma center's trauma registry; and
    - e. Performance improvement activities required in R9-25-1310; and
  - 7. Establishes, documents, and implements policies and procedures for the performance improvement program established according to subsection (B)(4), including:
    - a. A list of the positions of personnel members who have defined roles in the performance improvement program and, if applicable, a list of positions that are dedicated to performance improvement activities for

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- patients receiving trauma care from the trauma center;
- b. The qualifications, skills, and knowledge required of the personnel members in the positions specified according to subsection (B)(7)(a);
  - c. The role each personnel member specified according to subsection (B)(7)(a) plays in the performance improvement program;
  - d. The trauma care parameters to be reviewed as part of the performance improvement program;
  - e. The frequency of review of trauma care parameters;
  - f. If an issue related to trauma care or to trauma care parameters is identified:
    - i. How a plan to address the issue is developed to reduce the chance of the issue recurring in the future;
    - ii. How the plan is documented;
    - iii. The mechanism and criteria by which the plan is reviewed and approved;
    - iv. How the plan is implemented; and
    - v. How implementation of the plan and future recurrences are monitored;
  - g. If applicable, the composition, duties, responsibilities, and frequency of meetings of the multidisciplinary peer review committee established according to subsection (B)(5);
  - h. If applicable, how the multidisciplinary peer review committee collaborates with the trauma center's quality management program; and
  - i. How changes proposed by the performance improvement program are reviewed by the trauma center's quality management program.
- C. The owner of a trauma center shall ensure that:
1. The trauma registry, established according to subsection (B)(1), includes the information required in R9-25-1309 for each patient with whom the trauma center had contact who meets one or more of the following criteria:
    - a. A patient with injury or suspected injury who is:
      - i. Transported from a scene to a trauma center or an emergency department based on the responding emergency medical services provider's or ambulance service's triage protocol required in R9-25-201(E)(2)(b), or
      - ii. Transferred from one health care institution to another health care institution by an emergency medical services provider or ambulance service;
    - b. A patient with injury or suspected injury for whom a trauma team activation occurs; or
    - c. A patient with injury, who is admitted as a result of the injury or who dies as a result of the injury, and whose medical record includes one or more of specific ICD-codes indicating that:
      - i. At the initial encounter with the patient, the patient had:
        - (1) An injury or injuries to specific body parts,
        - (2) Unspecified multiple injuries,
        - (3) Injury of an unspecified body region,
        - (4) A burn or burns to specific body parts,
        - (5) Burns assessed through Total Body Surface Area percentages, or
        - (6) Traumatic Compartment Syndrome; and
      - ii. The patient's injuries or burns were not only:
        - (1) An isolated distal extremity fracture from a same-level fall,
        - (2) An isolated femoral neck fracture from a same-level fall,
        - (3) Effects resulting from an injury or burn that developed after the initial encounter,
        - (4) A superficial injury or contusion, or
        - (5) A foreign body entering through an orifice;
  2. The following information is submitted to the Department, in a Department-provided format, according to subsection (C)(3):
    - a. The name and physical address of the trauma center;
    - b. The date the trauma registry information is being submitted to the Department;
    - c. The total number of patients whose trauma registry information is being submitted;
    - d. The quarter and year for which the trauma registry information is being submitted;
    - e. The range of emergency department or hospital arrival dates for the patients for whom trauma registry information is being submitted;
    - f. The name, title, email address, telephone number, and, if available, fax number of the trauma center's point of contact for the trauma registry information;
    - g. Any special instructions or comments to the Department from the trauma center's point of contact;
    - h. The information from the trauma registry for patients identified during the quarter specified according to subsection (C)(2)(d); and
    - i. Updated information for any patients identified during the previous quarter, including the patient's name, medical record number, and admission date; and
  3. The information required in subsection (C)(2) is submitted:
    - a. For patients identified between January 1 and March 31, so that the information in subsections (C)(2)(a) through (h) is received by the Department by July 1 of the same calendar year;
    - b. For patients identified between April 1 and June 30, so that the information in subsections (C)(2)(a) through (h) is received by the Department by October 1 of the same calendar year;
    - c. For patients identified between July 1 and September 30, so that the information in subsections (C)(2)(a) through (h) is received by the Department by January 2 of the following calendar year; and
    - d. For patients identified between October 1 and December 31, so that the information in subsections (C)(2)(a) through (h) is received by the Department by April 1 of the following calendar year.
- D. Trauma centers under the same governing authority, as defined in A.R.S. § 36-401, may establish a single, centralized trauma registry and submit to the Department consolidated information from the trauma registry, according to subsections (C)(2) and (3), if:
1. The information submitted to the Department specifies for each patient in the trauma registry the trauma center that had contact with the patient; and
  2. Each trauma center contributing information to the centralized trauma registry is able to:



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- a. Access, edit, and update the information contributed by the trauma center to the centralized trauma registry; and
  - b. Use the information contributed by the trauma center to the centralized trauma registry when complying with performance improvement program requirements in this Section.
- E. As part of the performance improvement program, the owner of a trauma center shall ensure that the trauma program manager and, if applicable, trauma medical director periodically, according to policies and procedures:
  1. Review the information in the trauma center's trauma registry; and
  2. Monitor at least the following trauma care parameters, as applicable, for patients in the trauma registry:
    - a. EMS received by a patient;
    - b. Length of stay longer than two hours in the emergency department before transfer;
    - c. Instances of trauma team activation to determine if trauma team activation was timely and appropriate;
    - d. Instances where trauma care was provided to a patient but trauma team activation did not occur;
    - e. Time from notification of a surgeon on the trauma team that a patient described in subsection (H)(6)(b)(i) is in the emergency department to when the surgeon arrives in the emergency department;
    - f. Documentation of the nursing services provided to a patient;
    - g. Instances and reasons for transfer of a patient;
    - h. Instances and reasons for transfer to a hospital not designated as a trauma center;
    - i. For a hospital designated as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, instances and reasons for diversion, as defined in A.A.C. R9-10-201, of a patient requiring trauma care;
    - j. Instances of and circumstances related to the death of a patient;
    - k. Instances related to the assessment of child maltreatment;
    - l. Other patient outcomes;
    - m. Trauma care parameters for pediatric patients, including pediatric-specific measures; and
    - n. The completeness and timeliness of trauma data submission.
- F. In addition to the requirements in subsections (A) through (E), the owner of a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 shall:
  1. Ensure that a trauma service is established if required by Table 13.1;
  2. Ensure that policies and procedures for the trauma service are established, documented, and implemented that include:
    - a. The composition of the trauma team;
    - b. The qualifications, skills, and knowledge required of each personnel member of the trauma team;
    - c. Continuing education or continuing medical education requirements for each personnel member of the trauma team;
    - d. The roles and responsibilities of each personnel member of the trauma team;
    - e. Under what circumstances the trauma team is activated; and
    - f. How the trauma team is activated;
  3. Ensure that the personnel members on the trauma team have the qualifications, skills, and knowledge required in the policies and procedures;
  4. If the trauma center is required according to Table 13.1 to have a trauma medical director, appoint a board-certified or board-eligible surgeon as trauma medical director;
  5. Prohibit a physician from serving as trauma medical director for the trauma center if the physician is serving as trauma medical director for another health care institution;
  6. Ensure that the trauma medical director completes:
    - a. If the trauma center's designation is for a three-year period, at least 48 hours of external trauma-related continuing medical education during the term of the designation;
    - b. If the trauma center's designation is for a one-year period, at least 16 hours of external trauma-related continuing medical education during the term of the designation; and
    - c. If the trauma center is designated as a Level I Pediatric trauma center or Level II Pediatric trauma center, at least 12 of the 48 hours required in subsection (F)(6)(a) or four of the 16 hours required in subsection (F)(6)(b) in pediatric trauma-related continuing medical education;
  7. Appoint an individual to act as trauma program manager to coordinate trauma service activities;
  8. If the trauma center is required by Table 13.1 to have a multidisciplinary peer review committee, ensure that each surgeon on the trauma team designated according to subsection (F)(3) attends at least 50% of the meetings of the multidisciplinary peer review committee;
  9. If the trauma center provides surgical services, ensure that policies and procedures for operating rooms and an operating room team are established, documented, and implemented that include:
    - a. The availability of an operating room for trauma care;
    - b. The composition of an operating room team;
    - c. The qualifications, skills, and knowledge required of each personnel member of an operating room team;
    - d. The roles and responsibilities of each personnel member of an operating room team;
    - e. If an operating room team is not on the premises of the health care institution 24 hours a day, under what circumstances the operating room team is notified to come to the trauma center; and
    - f. How the operating room team is notified;
  10. Ensure that the following personnel members on the trauma team:
    - a. Hold current certification in a trauma critical care course:
      - i. Trauma medical director, if applicable;
      - ii. Each emergency medicine physician who is not board-certified or board-eligible; and
      - iii. Each physician assistant or registered nurse practitioner who is responsible for providing trauma care to patients in an emergency department in the absence of an emergency physician; or
    - b. Have held certification in a trauma critical care course;

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- i. Each general surgeon other than the trauma medical director, and
    - ii. Each emergency medicine physician who is board-certified or board-eligible;
  11. If the trauma center is designated as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, ensure that each of the trauma team personnel members required in Table 13.1(C)(2) and (C)(3)(a) through (f) are board-certified or board-eligible;
  12. If the trauma center is designated as a Level I Pediatric trauma center, ensure that the following trauma team members are fellowship-trained:
    - a. The surgeon credentialed for pediatric trauma care required in Table 13.1(C)(2)(a)(iii),
    - b. The pediatric emergency medicine physician required in Table 13.1(C)(2)(c),
    - c. The pediatric-credentialed orthopedic surgeon required in Table 13.1(C)(3)(b),
    - d. The pediatric-credentialed neurosurgeon required in Table 13.1(C)(3)(d), and
    - e. The pediatric-credentialed critical care medicine physician required in Table 13.1(C)(3)(f);
  13. If the trauma center is designated as a Level II Pediatric trauma center, ensure that:
    - a. The pediatric-credentialed critical care medicine physician required in Table 13.1(C)(3)(f) is fellowship-trained, and
    - b. A fellowship-trained pediatric emergency medicine physician:
      - i. Provides direction for pediatric emergency trauma care and oversight of the treatment of pediatric patients as part of the performance improvement program, and
      - ii. Is appointed as a liaison to the multidisciplinary peer review committee established according to subsection (B)(5); and
  14. If the trauma center is not designated as a Level I Pediatric trauma center or Level II Pediatric trauma center and annually provides trauma care to 100 or more injured children younger than 15 years of age who meet one or more of the criteria in subsection (C)(1)(c), ensure that the trauma center:
    - a. Complies with subsection (F)(13) and Table 13.1(C)(2)(a)(iii), (3)(b), (3)(d), and (3)(f) and (F)(2); and
    - b. Has a:
      - i. Pediatric emergency department area,
      - ii. Pediatric intensive care area, and
      - iii. Pediatric-specific trauma performance improvement program.
- G.** In addition to the requirements in subsections (A) through (E), the owner of a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 shall ensure that the trauma center:
1. Establishes, documents, and implements a patient transfer plan, consistent with A.A.C. R9-10-211, that includes:
    - a. The criteria for transferring a patient,
    - b. The health care institution to which a patient meeting specific criteria will be transferred,
    - c. The personnel members who are responsible for coordinating the transfer of a patient, and
    - d. The process for transferring a patient;
  2. Participates in state, local, or regional trauma-related activities such as:
    - a. The State Trauma Advisory Board, established by A.R.S. § 36-2222;
    - b. A regional emergency medical services coordinating council described in A.R.S. § 36-2222(A)(3);
    - c. Trauma Registry Users Group, established by the Department;
    - d. Trauma Managers Workgroup, established by the Department; or
    - e. Injury Prevention Council;
  3. Participates in injury prevention programs specific to the trauma center's patient population at the national, regional, state, or local levels;
  4. Except for a Level IV trauma center, conducts trauma care continuing education activities for physicians, trauma center personnel members, and EMCTs;
  5. If required for the trauma center according to Table 13.1, establishes and maintains:
    - a. An injury prevention program:
      - i. Independently or in collaboration with other health care institutions, health advocacy groups, or the Department; and
      - ii. That includes:
        - (1) Designating a prevention coordinator who serves as the trauma center's representative for injury prevention and injury control activities;
        - (2) Carrying out injury prevention and injury control activities, including activities specific to the patient population;
        - (3) Conducting injury control studies;
        - (4) Monitoring the progress and effect of the injury prevention program; and
        - (5) Providing injury prevention and injury control information resources for the public; and
    - b. An educational outreach program:
      - i. Independently or in collaboration with other health care institutions, health advocacy groups, or the Department;
      - ii. That includes providing education to physicians, trauma center personnel members, EMCTs, and the general public; and
      - iii. That may include education about:
        - (1) Injury prevention,
        - (2) Trauma care,
        - (3) Other topics specific to the patient population,
        - (4) Criteria for assessing a patient who may require trauma care, and
        - (5) Criteria for the transfer of a patient requiring trauma care; and
  6. If the trauma center holds a designation as a Level I trauma center or Level I Pediatric trauma center:
    - a. Establishes and maintains, either independently or in collaboration with other hospitals, a residency program or fellowship program that provides advanced medical training in emergency medicine, general surgery, orthopedic surgery, or neurosurgery;
    - b. Participates in the provision of a trauma critical care course;
    - c. Conducts or participates in research related to trauma and trauma care; and

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- d. Maintains an Institutional Review Board, established consistent with 45 CFR Part 46, to review biomedical and behavioral research related to trauma and trauma care involving human subjects, conducted, funded, or sponsored by the trauma center, in order to protect the rights of the human subjects of such research.
- H. In addition to the requirements in subsections (A) through (E), the owner of a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 shall:
  - 1. Ensure the presence of a surgeon at all operative procedures;
  - 2. If the trauma center provides emergency medicine, neurosurgery, orthopedic surgery, anesthesiology, critical care, or radiology as an organized service, ensure that:
    - a. A physician from the organized service is appointed to act as a liaison between the organized service and the trauma center's trauma service;
    - b. The physician in subsection (H)(2)(a) completes:
      - i. If the trauma center's designation is for a three-year period, at least 48 hours of trauma-related continuing medical education during the term of the designation;
      - ii. If the trauma center's designation is for a one-year period, at least 16 hours of trauma-related continuing medical education during the term of the designation; and
      - iii. If the trauma center is designated as a Level I Pediatric trauma center or Level II Pediatric trauma center, at least 12 of the 48 hours required in subsection (H)(2)(b)(i) or four of the 16 hours required in subsection (H)(2)(b)(ii) in pediatric trauma-related continuing medical education; and
    - c. If the trauma center is required by Table 13.1 to have a multidisciplinary peer review committee, ensure the physician in subsection (H)(2)(a) attends at least 50% of the meetings of the multidisciplinary peer review committee;
  - 3. Ensure that, when a physician is on-call for general surgery, neurosurgery, or orthopedic surgery, the physician is not on-call or on a back-up call list at another health care institution;
  - 4. Ensure that policies and procedures are established, documented, and implemented for:
    - a. Except for a Level IV trauma center, the formulation of blood products to be available during an event requiring multiple blood transfusions for a patient or patients; and
    - b. For a Level IV trauma center, the expedited release of blood products during an event requiring multiple blood transfusions for a patient or patients;
  - 5. Ensure that the patient transfer plan required in subsection (G)(1) includes processes for transferring a patient needing:
    - a. Acute hemodialysis or pediatric trauma care to a hospital providing the required service if the trauma center is designated as a:
      - i. Level III or Level IV trauma center; or
      - ii. Level II trauma center and does not provide, as applicable, acute hemodialysis or pediatric trauma care;
    - b. Burn care as an organized service, acute spinal cord management, microvascular surgery, or replant surgery to a hospital providing the required service if the trauma center is designated as a:
      - i. Level III or Level IV trauma center; or
      - ii. Level I or Level II trauma center and does not provide, as applicable, burn care as an organized service, acute spinal cord management, microvascular surgery, or replant surgery; or
    - c. Another service that the trauma center is not authorized or not able to provide to a hospital providing the required service;
  - 6. Except for a Level IV trauma center or as provided in subsection (I), require that:
    - a. An emergency medicine physician is present in the emergency department at all times;
    - b. A surgeon on the trauma team is present in the emergency department:
      - i. For a patient:
        - (1) If an adult, with a systolic blood pressure less than 90 mm Hg or, if a child, with confirmed age-specific hypotension;
        - (2) With respiratory compromise, respiratory obstruction, or intubation;
        - (3) Who is transferred from another hospital and is receiving blood to maintain vital signs;
        - (4) Who has a gunshot wound to the abdomen, neck, or chest;
        - (5) Who has a Glasgow Coma Scale score less than 8 associated with an injury attributed to trauma; or
        - (6) Who is determined by an emergency department physician to have an injury that has the potential to cause prolonged disability or death; and
      - ii. No later than the following times:
        - (1) For a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, within 15 minutes after notification or at the time the patient arrives in the emergency department, whichever is later; or
        - (2) For a Level III trauma center, within 30 minutes after notification or at the time the patient arrives in the emergency department, whichever is later; and
    - c. One of the following anesthesia personnel members is available for an operative procedure on a patient at the indicated time point:
      - i. For a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, an anesthesiologist, anesthesiology chief resident, or certified registered nurse anesthetist is present in the emergency department or in an operating room area awaiting the patient no later than 15 minutes after patient arrival in the emergency department; and
      - ii. For a Level III trauma center, an anesthesiologist, anesthesiology chief resident, or certified registered nurse anesthetist is present in the emergency department or in an operating room area awaiting the patient no later than 30 minutes after patient arrival in the emergency department; and

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- utes after patient arrival in the emergency department;
7. For a clinical capability required for the trauma center according to Table 13.1(C)(3), require that the on-call radiologist, critical care medicine physician, or surgical specialist is available to provide medical services, as applicable to the specialist, for a patient requiring trauma care within 45 minutes after notification; and
  8. For personnel members assigned to an operating room team according to subsection (F)(9), require that the personnel members on the operating room team are on the premises of the trauma center while on duty or:
    - a. For a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, Level II Pediatric trauma center:
      - i. Are available to provide operative services for a patient requiring trauma care within 15 minutes after notification or patient arrival at the trauma center, whichever is later; and
      - ii. Have response times and patient outcomes monitored through the performance improvement program; and
    - b. For a Level III trauma center or Level IV trauma center, if the Level IV trauma center provides surgical services:
      - i. Are available to provide operative services for a patient requiring trauma care within 30 minutes after notification or patient arrival at the trauma center, whichever is later; and
      - ii. Have response times and patient outcomes monitored through the performance improvement program.
  - I. The Department shall consider a trauma center designated based on meeting the applicable standards specified in this Section and Table 13.1 to be in compliance with subsection (H)(6)(a), (b), or (c), as applicable, if the trauma center has documentation showing that:
    1. The individual required to be present at the indicated location and within the indicated time period was present 80% or more of the time, and
    2. The trauma center monitors the rate of compliance with subsection (H)(6) and patient outcomes through the performance improvement program.
  - J. The requirement in subsection (H)(6)(b) applies whether or not the owner of a trauma center allows a surgery resident in the fourth or fifth year of residency training to begin treating a patient described in subsection (H)(6)(b)(i) while awaiting the arrival of the surgeon on the trauma team, as required in subsection (H)(6)(b)(ii)(1) or (2).
  - K. An ALS base hospital certificate holder that chooses to submit trauma registry information to the Department, as allowed by A.R.S. § 36-2221(A), shall:
    1. Include in the ALS base hospital's trauma registry at least the information required in R9-25-1309(A) for each patient who meets one or more of the criteria in subsections (C)(1)(a) through (c), and
    2. Comply with the submission requirements in subsections (C)(2) and (3).
- (Supp. 17-3). Incomplete citations to Table 13.1(C)(3)(f) under subsections (F)(12)(e) and (F)(13)(a) corrected at the request of the Department (Supp. 18-4). Amended by final expedited rulemaking at 29 A.A.R. 2321 (October 6, 2023), with an immediate effective date of September 18, 2023 (Supp. 23-3).
- R9-25-1309. Trauma Registry Data (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2221, and 36-2225(A)(5) and (6))**
- A. A trauma registry established according to R9-25-1308(B)(1) includes the following in the record of a patient's episode of care, as defined in A.A.C. R9-11-101, for each patient meeting the criteria in R9-25-1308(C)(1):
1. An identification code specific to the health care institution that had contact with the patient during the episode of care;
  2. Demographic information about the patient:
    - a. The unique number assigned by the health care institution to the patient;
    - b. A code indicating whether the patient's record will be submitted to the Department as required in R9-25-1308(C)(2);
    - c. The unique number assigned by the health care institution for the episode of care;
    - d. The date the patient arrived at the health care institution for the episode of care;
    - e. For the episode of care, a code indicating whether the patient:
      - i. Was directly admitted to the health care institution,
      - ii. Was admitted to the health care institution through the emergency department,
      - iii. Was seen in the emergency department then transferred to another health care institution by an ambulance service or emergency medical services provider,
      - iv. Was seen in the emergency department and discharged, or
      - v. Died in the emergency department or was dead on arrival;
    - f. The patient's first name, middle initial, and last name;
    - g. The patient's Social Security Number;
    - h. The patient's date of birth and age;
    - i. Codes indicating the patient's gender, race, and ethnicity;
    - j. The zip code of the patient's residence or, if applicable, an indication of why no zip code was reported; and
    - k. The city, state, and county of the patient's residence;
  3. Information about the occurrence of the patient's injury:
    - a. The date and time the injury occurred;
    - b. The ICD-code describing the type of location where the injury occurred;
    - c. The zip code of the location where the injury occurred;
    - d. The city, state, and county where the injury occurred;
    - e. A code indicating whether the patient's injury resulted from blunt force trauma, a penetrating wound, or a burn;
    - f. The ICD-code indicating the primary mechanism or cause of the patient's injury resulting in the episode

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1308 renumbered to R9-25-1304; new Section R9-25-1308 renumbered from R9-25-1313 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018

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- of care and the manner or intent through which the injury occurred;
- g. A description of the cause and circumstances leading to the patient's injury;
  - h. Whether the patient was using a protective device or safety equipment at the time of the injury and, if so, the type or types of protective device or safety equipment being used;
  - i. If the patient was subject to the requirements in A.R.S. § 28-907 at the time of the injury, whether the patient was using a child restraint system, as defined in A.R.S. § 28-907, at the time of the injury and, if so, the type of child restraint system being used; and
  - j. If the patient's injury resulted from a motor vehicle crash, a code describing the status of airbag deployment;
4. Information about the patient's arrival at the health care institution:
    - a. A code identifying the mode of transportation by which the patient arrived at the health care institution; and
    - b. If applicable:
      - i. The ambulance service or emergency medical services provider that transported the patient to the health care institution;
      - ii. The unique identifier given by the ambulance service or emergency medical services provider to the incident during which the patient received EMS;
      - iii. The date the ambulance service or emergency medical services provider transported the patient to the trauma center; and
      - iv. If the patient was transferred from another health care institution, the name of the other health care institution;
  5. Information about the health care institution's assessment or treatment of the patient in the emergency department:
    - a. A code indicating which of the criteria in R9-25-1308(C)(1) the patient met;
    - b. A code indicating whether an ambulance service or emergency medical services provider transported the patient to the health care institution and, if so, the criteria used by the transporting ambulance service or emergency medical services provider for transporting the patient to the health care institution;
    - c. The date and time the patient arrived at the emergency department of the health care institution for the episode of care;
    - d. The date and time the patient died or left the emergency department of the health care institution for the episode of care;
    - e. The length of time in hours and in minutes that the patient remained in the emergency department of the health care institution during the episode of care;
    - f. If trauma team activation occurred, the time when the last trauma team personnel member arrived at their assigned location in the health care institution;
    - g. Whether the patient showed signs of life when the patient arrived at the health care institution;
    - h. The values of the following for the patient at the time of their first assessment at the health care institution:
      - i. Pulse rate;
      - ii. Respiratory rate;
      - iii. Oxygen saturation;
      - iv. Systolic blood pressure; and
      - v. Temperature, including the units of temperature and the route used to measure the patient's temperature;
    - i. A code indicating whether the patient was receiving respiratory assistance at the time the patient's respiratory rate was assessed;
    - j. A code indicating whether the patient was receiving supplemental oxygen at the time the patient's oxygen saturation was assessed;
    - k. Codes indicating the Glasgow Coma Score for:
      - i. Eye opening,
      - ii. Verbal response to stimulus, and
      - iii. Motor response to stimulus;
    - l. The patient's total Glasgow Coma Score;
    - m. Whether the patient was intubated at the time of the patient's assessments in subsections (A)(5)(h)(ii), (k)(ii), and (l);
    - n. A code indicating whether a paralytic agent or sedative had been administered to the patient at the time the patient's Glasgow Coma Score was measured;
    - o. A code indicating another factor that may have affected the patient's Glasgow Coma Score;
    - p. A revised trauma score for the patient, auto-calculated based on the patient's systolic blood pressure, respiratory rate, and Glasgow Coma Score;
    - q. A code indicating the status of alcohol use by the patient and, if applicable, the blood alcohol concentration in the patient's blood;
    - r. A code indicating the status of drug use by the patient and, if applicable, the code for each drug class detected in the patient's blood;
    - s. A code indicating the disposition of the patient at the time the patient was discharged from the emergency department; and
    - t. If the patient was transferred to another health care institution upon discharge from the emergency department:
      - i. The name of the health care institution to which the patient was transferred;
      - ii. The name of the ambulance service or emergency medical services provider providing the interfacility transport;
      - iii. A code indicating the reason for transfer; and
      - iv. If there was a delay in transferring the patient to another health care institution, a code indicating the reason for the delay;
  6. Information about the patient's discharge from the health care institution:
    - a. The date and time the patient was discharged from the health care institution;
    - b. The length of time the patient remained as an inpatient, as defined in A.A.C. R9-10-201, in the health care institution;
    - c. The length of time the patient remained in the health care institution's intensive care unit;
    - d. A code indicating whether the patient was alive or dead at the time of discharge from the health care institution;
    - e. The ICD-code for each injury identified in the patient, including an indication of whether the ICD-code is for:

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- i. The principle diagnosis, the reason believed by the health care institution to be chiefly responsible for the patient's need for the episode of care; or
  - ii. A secondary diagnosis, another reason believed by the health care institution to have contributed to the patient's need for the episode of care;
- f. The patient's Injury Severity Score;
- g. A code indicating the disposition of the patient at the time the patient was discharged from the health care institution;
- h. Whether a report of suspected physical abuse was reported to law enforcement or as required by A.R.S. § 13-3620 or 46-454, if applicable, and, if so:
  - i. Whether an investigation into the suspected physical abuse was initiated by an entity to which the suspected physical abuse was reported; and
  - ii. If the patient is a child, whether the patient was discharged in the care of a person other than the person responsible for the care of the patient at the time the patient arrived at the health care institution; and
- i. If the patient was transferred to a hospital upon discharge from the health care institution:
  - i. The name of the hospital to which the patient was transferred,
  - ii. The name of the ambulance service or emergency medical services provider providing the interfacility transport, and
  - iii. A code indicating the reason for transfer; and
- 7. Financial information about the episode of care:
  - a. A code for the primary source of payment for the episode of care;
  - b. A code for a secondary source of payment for the episode of care, if applicable;
  - c. The total amount of charges for the episode of care; and
  - d. The total amount collected by the health care institution for the episode of care.
- B.** In addition to the information required in subsection (A), a trauma registry established according to R9-25-1308(B)(1) by a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, Level II Pediatric trauma center, or Level III trauma center includes the following in the record of a patient's episode of care, as defined in A.A.C. R9-11-101, for each patient meeting the criteria in R9-25-1308(C)(1):
  - 1. Demographic information about the patient:
    - a. The country of the patient's residence;
    - b. The country where the patient was found or from which an ambulance service or emergency medical services provider transported the patient; and
    - c. Any pre-existing medical conditions diagnosed for the patient, unrelated to the reason for the episode of care;
  - 2. Information about the occurrence of the patient's injury:
    - a. Whether the time specified according to subsection (A)(3)(a) is the actual time of occurrence or an estimate;
    - b. The street address of the location where the injury occurred or, if the location at which the injury occurred does not have a street address, another indicator of the location at which the injury occurred;
  - c. Any additional ICD-code describing the mechanism or cause of the patient's injury resulting in the episode of care and the manner or intent through which the injury occurred;
  - d. The ICD-code indicating the activity the patient was engaged in that resulted in the patient's injury;
  - e. If the patient's injury resulted from a crash involving a means of transportation, including a motor vehicle, other motorized means of transportation, watercraft, bicycle, or aircraft, a code describing the type of vehicle in use at the time of the injury and the patient's location in the vehicle;
  - f. A description of any issues related to a protective device or safety equipment in use at the time of the patient's injury; and
  - g. Whether the patient's injury occurred during the patient's paid employment and, if so, a code indicating:
    - i. The type of occupation associated with the patient's employment, and
    - ii. The patient's occupation;
- 3. A code indicating whether EMS was provided to the patient and, if applicable, the type of transport provided to the patient;
- 4. If EMS was provided to the patient, whether a prehospital incident history report was provided to the trauma center and, if so:
  - a. The date on the prehospital incident history report;
  - b. The identifying number on the prehospital incident history report assigned by the ambulance service or emergency medical services provider;
  - c. The date and time the ambulance service or emergency medical services provider was dispatched, as defined in R9-25-901, to the scene;
  - d. The date and time the ambulance service or emergency medical services provider responded to the dispatch;
  - e. The date and time the ambulance service or emergency medical services provider arrived at the scene;
  - f. The date and time the ambulance service or emergency medical services provider established contact with the patient;
  - g. The date and time the ambulance service or emergency medical services provider left the scene;
  - h. The date and time the ambulance service or emergency medical services provider arrived at the health care institution that was the transport destination;
  - i. The date and time the patient's pulse, respiration, oxygen saturation, and systolic blood pressure were first measured;
  - j. At the date and time the patient's pulse, respiration, oxygen saturation, and systolic blood pressure were first measured, the patient's:
    - i. Pulse rate,
    - ii. Respiratory rate,
    - iii. Oxygen saturation, and
    - iv. Systolic blood pressure;
  - k. Whether the patient was intubated at the date and time the patient's pulse, respiration, and oxygen saturation were first measured;
  - l. Codes indicating the Glasgow Coma Score for:
    - i. Eye opening,

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- ii. Verbal response to stimulus, and
    - iii. Motor response to stimulus;
  - m. The patient's total Glasgow Coma Score;
  - n. A code indicating whether a paralytic agent or sedative had been administered to the patient at the date and time the patient's Glasgow Coma Score was measured;
  - o. A revised trauma score for the patient, auto-calculated based on the patient's systolic blood pressure, respiratory rate, and Glasgow Coma Score;
  - p. Codes indicating all airway management procedures performed on the patient by an ambulance service or emergency medical services provider before the patient's arrival at the first health care institution; and
  - q. Whether the patient experienced cardiac arrest subsequent to the injury before the patient's arrival at the first health care institution;
5. The amount of time that elapsed from the date and time the ambulance service or emergency medical services provider:
    - a. Was dispatched and the date and time the ambulance service or emergency medical services provider arrived at the scene,
    - b. Arrived at the scene and the date and time the ambulance service or emergency medical services provider left the scene,
    - c. Left the scene and the date and time the ambulance service or emergency medical services provider arrived at the transport destination, and
    - d. Was dispatched and the date and time the ambulance service or emergency medical services provider arrived at the transport destination;
  6. Whether the patient arrived at the trauma center for treatment of the injury resulting in the episode of care through an interfacility transport;
  7. If the patient arrived at the trauma center through an interfacility transport, the following information about the health care institution at which the patient was seen immediately before arriving at the trauma center:
    - a. The name of the health care institution;
    - b. The date and time the patient arrived at the health care institution in subsection (B)(7)(a); and
    - c. The date and time the patient left the health care institution in subsection (B)(7)(a);
  8. If the patient arrived at the health care institution in subsection (B)(7)(a) through an interfacility transport, the information in subsections (B)(7)(a) through (c) about each health care institution at which the patient was seen for the injury resulting in the episode of care before arriving at the health care institution in subsection (B)(7)(a);
  9. If the patient arrived at the trauma center through an interfacility transport, for each health care institution at which the patient was seen for the injury resulting in the episode of care before arriving at the trauma center, information for the first instance of assessing the patient's:
    - a. Respiratory rate,
    - b. Systolic blood pressure,
    - c. The patient's total Glasgow Coma Score, and
    - d. Revised trauma score; and
  10. Information about the patient's episode of care at the trauma center and the patient's discharge from the trauma center:
    - a. The patient's height and weight when the patient arrived at the trauma center;
    - b. The number of days the patient spent on a mechanical ventilator;
    - c. If applicable, the identification number assigned by a medical examiner or alternate medical examiner, as defined in A.R.S. § 11-591, to the documentation of the patient's autopsy;
    - d. The total length of time the patient remained at the trauma center before discharge;
    - e. For each ICD-code identified according to subsection (A)(6)(e), a code that reflects the severity of the injury to which the ICD-code refers;
    - f. For each ICD-code identified according to subsection (A)(6)(e) that does not include an indication of the part of the patient's body that was injured, a code supplementing the ICD-code that indicates the part of the body that was injured;
    - g. For each procedure performed on the patient:
      - i. The ICD-code for the procedure,
      - ii. The health care institution at which the procedure was performed,
      - iii. A code indicating the organized service unit within the health care institution in which the procedure was performed, and
      - iv. The date and time the procedure was begun;
    - h. Any complications experienced by the patient while the patient remained at the trauma center;
    - i. The Abbreviated Injury Scale code indicating the severity of each of the patient's injuries;
    - j. The Abbreviated Injury Scale code indicating the body region affected by each of the patient's injuries;
    - k. If the trauma center is designated as a Level I trauma center or Level I Pediatric trauma center, the six-digit Abbreviated Injury Scale code and the software version used to calculate the six-digit Abbreviated Injury Scale code; and
    - l. The patient's probability of survival.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1309 renumbered to R9-25-1305; new Section R9-25-1309 made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1310. Trauma Registry Data Quality Assurance (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2220(A), 36-2221, and 36-2225(A)(5) and (6))**

- A. To ensure the completeness and accuracy of trauma registry reporting, a health care institution submitting trauma registry information to the Department shall allow the Department to review the following, upon prior notice from the Department of at least five business days:
  1. The health care institution's trauma registry or other database containing trauma registry information;
  2. Patient medical records; and
  3. Any record, other than those specified in subsections (A)(1) and (2), that may contain information about diagnostic evaluation or treatment provided to a patient receiving trauma care.
- B. Upon prior notice from the Department of at least five business days, a health care institution submitting trauma registry information to the Department shall provide the Department

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with all patient medical records for a time period specified by the Department, to allow the Department to determine the accuracy and completeness of the information submitted to the trauma registry for patients receiving trauma care during the period.

- C. For purposes of subsection (B), the Department considers a health care institution to be in compliance with R9-25-1308(C)(2) if the health care institution submitted to the Department trauma registry information for 97% of the patients receiving trauma care during the period.
- D. If trauma registry information submitted to the Department by a health care institution according to R9-25-1308(C)(2) and (3) is not in compliance with requirements in R9-25-1308 or R9-25-1309, the Department shall:
  1. Notify the health care institution that the trauma registry information submitted to the Department is not in compliance with requirements in R9-25-1308 or R9-25-1309, and
  2. Identify the revisions or actions that are needed to bring the data into compliance with R9-25-1308 and R9-25-1309.
- E. A health care institution that has trauma registry information returned, as provided in subsection (D), shall:
  1. Revise the trauma registry information as identified by the Department, and
  2. Submit the revised data to the Department within 15 business days after the date the Department notified the health care institution according to subsection (D)(1) or within a longer period agreed upon between the Department and the health care institution.
- F. Within 15 business days after receiving a written request from the Department that includes a simulated patient medical record, a health care institution submitting trauma registry information to the Department shall prepare and submit to the Department the information required in R9-25-1309, applicable to the Level of health care institution, for the patient described in the simulated patient medical record.

**Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1310 repealed; new Section R9-25-1310 renumbered from R9-25-1406 and amended by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1311. Repealed****Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363,

effective October 6, 2005 (Supp. 05-4). Section R9-25-1311 repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1312. Renumbered****Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1312 renumbered to R9-25-1307 by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1313. Renumbered****Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section R9-25-1313 renumbered to R9-25-1308 by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1314. Expired****Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

**R9-25-1315. Repealed****Historical Note**

New Section made by final rulemaking 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**Table 1. Repealed****Historical Note**

New Table made by final rulemaking at 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Table 1 Application Processing Time Periods repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**Exhibit I. Repealed****Historical Note**

New Exhibit made by final rulemaking at 11 A.A.R. 4363, effective October 6, 2005 (Supp. 05-4). Exhibit 1 Arizona Trauma Center Standards repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).



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**Table 13.1. Arizona Trauma Center Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**

**Key:**

E = Essential and required

I(P) = Level I Pediatric trauma center

II(P) = Level II Pediatric trauma center

ICU = Intensive care unit

In-house = On the premises of the health care institution

ISS = Injury severity score, the sum of the squares of the abbreviated injury scale scores of the three most severely injured body regions

Child life = A program of support to injured children and their families to reduce stress and anxiety by:

- a. Explaining medical equipment and procedures to children in a non-threatening and age-appropriate manner,
- b. Explaining a diagnosis to a child in an age-appropriate manner, and
- c. Helping children and their families develop strategies to cope with the diagnosis and expected outcome

Trauma Facilities Criteria	Levels					
	I	I(P)	II	II(P)	III	IV
<b>A. Institutional Organization</b>						
1. Trauma service	E	E	E	E	E	-
2. Trauma medical director	E	E	E	E	E	-
3. Trauma multidisciplinary peer review committee	E	E	E	E	E	-
4. Injury prevention program (R9-25-1308(G)(5)(a))	E	E	E	E	-	-
5. Injury prevention activities (R9-25-1308(G)(3))	E	E	E	E	E	E
6. Educational outreach program (R9-25-1308(G)(5)(b))	E	E	E	E	-	-
7. Educational outreach activities (R9-25-1308(G)(4))	E	E	E	E	E	-
8. Child maltreatment assessment capability	E	E	E	E	E	E
<b>B. Hospital Departments/Divisions/Sections</b>						
1. Surgery	E	E	E	E	E	-
2. Neurosurgery	E	E	E	E	-	-
3. Orthopedic surgery	E	E	E	E	E	-
4. Emergency medicine	E	E	E	E	E	-
5. Pediatric emergency department area	-	E	-	E	-	-
6. Anesthesia	E	E	E	E	E	-
<b>C. Clinical Capabilities</b>						
1. Written on-call schedule for each component of the trauma service if a team member is not in-house	E	E	E	E	E	E
2. Physician specialist available 24 hours/day						
a. General surgeon	E	E	E	E	E	-
i. Published back-up schedule	E	E	E	E	-	-
ii. Dedicated to single hospital when on-call	E	E	E	E	-	-
iii. Surgeon credentialed for pediatric trauma care	-	E	-	E	-	-
b. Emergency medicine physician	E	E	E	E	E	-
c. Pediatric emergency medicine physician	-	E	-	-	-	-
3. Specialist on-call and available 24 hours/day						
a. Orthopedic surgeon	E	E	E	E	E	-
b. Pediatric-credentialed orthopedic surgeon	-	E	-	E	-	-
c. Neurosurgeon	E	E	E	E	-	-
d. Pediatric-credentialed neurosurgeon	-	E	-	E	-	-
e. Critical care medicine physician	E	E	E	E	-	-
f. Pediatric-credentialed critical care medicine physician	-	E	-	E	-	-
g. Radiologist	E	E	E	E	E	
h. Hand surgeon	E	E	E	E	-	-
i. Ophthalmic surgeon	E	E	E	E	-	-
j. Plastic surgeon	E	E	E	E	-	-
k. Thoracic surgeon	E	E	E	E	-	-
l. Cardiac surgeon	E	E	-	-	-	-
m. Obstetrics/gynecologic surgeon	E	E	-	-	-	-
n. Oral/maxillofacial surgeon (plastic surgeon, otolaryngologist, or oral/maxillofacial surgeon)	E	E	E	E	-	-

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4. Qualified anesthesia personnel member on-call and available 24 hours/day						
a. Physician or certified nurse anesthetist	E	E	E	E	E	-
b. Physician or certified nurse anesthetist with a pediatric credential	-	E	-	E	-	-
5. Volume performance standards:						
a. 1200 trauma admissions per year,	E	-	-	-	-	-
b. 240 admissions with ISS > 15 per year, or						
c. Average of 35 patients with ISS > 15 for each trauma team surgeon per year						
d. 200 trauma admissions < 15 years of age per year,	-	E	-	-	-	-
<b>D. Facilities/Resources/Capabilities</b>						
1. Emergency department						
a. Designated physician director	E	E	E	E	E	-
b. Personnel members with pediatric-specific trauma-related training	-	E	-	E	-	-
c. Resuscitation equipment for patients of all sizes						
i. Airway control and ventilation equipment	E	E	E	E	E	E
ii. Pulse oximetry	E	E	E	E	E	E
iii. Suction devices	E	E	E	E	E	E
iv. Electrocardiograph-oscilloscope-defibrillator	E	E	E	E	E	E
v. Color-coded, length-based tool to assist with medication dosing and equipment selection for children	E	E	E	E	E	E
vi. Central venous pressure monitoring equipment	E	E	E	E	E	-
vii. Standard intravenous fluids and administration sets	E	E	E	E	E	E
viii. Large-bore intravenous catheters	E	E	E	E	E	E
ix. Sterile surgical sets for:						
(1) Airway control/cricothyrotomy	E	E	E	E	E	E
(2) Thoracostomy	E	E	E	E	E	E
(3) Central line insertion	E	E	E	E	E	-
(4) Thoracotomy	E	E	E	E	E	-
x. Arterial catheters	E	E	E	E	-	-
xi. X-ray availability 24 hours/day	E	E	E	E	E	-
xii. Thermal control equipment						
(1) For patient	E	E	E	E	E	E
(2) For fluids and blood	E	E	E	E	E	E
xiii. Rapid infusion system/capability	E	E	E	E	E	E
xiv. Qualitative end-tidal CO <sub>2</sub> monitoring	E	E	E	E	E	E
d. Communication with EMS personnel	E	E	E	E	E	E
e. Capability to resuscitate, stabilize, and transfer pediatric patients	E	E	E	E	E	E
2. Operating room						
a. Immediately available 24 hours/day	E	E	E	E	-	-
b. Size-specific equipment						
i. Cardiopulmonary bypass	E	E	-	-	-	-
ii. Operating microscope	E	E	-	-	-	-
c. Thermal control equipment						
i. For patient	E	E	E	E	E	E
ii. For fluids and blood	E	E	E	E	E	E
d. X-ray capability including C-arm image intensifier	E	E	E	E	E	-
e. Endoscopes, bronchoscope	E	E	E	E	E	-
f. Craniotomy instruments	E	E	E	E	-	-
g. Equipment for long bone and pelvic fixation	E	E	E	E	E	-
h. Rapid infusion system/capability	E	E	E	E	E	E
3. Postanesthesia recovery room or surgical ICU						
a. Registered nurses available 24 hours/day	E	E	E	E	E	E
b. Equipment for monitoring and resuscitation	E	E	E	E	E	E
c. Intracranial pressure monitoring equipment	E	E	E	E	-	-
d. Pulse oximetry	E	E	E	E	E	E
e. Thermal control equipment						
i. For patient	E	E	E	E	E	E

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ii. For fluids and blood	E	E	E	E	E	E
4. ICU or critical care unit for injured patients						
a. Pediatric ICU	-	E	-	E	-	-
b. Registered nurses with trauma-related training	E	E	E	E	E	-
c. Registered nurses with pediatric-specific trauma-related training	-	E	-	E	-	-
d. Designated surgical director or surgical co-director	E	E	E	E	E	-
e. Physician (fourth year of residency training or higher) assigned to surgical ICU service and in-house 24 hours/day	E	E	-	-	-	-
f. Physician (fourth year of residency training or higher) with a pediatric credential assigned to surgical ICU service and in-house 24 hours/day	-	E	-	-	-	-
g. Surgically directed and staffed ICU service	E	E	E	E	-	-
h. Equipment for monitoring and resuscitation	E	E	E	E	E	-
i. Intracranial pressure monitoring equipment	E	E	E	E	-	-
5. Respiratory therapy services (Available 24 hours/day)						
a. Available in-house	E	E	E	E	-	-
b. On-call and available within 45 minutes after notification	-	-	-	-	E	-
6. Radiological services (Available 24 hours/day)						
a. In-house radiology technologist	E	E	E	E	E	-
b. Radiology technologist on-call and available within 45 minutes after notification	-	-	-	-	-	E
c. Resuscitation equipment for patients of all sizes, as specified in subsection (D)(1)(c)(i) to (v)	E	E	E	E	E	E
d. Angiography	E	E	E	E	-	-
e. Sonography	E	E	E	E	E	-
f. Computed tomography (CT)	E	E	E	E	E	-
i. In-house CT technician	E	E	E	E	-	-
ii. CT technician on-call and available within 45 minutes after notification	-	-	-	-	E	-
g. Magnetic resonance imaging	E	E	E	E	-	-
7. Clinical laboratory service (Available 24 hours/day)						
a. Standard analyses of blood, urine, and other body fluids	E	E	E	E	E	E
b. Blood typing and cross-matching	E	E	E	E	E	-
c. Coagulation studies	E	E	E	E	E	E
d. Comprehensive blood bank or access to a community central blood bank and adequate storage facilities	E	E	E	E	E	-
e. Blood gases and pH determinations	E	E	E	E	E	E
f. Microbiology	E	E	E	E	E	-
<b>E. Rehabilitation Services Specific to the Patient Population</b>						
1. Physical therapy	E	E	E	E	E	-
2. Occupational therapy	E	E	E	E	-	-
3. Speech therapy	E	E	E	E	-	-
<b>F. Social Services Specific to the Patient Population</b>						
1. Social services	E	E	E	E	E	-
2. Child life program	-	E	-	E	-	-
<b>G. Performance Improvement</b>						
1. Multidisciplinary peer review committee	E	E	E	E	E	-
2. Performance improvement personnel dedicated to the trauma service	E	E	E	E	-	-

**Historical Note**

Table 13.1, Arizona Trauma Center Standards, made by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3). Subsections under (D)(2) were incorrectly labeled at 23 A.A.R. 2656; clerical error corrected and labeled as f through h (Supp. 22-2). Amended by final expedited rulemaking at 29 A.A.R. 2321 (October 6, 2023), with an immediate effective date of September 18, 2023 (Supp. 23-3).

**ARTICLE 14. REPEALED**

January 1, 2018 (Supp. 17-3).

**R9-25-1401. Repealed**

**R9-25-1402. Repealed**

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective

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January 1, 2018 (Supp. 17-3).

**Table 1. Repealed****Historical Note**

New Table 1 made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Table 1 Trauma Registry Data Set, repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1403. Repealed****Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1404. Expired****Historical Note**

New Section made by final rulemaking at 13 A.A.R.

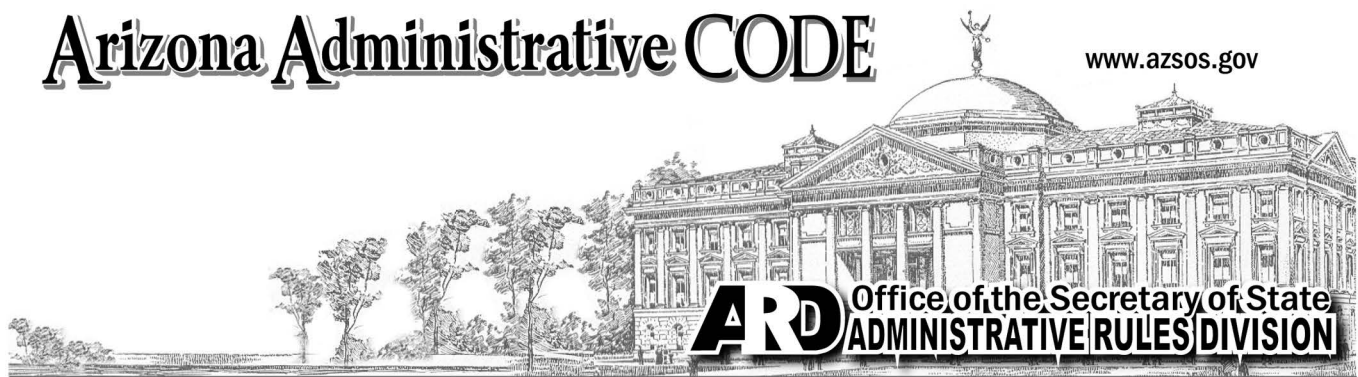
4301, effective January 12, 2008 (Supp. 07-4). Section expired under A.R.S. 41-1056(E) at 18 A.A.R. 2153, effective June 30, 2012 (Supp. 12-3).

**R9-25-1405. Repealed****Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section heading corrected at request of the Department, Office File No. M12-82, filed March 5, 2012 (Supp. 11-4). Section repealed by final rulemaking at 23 A.A.R. 2656, effective January 1, 2018 (Supp. 17-3).

**R9-25-1406. Renumbered****Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4301, effective January 12, 2008 (Supp. 07-4). Section R9-25-1406 renumbered to R9-25-1310, effective January 1, 2018 (Supp. 17-3).



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### CHAPTER 26. COMMISSION FOR THE DEAF AND THE HARD OF HEARING

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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**The release of this Chapter in Supp. 24-4 replaces Supp. 21-3, 1-12 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 9. HEALTH SERVICES

## CHAPTER 26. COMMISSION FOR THE DEAF AND THE HARD OF HEARING

Authority: A.R.S. §§ 36-1946 and 36-1947 et seq.

## Supp. 24-4

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(Authority: A.R.S. § 36-1946(A))

*Editor's Note: The emergency rulemakings amending R9-26-501 and R9-26-507 at 27 A.A.R. 549 were due to expire on September 27, 2021. The Commission amended these Sections by final rulemaking before the expiration of the emergency. These Sections became effective August 4, 2021, at 27 A.A.R. 1257 (Supp. 21-3).*

*Article 5, consisting of Sections R9-26-501 through R9-26-511, adopted effective April 4, 1997 (Supp. 97-2).*

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## TITLE 9. HEALTH SERVICES

## CHAPTER 26. COMMISSION FOR THE DEAF AND THE HARD OF HEARING

**ARTICLE 1. REPEALED****R9-26-101. Renumbered****Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Amended by final rulemaking at 8 A.A.R. 4292, effective November 18, 2002 (Supp. 02-3). Section R9-26-101 renumbered to Section R9-26-201 by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**ARTICLE 2. TELECOMMUNICATIONS EQUIPMENT DISTRIBUTION PROGRAM****R9-26-201. Definitions**

In addition to the definitions listed in A.R.S. § 36-1941, the following terms apply to this Article and A.R.S. § 36-1947:

“Applicant” means a person who applies to the Commission for telecommunications equipment.

“Audiologist” means a person who is licensed under A.R.S. § 36-1940 by the Arizona Department of Health Services.

“Deafblind” means a person who is either deaf or hard of hearing and:

Has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or

Has a field defect where the peripheral diameter of the visual field subtends an angular distance no greater than 20 degrees, or

Has a progressive visual loss with a prognosis of one or both of the conditions stated in the two preceding subsections.

“Director” means the Executive Director of the Commission.

“Hearing aid dispenser” has the same meaning as in A.R.S. § 36-1901.

“Hearing or speech-related disability” means a disability that prevents a person from hearing or articulating speech audibly or clearly, including deafness.

“Program” means the Telecommunications Equipment Distribution Program.

“Recipient” means a person who receives telecommunications equipment through the Program.

“Severely hearing or speech impaired” under A.R.S. § 36-1947(A) means a hearing or speech-related disability.

“Supplier” means a person that sells telecommunications equipment.

“Support service provider” means a trained individual who communicates visual, environmental, and social information to a DeafBlind individual to assist the DeafBlind individual to access the community and make decisions.

“Telecommunications equipment” means equipment that allows a person with a hearing or speech-related disability to access the telephone network.

“Vocational rehabilitation counselor” means an individual who has a Master’s degree in rehabilitation counseling from a university accredited by the National Council on Rehabilitation

Education and who is certified by the Commission on Rehabilitation Counseling.

“Voucher” means the Commission’s authorization of payment for telecommunications equipment.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4292, effective November 18, 2002 (Supp. 02-3). Section R9-26-201 renumbered to R9-26-202; new Section R9-26-201 renumbered from R9-26-101 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-202. Eligibility**

To be eligible for telecommunications equipment through the Program, a person shall:

1. Reside in Arizona;
2. Be a citizen of the U.S. or an alien whose presence in the U.S. is authorized under federal law;
3. Have a need for telecommunications equipment available through the Program due to a hearing or speech-related disability, as certified by an authorized person described in R9-26-203;
4. Have access to a telephone line; and
5. Not have used a voucher to purchase telecommunications equipment that is still under warranty unless the individual’s disability status changed during the warranty period.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed; new Section R9-26-202 renumbered from R9-26-301 and amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4292, effective November 18, 2002 (Supp. 02-3). Section R9-26-202 renumbered to R9-26-203; new Section R9-26-202 renumbered from R9-26-201 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-203. Application Process**

To apply for telecommunications equipment under the Program, an eligible person shall:

1. Obtain an application for participation in the Program from the Commission; and
2. Complete and return the application to the Commission with:
  - a. Certification from an authorized person described under R9-26-204 that the applicant has a hearing or speech-related disability and needs the telecommunications equipment requested on the application;
  - b. The eligible person’s authorization for the Commission to use the information provided in the application to administer the Program; and
  - c. As required under A.R.S. § 41-1080(A), the specified documentation of citizenship or alien status indicating the applicant’s presence in the U.S. is authorized under federal law.



## TITLE 9. HEALTH SERVICES

## CHAPTER 26. COMMISSION FOR THE DEAF AND THE HARD OF HEARING

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed; new Section R9-26-203 renumbered from R9-26-304 and amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4292, effective November 18, 2002 (Supp. 02-3). Section R9-26-203 renumbered to R9-26-204; new Section R9-26-203 renumbered from R9-26-202 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-204. Persons Authorized to Certify Need for Telecommunications Equipment**

- A. The following licensed professionals may certify an applicant's hearing or speech-related disability and need for the requested telecommunications equipment:
1. A dispensing audiologist licensed in accordance with A.R.S. Title 36, Chapter 17;
  2. An audiologist licensed in accordance with A.R.S. Title 36, Chapter 17;
  3. A physician licensed in accordance with A.R.S. Title 32, Chapter 13 or 17;
  4. A physician assistant licensed in accordance with A.R.S. Title 32, Chapter 25;
  5. A nurse practitioner licensed in accordance with A.R.S. Title 32, Chapter 15;
  6. A speech-language pathologist licensed in accordance with A.R.S. Title 36, Chapter 17;
  7. A hearing aid dispenser licensed in accordance with A.R.S. Title 36, Chapter 17; or
  8. A vocational rehabilitation counselor as defined at R9-26-201.
- B. By certifying a hearing or speech-related disability and need for the requested telecommunications equipment, the certifier attests that the certifier:
1. Is authorized to certify under subsection (A);
  2. Has evaluated the applicant's hearing or speech-related disability to determine the applicant's need for the telecommunications equipment requested on the application; and
  3. Has determined that the applicant will benefit from the telecommunications equipment requested on the application.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed; new Section R9-26-204 renumbered from R9-26-305 and amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section repealed; new Section made by final rulemaking at 8 A.A.R. 4292, effective November 18, 2002 (Supp. 02-3). Section R9-26-204 renumbered to R9-26-205; new Section R9-26-204 renumbered from R9-26-203 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-205. Vouchers**

- A. The Commission shall issue to an eligible applicant an individually numbered voucher for a specified dollar amount for the applicant to purchase telecommunications equipment for which the applicant has a certified need. The applicant shall

use the voucher only to purchase the telecommunications equipment specified on the voucher.

- B. Vouchers are non-transferable and have no cash value.
- C. A voucher expires 90 days after its issuance date.
- D. If a voucher is lost or stolen, the applicant may contact program staff for a replacement voucher and shall attest under penalty of perjury that:
1. The original voucher was stolen or lost; and
  2. If the original voucher is recovered, the applicant shall return the original voucher to the Commission within 30 days after the voucher is recovered.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section renumbered to R9-26-302 by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). New Section made by final rulemaking at 8 A.A.R. 4292, effective November 18, 2002 (Supp. 02-3). Section R9-26-205 renumbered to R9-26-206; new Section R9-26-205 renumbered from R9-26-204 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-206. Redeeming a Voucher**

- A. To redeem a voucher for telecommunications equipment under the Program, a supplier shall submit to the Commission the voucher with a copy of a receipt, which is signed by the supplier and the recipient of the telecommunications equipment and which specifies the telecommunications equipment sold and its purchase price.
- B. The Commission shall verify the accuracy of information submitted on the receipt and the validity of the voucher.
- C. The Commission shall reimburse to the supplier the portion of the purchase price of the telecommunications equipment that does not exceed the amount printed on the voucher.
- D. The Commission shall not reimburse to the supplier an amount in excess of the amount printed on the voucher.
- E. If the amount printed on the voucher exceeds the purchase price of the telecommunications equipment, the supplier shall not refund the difference between the two amounts to the recipient of the telecommunications equipment in any form including money, equipment, or other goods and services.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section renumbered to R9-26-301 by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). New Section made by final rulemaking at 8 A.A.R. 4292, effective November 18, 2002 (Supp. 02-3). Section R9-26-206 renumbered to R9-26-207; new Section R9-26-206 renumbered from R9-26-205 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-207. Confidentiality**

- A. As specified under R9-26-203, the Commission shall use the information provided by Program applicants or recipients solely to administer the Program.
- B. Except as provided under subsection (A), the Commission shall not disclose the name of an applicant for or recipient of telecommunications equipment without a written request for disclosure. Even with a written request for disclosure, the Commission shall not disclose personal identifying or protected health information regarding an applicant or recipient.

## TITLE 9. HEALTH SERVICES

## CHAPTER 26. COMMISSION FOR THE DEAF AND THE HARD OF HEARING

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). New Section R9-26-207 renumbered from R9-26-206 by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**ARTICLE 3. ADMINISTRATIVE PROCEDURES****R9-26-301. Making a Complaint**

- A. A complaint may be filed by:
1. An individual for whom interpreting is provided,
  2. A person having a direct or professional interest in the incident specified in the complaint, or
  3. A person having reason to believe that interpreting was provided by an individual who is not licensed by the Commission and not exempt from licensure under A.R.S. § 36-1971(C).
- B. Complaint requirements. A complainant shall:
1. Submit the complaint to the Commission in writing or by videotape. If a complaint is submitted by videotape, the Commission shall have the complaint interpreted and transcribed into English and forward the transcript to the complainant for review and approval;
  2. Submit the complaint to the Commission within 90 days of the alleged offense; and
  3. Specify in the complaint the name of the individual complained against, date and location of the alleged offense, and the action complained about.
- C. A complainant may withdraw a complaint at any time by providing notice to the Commission.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section renumbered to R9-26-202; new Section R9-26-301 renumbered from R9-26-206 and amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section repealed; new Section renumbered from R9-26-512 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-302. Hearing Procedures**

The Commission shall conduct all hearings in accordance with A.R.S. Title 41, Chapter 6, Article 10 and the rules established by the Office of Administrative Hearings.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed; new Section R9-26-302 renumbered from R9-26-205 and amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section repealed; new Section renumbered from R9-26-515 by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-303. Rehearing or Review of Commission Decision**

- A. The Commission shall provide for a rehearing and review of its decisions under A.R.S. Title 41, Chapter 6, Article 10 and the rules established by the Office of Administrative Hearings.
- B. A party may amend a motion for rehearing or review at any time before the Commission rules on the motion.
- C. The Commission may grant a rehearing or review for any of the following reasons materially affecting a party's rights:

1. Irregularity in the proceedings or an order or abuse of discretion that deprived the moving party of a fair hearing;
  2. Misconduct by the Commission, its staff, an administrative law judge, or the prevailing party;
  3. Accident or surprise that could not have been prevented by ordinary prudence;
  4. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
  5. Excessive penalty;
  6. Error in the admission or rejection of evidence or other errors of law occurring at the hearing or during the progress of the proceedings;
  7. The Commission's decision is the result of passion or prejudice; or
  8. The findings of fact or decision is not justified by the evidence or is contrary to law.
- D. The Commission may affirm or modify a decision or grant a rehearing to all or any of the parties on all or part of the issues for any of the reasons in subsection (C). The Commission shall specify the particular grounds for any order modifying a decision or granting a rehearing.
- E. When a motion for rehearing or review is based on affidavits, the affidavits shall be served with the motion. An opposing party may, within 15 days after service, serve opposing affidavits.
- F. No later than 15 days after the date of a decision, after giving parties notice and an opportunity to be heard, the Commission may grant a rehearing or review on its own initiative for any reason for which it might have granted relief on motion of a party. The Commission may grant a motion for rehearing or review, timely served, for a reason not stated in the motion.
- G. If a rehearing is granted, the Commission shall hold the rehearing within 60 days after the date on the order granting the rehearing.
- H. If the Commission makes a specific finding that a particular decision needs to be effective immediately to preserve the public peace, health, or safety and that a review or rehearing of the decision is impracticable, unnecessary, or contrary to the public interest, the Commission shall issue the decision as a final decision without an opportunity for rehearing or review.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section repealed; new Section renumbered from R9-26-516 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-304. Disciplinary Action**

After an opportunity for hearing and a Commission determination that a licensee violated A.R.S. Title 36, Chapter 17.1, or this Chapter, the Commission shall consider the following factors to determine the degree of discipline to impose under A.R.S. § 36-1976(A):

1. Prior conduct resulting in discipline;
2. Dishonest or self-serving motive;
3. Amount of experience as an interpreter;
4. Bad faith obstruction of the disciplinary proceeding by intentionally failing to comply with rules or orders of the Commission;
5. Submission of false evidence, false statements, or other deceptive practices during the investigative or disciplinary process;
6. Refusal to acknowledge wrongful nature of conduct;

## TITLE 9. HEALTH SERVICES

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7. Degree of harm resulting from the conduct; and
8. Whether harm resulting from the conduct was cured.

**Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section renumbered to R9-26-203 by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). New Section R9-26-304 renumbered from R9-26-517 and amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-305. Renumbered****Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section renumbered to R9-26-204 by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3).

**ARTICLE 4. EXPIRED****R9-26-401. Expired****Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 4411, effective September 30, 2007 (Supp. 07-4).

**R9-26-402. Expired****Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Amended by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 4411, effective September 30, 2007 (Supp. 07-4).

**R9-26-403. Repealed****Historical Note**

Adopted effective May 12, 1986 (Supp. 86-3). Section repealed by final rulemaking at 6 A.A.R. 3827, effective September 15, 2000 (Supp. 00-3).

**ARTICLE 5. INTERPRETER LICENSURE AND REGULATION****R9-26-501. Definitions**

In addition to the definitions in A.R.S. §§ 12-242 and 36-1941, in this Article, the following definitions apply unless otherwise specified:

“ACCI” means American Consortium of Certified Interpreters, an organization that certifies interpreters at one of three levels: ACCI Generalist, ACCI Advanced, or ACCI Master.

“Accredited” means approved by a regional or national accrediting agency recognized by the U.S. Department of Education.

“Applicant” means an individual seeking an original or renewal license from the Commission.

“Application” means the documents, forms, and additional information required by the Commission to be submitted by or on behalf of an applicant.

“BEI” means Board for Evaluation of Interpreters.

“CASLI” means the Center for the Assessment of Sign Language Interpretation, which administers the examinations used by RID in national certification programs.

“CDI” means certified deaf interpreter, a certification issued by RID or BEI.

“CI” means certificate of interpretation, a certification issued by RID.

“CIC” means Court Interpreter Certification, a legal specialist certification issued by BEI.

“CLIP-R” means conditional legal interpreting permit--relay, a certification issued by RID to a deaf or hard-of-hearing interpreter or transliterator who works in a legal setting.

“Continuing education” means a workshop, seminar, lecture, conference, class, or other educational activity relevant to the practice of interpreting.

“CSC” means comprehensive skills certificate, a certification issued by RID.

“CT” means certificate of transliteration, a certification issued by RID.

“Deaf interpreter” means an individual who is deaf or hard of hearing and provides interpreting for deaf individuals with special language needs.

“EIPA” means educational interpreter performance assessment, a diagnostic tool that measures proficiency in interpreting for children or young adults in an educational setting.

“Generalist interpreter” means an individual who provides interpreting in any community setting, except a legal setting, for which the individual is qualified by education, examination, and work history. A generalist interpreter provides interpreting in a legal setting only if appointed by a judge under A.R.S. § 12-242.

“IC” means interpretation certificate, a certification issued by RID.

“Intermediary Level III or V” means a certification issued by BEI for interpreters who are deaf or hard of hearing.

“Interpreter” means an individual who provides interpreting between American Sign Language and English.

“Legal interpreter” means an individual who is qualified by education, examination, and work history to provide interpreting in a legal setting.

“Class A legal interpreter” means a legal interpreter who provides interpreting in court proceedings or any other legal setting, as prescribed under A.R.S. § 12-242, and meets the certification requirement under R9-26-504(A)(1)(a).

“Class C legal interpreter” means a legal interpreter who provides interpreting in a legal setting, as prescribed under A.R.S. § 12-242, when teamed with a Class A legal interpreter and meets the certification requirement under R9-26-504(A)(1)(b).

“Class D legal interpreter” means a legal interpreter who meets the certification requirement under R9-26-504(A)(1)(c) and is either a deaf or hard-of-hearing interpreter or an oral transliterator.

“Legal training” means a structured program presented by the Commission, a court, Bar Association, law-enforcement association, RID, accredited institution, or comparable organization, providing information relevant to legal interpreting such as the following:

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The requirements of A.R.S. § 12-242,  
 The structure of the judiciary system of this state,  
 The judiciary process of this state,  
 Administrative adjudicatory procedures,  
 Law enforcement procedures, or  
 Commonly used legal terms.

“Level III, IV, or V” means a certification issued by BEI.

“Licensee” means an interpreter who holds a current license issued under A.R.S. § 36-1974 and this Article.

“License year” means the days between the date of license issuance and the date of license expiration.

“Mentor” means an individual licensed under R9-26-503 or R9-26-504 who agrees to assist a provisional licensee to develop as an interpreter by occasionally observing the provisional licensee providing interpreting services and providing feedback.

“MCSC” means master comprehensive skills certificate, a certification issued by RID.

“NAD” means the National Association of the Deaf.

“NAD III (generalist),” means a certification issued by NAD.

“NAD IV (advanced),” means a certification issued by NAD.

“NAD V (master),” means a certification issued by NAD.

“NIC” means National Interpreter Certification.

“NIC Advanced” means a certification issued by NAD-RID.

“NIC Certified” means a certification issued by NAD-RID.

“NIC Master” means a certification issued by NAD-RID.

“OC:B” means oral certificate: basic, a certification issued by BEI.

“OC:C” means oral certificate: comprehensive, a certification issued by BEI.

“OIC” means oral interpreting certificate, a certification issued by RID in one of three categories: comprehensive, spoken to visible, or visible to spoken.

“Oral transliteration” means to facilitate communication between an individual who is deaf or hard of hearing and an individual who hears by using inaudible speech and natural gestures to convey a message to the deaf or hard-of-hearing individual and understanding and verbalizing the message and intent of the speech and mouth movements of the individual who is deaf or hard of hearing.

“OTC” means oral transliteration certificate, a certification issued by RID.

“Platform or performance setting” means an environment involving an appearance by a designated speaker or performers, typically on a raised surface.

“Provisional interpreter” means an individual who is qualified by education, examination, and work history to provide interpreting while pursuing RID, NAD, or BEI certification.

“Class A provisional interpreter” means a provisional interpreter who provides oral transliteration and is working towards certification by RID, NAD, or BEI. A Class A provisional interpreter shall not provide interpreting services in a legal setting.

“Class B provisional interpreter” means a provisional interpreter who is qualified to provide interpreting services without a team interpreter licensed under R9-26-503(2)(a) or R9-26-504(A)(1)(a) and (b), except in a medical, mental health, platform or performance, or legal setting. A Class B provisional interpreter may provide interpreting services in a medical, mental health, or platform or performance setting only when working as part of a team that includes at least one individual licensed under R9-26-503(2)(a) or R9-26-504(A)(1)(a) or (b). A Class B provisional interpreter shall not provide interpreting services in a legal setting.

“Class C provisional interpreter” means a provisional interpreter who is qualified to provide interpreting services only when working as part of a team that includes at least one individual licensed under R9-26-503(2)(a) or R9-26-504(A)(1)(a) or (b). A Class C provisional interpreter shall not provide interpreting services in a legal setting.

“Class D provisional interpreter” means a provisional interpreter who is deaf or hard of hearing and is qualified to provide interpreting services only when working as part of a team that includes at least one individual licensed under R9-26-503(2)(a) or (b) or R9-26-504(A)(1)(a) through (c). A Class D provisional interpreter shall not provide interpreting services in a legal setting.

“Qualified interpreter” means an individual licensed under this Chapter who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary required by the interpreting situation.

“RID” means Registry of Interpreters for the Deaf.

“RSC” means reverse skills certificate, a certification issued by RID.

“SC:L” means specialist certificate: legal, a certification issued by RID.

“SC:PA” means specialist certificate: performing arts, a certification issued by RID.

“TC” means transliteration certificate, a certification issued by RID.

“State-issued certification” means a certification issued by a state regulatory board to an individual who demonstrates knowledge, skills, and abilities that meet or exceed the minimum needed by an American Sign Language interpreter to perform competently in a specified setting.

“Team” means two or more licensed interpreters, at least one of whom is licensed under R9-26-503(2)(a) or R9-26-504(A)(1)(a) or (b), providing interpreting for an individual or group of individuals during a single interpreting session.

“Trilingual Advanced or Master” means a specialist certification issued by BEI for interpreters of Spanish, English, and American Sign Language.

“Unprofessional conduct,” as used in A.R.S. § 36-1976, means:

Violation of the NAD-RID Code of Professional Conduct, 2005, which is incorporated by reference and available from the Commission and RID, 333 Commerce Street, Alexandria, VA 22314, or [www.rid.org](http://www.rid.org). The material incorporated includes no later edition or amendment; or

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Failure to comply with a provision of A.R.S. Title 36, Chapter 17.1, Article 2 or this Chapter.

“VRI” means video remote interpreting, a service that uses video telecommunication devices to provide interpreting between or among individuals who are at one or more locations separate from the interpreter.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Amended by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Section R9-26-501 amended by emergency rulemaking at 27 A.A.R. 549, with an immediate effective date of March 31, 2021; valid for 180 days under A.R.S. § 41-1026 (D) (Supp. 21-1). Section amended by final rulemaking at 27 A.A.R. 1257, with an immediate effective date of August 4, 2021 (Supp. 21-3). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-502. License Application**

- A. An applicant for an original license shall submit to the Commission the following information, on an application form provided by the Commission:
1. Applicant's full name;
  2. Applicant's Social Security number;
  3. Applicant's home or business address;
  4. Applicant's e-mail address;
  5. Applicant's home, business, or mobile telephone number;
  6. Applicant's birth date;
  7. Any name by which the applicant has ever been known;
  8. The start and end dates of the applicant's current certification cycle with RID, NAD, or BEI, as applicable;
  9. Category of licensure for which application is made and if applicable, the class of legal or provisional interpreter license for which application is made;
  10. Name of any state or foreign country in which the applicant is currently licensed or certified to practice as an interpreter, the license or certificate number, date issued, date of expiration, and a statement whether the license or certificate is or was the subject of discipline and if the answer is yes, a complete explanation of the discipline including date, nature of complaint, and discipline imposed;
  11. A statement of whether the applicant has ever been denied a license or certificate to practice as an interpreter by a government licensing authority and if the answer is yes, a complete explanation of the denial including date, name of the government licensing authority, and reason for denial;
  12. A statement of whether the applicant has ever been convicted of a felony or of an offense involving moral turpitude in this or any other jurisdiction and if the answer is yes, a complete explanation of the charge and place and date of conviction;
  13. A statement of whether the applicant has been adjudicated insane or incompetent and if the answer is yes, a complete explanation including date and place of adjudication;
  13. A statement of whether the applicant's NAD, RID, or BEI certification lapsed and if so, a complete explanation including date of and reason for the lapse;
  15. A statement of whether the applicant's interpreter license from Arizona or another jurisdiction lapsed and if so, a

complete explanation including date of and reason for the lapse;

16. A statement of whether the applicant's interpreter license from Arizona or another jurisdiction was subject to a complaint and if so, a complete explanation including date, allegation, and discipline imposed, if any;
  17. A statement of whether the applicant's NAD, RID, or BEI certification was subject to a complaint and if so, a complete explanation including date, allegation, and discipline imposed, if any; and
  18. A statement signed by the applicant verifying the truthfulness of the information provided and affirming that the applicant will comply with the NAD-RID Code of Professional Conduct;
- B. In addition to the form required under subsection (A), an applicant shall submit or have submitted on the applicant's behalf the following:
1. Documentation of name change if the applicant is applying under a name different from the name on any of the documents required under this Article;
  2. A photocopy of the applicant's:
    - a. High school diploma or GED or a transcript, official or unofficial, showing the degree awarded and date; or
    - b. Diploma from an accredited college or university or a transcript, official or unofficial, showing the degree awarded and date;
  3. If the answer to any item in subsections (A)(9) through (A)(15) is yes, a copy of any relevant order;
  4. As required under A.R.S. § 41-1080(A), the specified documentation of citizenship or alien status indicating the applicant's presence in the U.S. is authorized under federal law;
  5. Two identical passport-size photographs of the applicant that:
    - a. Are in color, and
    - b. Are taken no more than six months before the date of application; and
  6. The fee required under R9-26-508.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-503. Application for Generalist Interpreter License**

- A. To apply for a generalist interpreter license, an applicant shall:
1. Comply with R9-26-502; and
  2. Submit a photocopy of current documentation showing that the applicant holds one or more of the following certifications:
    - a. Hearing interpreters: NAD III, IV, or V; RID CI, CSC, CT, IC, MCSC, RSC, SC:L, SC:PA, or TC; NIC Certified, Advanced, or Master; or BEI Levels III, IV, or V, Basic, Advanced, Master, Trilingual Advanced, Trilingual Master, CIC, or other certification deemed appropriate by the Commission;
    - b. Deaf interpreters: RID CDI, CLIP-R, or SC:L; BEI Intermediary Level III or V, CDI, or other certification deemed appropriate by the Commission; or
    - c. Oral interpreters: RID OIC or OTC, BEI OC:B or OC:C, or other certification deemed appropriate by the Commission.

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- B. If an applicant's documentation of certification expires during the licensure process, the Commission shall not complete the licensure process until the applicant submits current documentation of certification.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-504. Application for Legal Interpreter License**

- A. To apply for a legal interpreter license, an applicant shall comply with R9-26-502 and submit documentation of the following:

1. Certification by RID, NAD, or BEI.
  - a. For a Class A legal interpreter license, RID SC:L, BEI CIC, or other legal specialist certification deemed appropriate by the Commission is required;
  - b. For a Class C legal interpreter license, NIC Certified, Advanced, or Master, NAD III, IV, or V, CI, CT, or CSC, or BEI Levels IV or V, Advanced, Master, Trilingual Advanced or Master, or other certification deemed appropriate by the Commission is required; and
  - c. For a Class D legal interpreter license, RID CDI, CLIP-R, OIC, or OTC or BEI OC:B, OC:C, Intermediary Levels III or V, or CDI, or other certification deemed appropriate by the Commission is required;
2. Hours of paid interpreting after initial certification by RID, NAD, or BEI.
  - a. For a Class C legal interpreter license, 10,000 hours are required; and
  - b. For a Class D legal interpreter license, 500 hours are required;
3. Hours of legal training. For a Class C or Class D legal interpreter, 50 hours obtained during the five years before the date of application are required.

- B. The Commission shall accept the following documentation:

1. RID, NAD, or BEI certification.
  - a. A photocopy of current documentation provided by RID, NAD, or BEI. If an applicant's documentation expires during the application process, the Commission shall not complete the licensure process until the applicant submits current documentation of certification; and
  - b. A photocopy of the certificate provided by RID, NAD, or BEI or a copy of the letter received from RID, NAD, or BEI at the time of initial certification;
2. Hours of paid interpreting.
  - a. An applicant shall submit an affidavit affirming that the applicant provided the number of hours of paid interpreting required under subsection (A)(2) after initial certification by RID, NAD, or BEI; and
  - b. Within the time provided under R9-26-509(F) and upon receipt of a comprehensive written request for documentation of the hours of paid interpreting provided, an applicant shall submit evidence that demonstrates the truthfulness of the affirmation provided under subsection (B)(2)(a).

3. Hours of legal training. A photocopy of documentation from the organization providing the legal training that includes the information required under R9-26-510(B).

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2).

Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-505. Application for Provisional Interpreter License**

- A. To apply for a provisional interpreter license, an applicant shall comply with R9-26-502 and submit documentation of the following:

1. Education. The following hours of participation in an interpreter-preparation training program offered by an accredited college or university or approved by RID, NAD, or BEI:
  - a. Class A or D provisional license: 40 hours; and
  - b. Class B or C provisional license: 80 hours;
2. Examination. Pass the written portion of the RID, NAD, or BEI examination; and
3. Work experience. The following hours of interpreting for which a license is not required under A.R.S. § 36-1971:
  - a. Class A provisional license: 24 hours;
  - b. Class B provisional license:
    - i. A score of at least 4.0 on the EIPA performance test; or
    - ii. ACCI certification; or
    - iii. A state-issued certification or certificate of competency in good standing;
  - c. Class C provisional license: 80 hours; and
  - d. Class D provisional license: 40 hours.

- B. In addition to the documentation required under subsection (A), an applicant for a Class B provisional license shall:

1. Have a letter submitted directly to the Commission by an individual licensed under R9-26-503 or R9-26-504 indicating that the individual agrees to:
  - a. Act as a mentor to the applicant if the applicant is granted a provisional license;
  - b. Observe the provisional licensee providing interpreting services at least once each month;
  - c. Provide feedback to the provisional licensee following each observation; and
  - d. Provide 30-days' notice to the provisional licensee and the Commission before terminating the mentoring relationship; and
2. Submit a letter to the Commission indicating that if the applicant is issued a provisional license, the applicant agrees to:
  - a. Make and maintain a record of each time the mentor observes the applicant and a summary of the feedback provided;
  - b. Make the record maintained under subsection (B)(2)(a) available to the Commission annually at license renewal; and
  - c. Provide 30 days' notice to the Commission and the mentor before terminating the mentoring relationship; or
3. Submit a letter to the Commission indicating that if the applicant is issued a provisional license, the applicant agrees to:

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- a. Team with an individual licensed under R9-26-503(2)(a) or R9-26-504(A)(1)(a) or (b) for at least eight hours each month;
  - b. Maintain a journal that records the dates on which and the name of the licensee with whom teaming was done and a summary of any feedback provided; and
  - c. Make the journal maintained under subsection (B)(3)(b) available to the Commission annually upon license renewal.
- C. The Commission shall accept the following documentation of the criteria in subsection (A):
  - 1. Education. A photocopy of documents showing that the applicant completed the hours required under subsection (A)(1);
  - 2. Examination. A photocopy of the letter provided by RID, NAD, or BEI indicating that the applicant passed the written portion of the RID, NAD, or BEI examination;
  - 3. Work experience.
    - a. One or more letters, each of which is signed by an individual or a representative of an entity for whom the applicant provided interpreting, indicating:
      - i. The name of the applicant,
      - ii. The dates on which interpreting was provided, and
      - iii. The hours of interpreting provided by the applicant; or
    - b. One or more paystubs, each of which indicates:
      - i. The name of the applicant,
      - ii. The job title of the applicant,
      - iii. The dates on which interpreting was provided by the applicant, and
      - iv. The hours of interpreting provided by the applicant, and
    - c. For an applicant for a Class B provisional license:
      - i. A photocopy of the letter provided by EIPA indicating the applicant's score on the EIPA performance test,
      - ii. A photocopy of the applicant's ACCI certificate, or
      - iii. A photocopy of the applicant's state-issued certification or certificate of competency in good standing.
- 5. Name, address, and contact information of the person or event for which interpreting services will be provided; and
- 6. Date of most recent short-term registration with the Commission, if any.
- B. In addition to complying with subsection (A), the interpreter shall submit a copy of current documentation from RID, NAD, or BEI showing the interpreter's certification is in good standing or a copy of the interpreter's license from another state's interpreter licensing authority.
- C. An interpreter who makes application under subsections (A) and (B) for a short-term registration shall not provide interpreting services in Arizona until the Commission provides notice the registration has been granted.
- D. Within five days after providing interpreting services under a short-term registration, the interpreter shall submit a report to the Commission that provides the dates on and persons or events for which interpreting services were provided.
- E. The Commission shall not issue more than two short-term registrations to an interpreter during the interpreter's lifetime.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2).

Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-507. License Renewal**

- A. Renewal of a generalist or legal interpreter license.
  - 1. A generalist or legal interpreter license expires one year after the license is issued. To continue to practice as a generalist or legal interpreter, the licensee shall, no more than 60 days before the expiration date, submit to the Commission a license renewal application form that provides the following information about the licensee:
    - a. Full name;
    - b. Social Security number;
    - c. Home or business address;
    - d. Email address;
    - e. Home, business, or mobile telephone number;
    - f. The start and end dates of the applicant's current certification cycle with RID, NAD, or BEI, as applicable;
    - g. Name of any state or country in which the licensee is currently licensed or certified to practice as an interpreter, the license or certificate number, date issued and date of expiration, and a statement whether the license or certificate is or has been the subject of discipline during the previous year and if the answer is yes, a complete explanation of the discipline including date, nature of complaint, and discipline imposed;
    - h. A statement of whether the licensee has been denied a license or certificate to practice as an interpreter by a licensing authority during the previous year and if the answer is yes, a complete explanation of the denial including date, name of the interpreter licensing authority, and reason for denial;
    - i. A statement of whether the licensee has been convicted of a felony or of an offense involving moral turpitude in this or any other jurisdiction during the previous year and if the answer is yes, a complete explanation of the charge and place and date of conviction;

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 35, effective September 30, 2002 (Supp. 02-4). New Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-506. Short-term Registration of an Interpreter**

- A. To register with the Commission to provide interpreting in Arizona in a non-legal situation for fewer than 20 days in a year, an interpreter shall submit the following information in writing to the Commission:
  - 1. Interpreter's name;
  - 2. Interpreter's residential and e-mail addresses;
  - 3. Interpreter's mobile telephone number;
  - 4. Dates on which interpreting will be provided;

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- j. A statement of whether the licensee has been adjudicated insane or incompetent during the previous year and if the answer is yes, a complete explanation including date and place of adjudication;
  - k. A statement of whether the applicant's NAD, RID, or BEI certification lapsed during the previous year and if so, a complete explanation including date of and reason for the lapse;
  - l. A statement of whether the applicant's interpreter license from Arizona or another jurisdiction lapsed during the previous year and if so, a complete explanation including date of and reason for the lapse;
  - m. A statement of whether the applicant's interpreter license from Arizona or another jurisdiction was subject to a complaint during the previous year and if so, a complete explanation including date, allegation, and discipline imposed, if any;
  - n. A statement of whether the applicant's NAD, RID, or BEI certification was subject to a complaint during the previous year and if so, a complete explanation including date, allegation, and discipline imposed, if any, and if discipline was imposed, a statement of whether the notice required under R9-26-518 was submitted to the Commission;
  - o. A statement of whether the applicant completed any continuing education during the previous year and if so, the number of hours completed; and
  - p. A statement signed by the licensee verifying the truthfulness of the information provided and affirming that the licensee will comply with the NAD-RID Code of Professional Conduct.
2. In addition to the license renewal application form required under subsection (A)(1), the generalist or legal licensee shall submit or have submitted on the licensee's behalf:
    - a. A photocopy of current documentation showing the applicant's NAD, RID, or BEI certification is in good standing. If the licensee's documentation expires during the renewal process, the Commission shall not complete the license renewal process until the licensee submits a photocopy of current documentation;
    - b. If the answer to any item in subsections (A)(1)(g) through (A)(1)(m) is yes, a copy of any relevant order; and
    - c. The fee required under R9-26-508.
  3. If a generalist or legal licensee fails to comply with subsections (A)(1) and (A)(2) on or before the license expiration date, the license expires. The former licensee may renew the expired license by complying with subsections (A)(1) and (A)(2), and paying the penalty prescribed under R9-26-508 no later than 30 days after the license expired. If a former licensee fails to renew an expired license within the 30 days provided in this subsection, the former licensee shall stop providing interpreting for which a license is required under A.R.S. § 36-1971.
  4. If an expired license is not renewed under subsection (A)(3), the former licensee may obtain a license only by applying as a new applicant.
- B. Renewal of a provisional interpreter license.**
1. A provisional interpreter license expires one year after the date of issuance.
  2. To continue to practice as a provisional interpreter, the licensee shall, no more than 60 days before the expiration date, submit to the Commission a license renewal application form that provides the information specified under subsection (A)(1).
3. In addition to the license renewal application form required under subsection (B)(2), the provisional licensee shall submit or have submitted on the licensee's behalf:
    - a. If the answer to any item in subsections (A)(1)(h) through (A)(1)(m) is yes, a copy of any relevant order;
    - b. Documentation required under R9-26-510(C) that demonstrates compliance with the continuing education requirement in R9-26-510; and
    - c. The fee required under R9-26-508;
    - d. If a Class B provisional licensee wishes to renew the Class B provisional license, letters that meet the standards at R9-26-505(B)(1) and (2) or a letter that meets the standards at R9-26-505(B)(3); and
    - e. If a Class C provisional licensee wishes to renew the Class C provisional license, an affirmation that the licensee has provided and will continue to provide interpreting services only when working as part of a team that includes at least one individual licensed under R9-26-503(2)(a) or R9-26-504(A)(1)(a) or (b); or
    - f. If a Class C provisional licensee wishes to move to a Class B provisional license:
      - i. Letters that meet the standards at R9-26-505(B)(1) and (2) or a letter that meets the standards at R9-26-505(B)(3), and
      - ii. Evidence required under R9-26-505(C)(3)(a) or (b) showing at least 500 hours of work experience earned while working as part of a team that includes at least one individual licensed under R9-26-503(2)(a) or R9-26-504(A)(1)(a) or (b), or
      - iii. A score of at least 4.0 on the EIPA performance test.
  4. If a provisional licensee fails to comply with subsections (B)(2) and (3) on or before the license expiration date, the license expires. Unless the expired provisional license has previously been renewed under subsections (B)(2) and (3), the former licensee may renew the expired license by complying with subsections (B)(2) and (3) and paying the penalty prescribed under R9-26-508 no later than 30 days after the license expired. If a former licensee fails to renew an expired license within the 30 days provided in this subsection, the former licensee shall stop providing interpreting for which a license is required under A.R.S. § 36-1971.
  5. The Commission shall not issue a provisional interpreter license to an interpreter for more than five years over the interpreter's lifetime.
- C.** If the documentation previously submitted under R9-26-502(B)(4) was a limited form of work authorization issued by the federal government, an applicant for license renewal shall submit evidence that the work authorization has not expired.
- D.** The Commission shall require a licensee to submit the information required under R9-26-502(B)(5) every five years so an updated photograph is used in the identification badge required under R9-26-515.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2).



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## CHAPTER 26. COMMISSION FOR THE DEAF AND THE HARD OF HEARING

Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Section R9-26-507 amended by emergency rulemaking at 27 A.A.R. 549, with an immediate effective date of March 31, 2021; valid for 180 days under A.R.S. § 41-1026 (D) (Supp. 21-1). Section amended by final rulemaking at 27 A.A.R. 1257, with an immediate effective date of August 4, 2021 (Supp. 21-3). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-508. Fees and Charges**

- A.** Under the authority provided by A.R.S. §§ 36-1973(A) and 36-1974(C), the Commission establishes and shall collect the following fees, which are not refundable unless A.R.S. § 41-1077 applies:
1. Generalist or legal license application fee, \$125;
  2. Generalist or legal license renewal application fee, \$50;
  3. Provisional license application fee, \$25;
  4. Provisional license renewal application fee, \$25; and
  5. Penalty for late license renewal, \$100.
- B.** The Commission shall charge \$25 to:
1. Replace an identification badge,
  2. Issue a duplicate license.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-509. Procedures for Processing Applications; Time Frames**

- A.** For the purpose of A.R.S. § 41-1073, the Commission establishes the following licensing time frames:
1. Administrative completeness review time frame: 30 days;
  2. Substantive review time frame: 60 days; and
  3. Overall time frame: 90 days.
- B.** The administrative completeness review time frame listed in subsection (A)(1) begins on the date the Commission receives a license application or license renewal application. During the administrative completeness review time frame, the Commission shall notify the applicant that the application is either complete or incomplete. If the application is incomplete, the Commission shall specify in the notice what information is missing.
- C.** An applicant with an incomplete application shall supply the missing information within 30 days from the date of the notice. Both the administrative completeness review and overall time frames are suspended from the date of the Commission's notice until the date that the Commission's office receives all missing information.
- D.** Upon receipt of all missing information, the Commission shall notify the applicant that the application is complete. The Commission shall not send a separate notice of completeness if the Commission grants or denies a license within the administrative completeness review time frame in subsection (A)(1).
- E.** The substantive review time frame listed in subsection (A)(2) begins on the date of the Commission's notice of administrative completeness or on expiration of the time listed in subsection (A)(1).
- F.** If the Commission determines during the substantive review time frame that additional information is needed, the Commission shall send the applicant a comprehensive written request for the additional information. The applicant shall supply the

additional information within 60 days from the date of the request. Both the substantive review and overall time frames are suspended from the date on the Commission's request until the date the Commission office receives the additional information.

- G.** If an applicant needs additional time in which to respond under subsection (C) or (F), the applicant shall submit a written notice of a 120-day extension to the Commission before expiration of the time to respond established under subsection (C) or (F).
- H.** If an applicant fails to submit information within the time provided under subsection (C) or (F) or as extended under subsection (G), the Commission shall close the applicant's file. An applicant whose file is closed and who later wishes to be licensed, shall apply anew.
- I.** Within the time listed in subsection (A)(3), the Commission shall:
1. Grant a license to an applicant who meets the requirements in A.R.S. § 36-1973 and this Article, or
  2. Deny a license to an applicant who does not meet the requirements in A.R.S. § 36-1973 or this Article.
- J.** If the Commission denies a license, the Commission shall send the applicant a written notice explaining:
1. The reason for the denial with citations to supporting statutes or rules,
  2. The applicant's right to appeal the denial and have a hearing,
  3. The time for appealing the denial, and
  4. The applicant's right to request an informal settlement conference.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2). Amended by final rulemaking at 30 A.A.R. 3887 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R9-26-510. Continuing Education Requirement; Waiver; Extension of Time to Complete**

- A.** Continuing education is required as a condition of licensure renewal.
1. A generalist interpreter shall complete continuing education required by NAD, RID, or BEI to maintain certification by NAD, RID, or BEI. If the certification of a generalist interpreter is suspended or revoked by NAD, RID, or BEI because the generalist interpreter failed to complete the required continuing education, the Commission shall initiate proceedings under Article 3 against the generalist interpreter's license.
  2. A Class A legal interpreter shall complete continuing education required by NAD, RID, or BEI to maintain legal certification by NAD, RID, or BEI. If the certification of a Class A legal interpreter is suspended or revoked by NAD, RID, or BEI because the Class A legal interpreter failed to complete the required continuing education, the Commission shall initiate proceedings under Article 3 against the legal interpreter's license.
  3. A Class C or D legal interpreter shall complete continuing education required by NAD, RID, or BEI to maintain certification by NAD, RID, or BEI including at least 20 hours of legal training. If the certification of a Class C or D legal interpreter is suspended or revoked by NAD,

## TITLE 9. HEALTH SERVICES

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RID, or BEI because the Class C or D legal interpreter failed to complete the required continuing education or if the Class C or D legal interpreter fails to complete the required hours of legal training, the Commission shall initiate proceedings under Article 3 against the legal interpreter's license.

4. When renewing a license under R9-26-507(B), a provisional interpreter shall submit the evidence required under subsection (B) showing completion of 12 hours of continuing education. The Commission shall accept continuing education:
  - a. Designed to enhance the provisional licensee's skill and ability to provide quality interpreting to the deaf and hard-of-hearing community;
  - b. Approved by RID, NAD, or BEI, as applicable, for certification maintenance;
  - c. Provided by an accredited institution of higher education; or
  - d. Provided by an entity involved with the deaf and hard-of-hearing community; and
- B. A provisional licensee shall obtain from the provider of a continuing education attended by the licensee documentation that includes:
  1. Licensee's name,
  2. Name of the continuing education provider,
  3. Name of the continuing education,
  4. Number of hours of attendance, and
  5. Date of the continuing education.
- C. Waiver of continuing education requirement.
  1. To obtain a waiver of the continuing education requirement, a provisional licensee shall submit to the Commission a written request that includes the following:
    - a. The period for which the waiver is requested,
    - b. Continuing education completed during the current license year and the documentation required under subsection (B), and
    - c. Reason a waiver is needed and supporting documentation:
      - i. For military service. A copy of current orders or a letter on official letterhead from the licensee's commanding officer;
      - ii. For absence from the United States. A copy of pages from the licensee's passport showing exit and reentry dates;
      - iii. For disability. A letter from the licensee's treating physician stating the nature of the disability; and
      - iv. For circumstances beyond the licensee's control. A letter from the licensee stating the nature of the circumstances and documentation that provides evidence of the circumstances.
  2. The Commission shall grant a request for waiver of the continuing education requirement that:
    - a. Is based on a reason listed in subsection (C)(1)(c),
    - b. Is supported by the required documentation,
    - c. Is submitted no sooner than 60 days before and no later than the license expiration date, and
    - d. Will promote the safe and professional practice of interpreting in this state.
- D. Extension of time to complete continuing education requirement.
  1. To obtain an extension of time to complete the continuing education requirement, a provisional licensee shall sub-

mit to the Commission a written request that includes the following:

- a. Ending date of the requested extension,
  - b. Continuing education completed during the current license year and the documentation required under subsection (B),
  - c. Proof of registration for additional continuing education that is sufficient to enable the provisional licensee to complete all continuing education required for license renewal before the end of the requested extension, and
  - d. Licensee's attestation that the continuing education obtained under the extension will be reported only to fulfill the current license renewal requirement and will not be reported on a subsequent license renewal application.
2. The Commission shall grant a request for an extension that:
    - a. Specifies an ending date no more than three months from the current license expiration date,
    - b. Includes the required documentation and attestation,
    - c. Is submitted no sooner than 60 days before and no later than the license expiration date, and
    - d. Will promote the safe and professional practice of interpreting in this state.
- E. Except as provided in subsection (D), a provisional licensee shall report only hours of continuing education obtained during the license year immediately preceding license renewal. A licensee shall not carry over hours in excess of those required under subsection (A)(4) to a subsequent license year.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-511. Video Remote Interpreting**

- A. An interpreter who is licensed under A.R.S. Title 36, Chapter 17.1 and this Article is authorized to provide VRI only for individuals who are located in Arizona.
- B. An interpreter who is licensed under A.R.S. Title 36, Chapter 17.1 and this Article and provides VRI shall comply fully with the requirements of this Article.
- C. An interpreter who is located outside of Arizona shall not provide VRI for an individual located in Arizona before being licensed under A.R.S. Title 36, Chapter 17.1 and this Article.

**Historical Note**

Adopted effective April 4, 1997 (Supp. 97-2). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Section repealed; new Section made by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-512. Renumbered****Historical Note**

New Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Section R9-26-

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512 renumbered to R9-26-301 by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-513. Reserved****R9-26-514. Reserved****R9-26-515. Identification Badge Required**

- A. To protect the public, a licensee shall have and present on request, an identification badge issued by the Commission whenever the licensee provides interpreting services.
- B. A licensee who loses or damages the identification badge required under subsection (A) may obtain a replacement identification badge by submitting a request to the Commission and paying the charge specified under R9-26-508.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Section R9-26-515 renumbered to R9-26-302; new Section R9-26-515 made by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-516. Renumbered****Historical Note**

New Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Section renumbered to R9-26-303 by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

**R9-26-517. Renumbered****Historical Note**

New Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Section renumbered to R9-26-304 by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

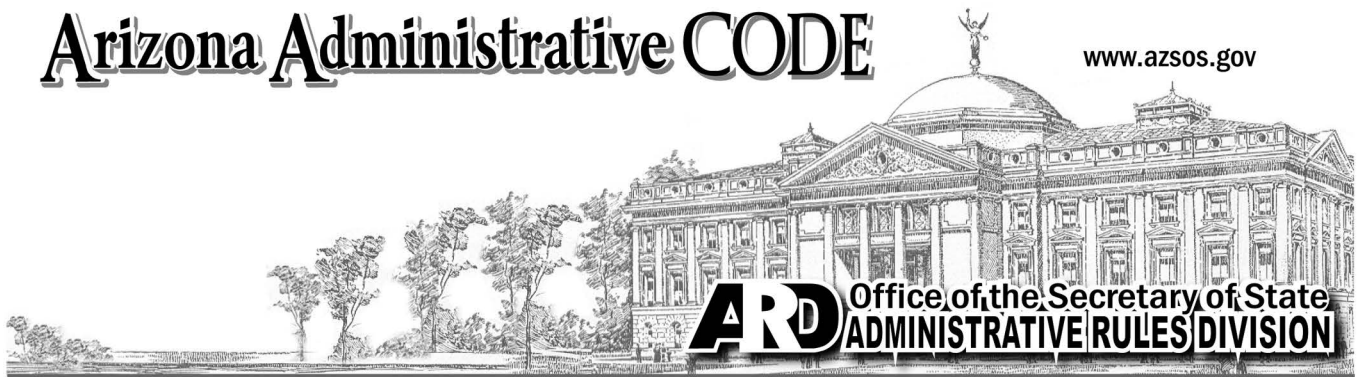
**R9-26-518. Required Notices to the Commission**

- A. If a licensee's certification by RID, NAD, BEI, or other acceptable certifying entity is suspended, revoked, or subject to other disciplinary action by RID, NAD, BEI, or the other acceptable certifying entity, the licensee shall provide immediate written notice of the disciplinary action to the Commission. Failure to provide the notice required under this subsection is unprofessional conduct.
- B. If a licensee's state-issued certification submitted as qualification for a Class B provisional license is suspended, revoked, or subject to other disciplinary action by the state that issued the certification, the licensee shall provide immediate written notice of the disciplinary action to the Commission. Failure to provide the notice required under this subsection is unprofessional conduct.
- C. The Commission shall communicate with a licensee or applicant using the name and address provided to the Commission by the licensee or applicant. To ensure timely receipt of communication from the Commission, a licensee or applicant shall notify the Commission of any change in the licensee's or applicant's name or address.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 1720, effective May 1, 2007 (Supp. 07-2). Amended by final rulemaking at 22 A.A.R. 1675, effective August 15, 2016 (Supp. 16-2).

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## TITLE 12. NATURAL RESOURCES

### CHAPTER 15. DEPARTMENT OF WATER RESOURCES

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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**The release of this Chapter in Supp. 24-4 replaces Supp. 23-4, 1-88 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

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### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 12. NATURAL RESOURCES

## CHAPTER 15. DEPARTMENT OF WATER RESOURCES

Authority: A.R.S. § 45-101 et seq.

## Supp. 24-4

*Editor's Note: The lowercase references to the Department Director and Department have been changed to title case for continuity in this Chapter (Supp. 22-1).*

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*Article 8, consisting of Sections R12-15-801 through R12-15-821, adopted effective March 5, 1984.*

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*Article 12, consisting of Sections R12-15-1201 through R12-15-1206, repealed; new Article 12, consisting of Sections R12-15-1201 through R12-15-1226 et seq., adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).*

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ARTICLE 1. FEES

**R12-15-101. Definitions**

In addition to the definitions in A.R.S. §§ 45-101, 45-271, 45-402, 45-511, 45-561, 45-802.01, 45-1001, 45-1201 and R12-15-701, the following definitions apply to this Article:

1. "Application" means a written request submitted by an applicant to the Department for the purpose of obtaining a permit, license or other legal authorization issued by the Department.
2. "Fiscal year" means the year beginning July 1 and ending June 30.
3. "Mileage expenses" means the Department's mileage expenses for traveling to and from a site inspection calculated at the rate set by the Arizona Department of Administration for state travel by motor vehicle.
4. "Municipality" means an incorporated city or town.
5. "Pre-decision administrative hearing" means an administrative hearing held on an application before the Department makes any decision on the application.
6. "Population" means the population according to the most recent United States decennial census.
7. "Review hours" means the hours or portions of hours spent by Department employees in reviewing an application and making a decision thereon, including pre-application consultation time in excess of 60 minutes and site inspection time. Only time spent by the program staff members and technical review team members responsible for processing the application shall be included as review hours. Review hours do not include the first 60 minutes of pre-application consultation time, the time spent traveling to and from a site inspection, any time spent on a pre-decision administrative hearing and any time spent on the application after a party appeals the Director's decision on the application pursuant to A.R.S. § 41-1092.03(B).
8. "Site inspection" means an inspection conducted by the Department before issuing a decision on an application or before issuing a decision on whether water may be stored at an underground storage facility.
9. "Site inspection time" means time spent on a site inspection. Site inspection time includes the time spent conducting the inspection and the time spent preparing an inspection report following the inspection, but does not include the time spent traveling to and from the inspection.
10. "Water resources fund" means the water resources fund established by A.R.S. § 45-117.

**Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 776, effective April 15, 2011 with an automatic repeal date effective June 4, 2011; new Section made by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Amended by final rulemaking at 18 A.A.R. 203, effective July 1, 2012 (Supp. 12-1).

**R12-15-102. Fees for Applications and Filings**

- A. A person submitting an application or filing to the Department on or after the effective date of this Section shall pay an hourly application fee as provided in R12-15-103 or a fixed application or filing fee as provided in R12-15-104, whichever applies. Application fees for an initial certificate of grandfa-

thered right following the designation of a subsequent active management area or an initial notice of irrigation authority in a subsequent irrigation non-expansion area fall under a fixed application or filing fee structure, as outlined in R12-15-104. Fees for applications and filings shall be paid in U.S. dollars by cash, check, cashier's check, money order, or any other method acceptable to the Department.

- B. A person with an application or filing pending before the Department prior to the effective date of this Section shall pay the application or filing fees and costs in effect when the application or filing was submitted to the Department.
- C. For an application for an initial certificate of grandfathered right in a subsequent active management area or a notice of irrigation authority in a subsequent irrigation non-expansion area submitted prior to the effective date of this Section the applicant shall only be responsible for the fees and costs in effect on the effective date of this Section. The Department shall refund the difference in the fees and costs paid when the application was submitted to the applicant within 60 days of the effective date of this Section.

**Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 776, effective April 15, 2011 with an automatic repeal date effective June 4, 2011; new Section made by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Amended by final expedited rulemaking at 29 A.A.R. 3478 (November 3, 2023), with an immediate effective date of October 13, 2023 (Supp. 23-4).

**R12-15-103. Applications Subject to Hourly Fee; Amount of Fee; Initial Fee; Billing and Payment; Request for Reconsideration of Fee; Past Due Fee**

- A. The Department shall calculate the fee for an application listed in subsection (B) by multiplying the number of review hours for the application by an hourly rate of \$118.00, plus any mileage expenses and the actual cost of mailing or publishing any legal notice of the application.
- B. A person submitting an application listed in subsections (B)(1) through (10) shall pay an hourly fee for the application, not to exceed the maximum fee shown for the application:

1. Wells:

Type of Application	Maximum Fee
Variance from well construction requirements that has not been pre-approved by the Department	\$10,000.00

2. Groundwater:

Type of Application	Maximum Fee
a. Issuance, renewal or modification of groundwater withdrawal permit	\$10,000.00
b. Approval of contract by a city, town or private water company to supply groundwater to another city, town or private water company pursuant to A.R.S. § 45-492(C)	\$10,000.00
c. Notice of intent to establish new service area right by a city, town or private water company	\$10,000.00

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d.	Final petition to establish new service area right by a city, town or private water company	\$10,000.00
e.	Extension of the service area of a city, town or private water company to furnish disproportionately large amounts of water to an industrial or other large water user pursuant to A.R.S. § 45-493(A)(2)	\$10,000.00
f.	Addition and exclusion of area by an irrigation district pursuant to A.R.S. § 45-494.01	\$10,000.00
g.	Delivery of groundwater by an irrigation district to an industrial user with a general industrial use permit pursuant to A.R.S. § 45-497(B)	\$10,000.00
h.	Determination of historically irrigated acres or annual transportation allotment for lands in McMullen valley groundwater basin pursuant to A.R.S. § 45-552	\$10,000.00
i.	Determination of volume of groundwater that can be transported from lands in Harquahala irrigation non-expansion area to an initial active management area pursuant to A.R.S. § 45-554	\$10,000.00
j.	Determination of historically irrigated acres or annual transportation allotment for lands in the Big Chino sub-basin of the Verde River groundwater basin pursuant to A.R.S. § 45-555	\$10,000.00
k.	Permit to transport groundwater away from the Yuma groundwater basin pursuant to A.R.S. § 45-547	\$10,000.00
l.	Drought emergency groundwater transfer away from a groundwater basin outside of an active management area	\$10,000.00

## 3. Grandfathered Rights:

Type of Application	Maximum Fee
a. Type 1 non-irrigation grandfathered right for land retired from irrigation after date of designation of active management area pursuant to A.R.S. § 45-469 or 45-472	\$10,000.00
b. Restoration of retired irrigation grandfathered right pursuant to A.R.S. § 45-469(O)	\$10,000.00

## 4. Substitution of Acres:

Type of Application	Maximum Fee
a. Substitution of flood damaged acres in an active management area or an irrigation non-expansion area	\$10,000.00

b.	Substitution of acres to eliminate limiting condition impeding efficient irrigation in an active management area or an irrigation non-expansion area	\$10,000.00
c.	Substitution of acres to allow irrigation with Central Arizona Project water in an active management area	\$10,000.00

## 5. Lakes:

Type of Application	Maximum Fee
a. Permit to fill body of water with poor quality water pursuant to A.R.S. § 45-132(C)	\$10,000.00
b. Permit for interim water use in a body of water	\$10,000.00
c. Temporary emergency permit for use of surface water or groundwater in a body of water	\$10,000.00

## 6. Water Exchange:

Type of Application	Maximum Fee
a. Issuance, renewal or modification of water exchange permit	\$10,000.00
b. Notice of water exchange for which approval is required pursuant to A.R.S. § 45-1052(6)(b)	\$10,000.00

## 7. Water Exportation:

Type of Application	Maximum Fee
Permit to transport water from this state	\$25,000.00

## 8. Underground Water Storage, Savings and Replenishment:

Type of Application	Maximum Fee
a. Issuance, renewal or modification of an underground storage facility permit	\$25,000.00
b. Issuance, renewal or modification of a groundwater savings facility permit	\$10,000.00
c. Issuance, renewal or modification of a water storage permit	\$10,000.00
d. Recovery well permit, including an emergency temporary recovery well permit	\$10,000.00

## 9. Assured and Adequate Water Supply:

Type of Application	Maximum Fee
a. Physical availability determination	\$10,000.00
b. Analysis of assured or adequate water supply	\$10,000.00
c. Renewal of analysis of assured or adequate water supply	\$10,000.00
d. Certificate of assured water supply	\$10,000.00
e. Issuance or modification of designation of assured water supply	\$35,000.00

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f.	Issuance or modification of designation of adequate water supply	\$25,000.00
g.	Water report (outside an AMA)	\$10,000.00
h.	Assignment of Type A certificate of assured water supply	\$5,000.00
i.	Assignment of Type B certificate of assured water supply	\$5,000.00
j.	Classification of Type A certificate of assured water supply pursuant to R12-15-707	\$10,000.00
k.	Review of revised plat to determine whether changes are material	\$10,000.00
l.	New certificate of assured water supply pursuant to R12-15-704(G)	\$10,000.00
m.	Letter stating that owner is not required to obtain a certificate of assured water supply pursuant to R12-15-704(M)	\$10,000.00

## 10. Surface Water:

Type of Application	Maximum Fee
a. Permit to appropriate public water	\$10,000.00
b. Certificate of water right	\$10,000.00
c. Primary reservoir permit or secondary reservoir permit	\$10,000.00
d. Change in use of water	\$10,000.00
e. Severance and transfer of water right to land that is not within the same parcel or farm unit as the current use, or that includes a change in water source, use or ownership	\$25,000.00
f. Severance and transfer of water right to land that is within the same parcel or farm unit as the current use and that does not include a change in water source, use or ownership	\$2,500.00
g. Request for extension of time to complete construction	\$10,000.00

- C. A person filing an application that is subject to an hourly fee shall submit an initial fee at the time the application is submitted to the Department. The initial fee for applications described in subsections (B)(7), (B)(8)(a), (B)(9)(e), (f) and (B)(10)(e) shall be \$2,000.00. The initial fee for all other applications shall be \$1,000.00. If requested by the applicant, the Department may set a lower initial fee if the Department estimates that the total application fee will be less than the initial fee specified in this subsection. The Department shall not accept an application for which an initial fee is required under this subsection unless the initial fee is included with the application.
- D. The Department shall bill the applicant for processing the application no more than monthly, but at least quarterly. Each bill shall contain the following information for the billing period:
1. The number of review hours accrued by activity and sub-activity code during the billing period, the date of each activity, a description of each activity and the effective hourly rate for all activities;

2. A description and amount of any mileage expenses charged for the application;
  3. A description and amount of the cost of mailing or publishing any legal notice of the application or notice of a pre-decision administrative hearing on the application; and
  4. The total fees paid to date, the total fees due for the billing period, the date when the fees are payable, which shall be at least 60 days after the date of the bill, and the maximum fee for the application.
- E. A bill for hourly fees becomes past due if the applicant does not pay the bill in full by the due date specified in the bill, unless the applicant submits a timely request for reconsideration of the bill pursuant to subsection (G). If the applicant submits a timely request for reconsideration of the bill, the bill becomes past due if the applicant does not pay the amount due under the Director's decision on the request by the date specified in the decision. If a bill for hourly fees becomes past due, the following shall apply:
1. The applicable review time-frame shall be suspended from the date the bill became past due until the applicant pays the bill in full or the application is denied under subsection (E)(2), whichever applies.
  2. The Department shall suspend its review of the application and send a written notice to the applicant that the bill is past due. If the applicant does not pay the outstanding bill by the date specified in the notice, which shall be at least 35 days from the date of the notice, the application shall be denied.
- F. After the Department makes a determination whether to grant or deny the application, or when an applicant withdraws the application, the Department shall prepare and send to the applicant a final itemized billing statement for the application fee.
1. If the total fee exceeds the amount of the initial fee paid plus all other payments made to date, the applicant shall pay the balance, up to the maximum fee for the application, plus any mileage expenses and the actual cost of mailing or publishing any legal notice of the application or notice of a pre-decision administrative hearing on the application, by the date specified in the statement, unless the applicant submits a timely request for reconsideration of the bill pursuant to subsection (G). The statement shall specify a date, at least 60 days from the date of the statement, by which the applicant must pay the bill. If the applicant submits a timely request for reconsideration of the bill, the applicant shall pay the amount due under the Director's decision on the request by the date specified in the decision. The Department shall not release the final permit or approval until the final bill is paid in full.
  2. If the total fee is less than the initial fee plus all other payments made to date, the Department shall refund the difference to the applicant within 35 days of the date of the statement.
- G. An applicant may seek reconsideration of a bill for hourly fees by filing a written request for reconsideration with the Director. The request shall specify, in detail, why the bill is in dispute and shall include any supporting documentation. The written request for reconsideration shall be delivered to the Director in person, by mail, or by facsimile on or before the payment due date. The Director shall make a final decision on the request for reconsideration of the bill and mail a final written decision to the person within 20 business days after the date the Director receives the written request. The decision

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shall specify a date, at least 35 days from the date of the decision, by which the applicant must pay the bill. The Director may reduce the amount of any fees billed under this Section if the Director determines that the number of review hours or mileage expenses billed to the applicant was incorrect or that time spent by the Department to review the application and make a decision thereon was not necessary or advisable.

- H. If a person receives a bill under this Section and the bill becomes past due under subsection (E) or (F), the Department shall not accept for filing any other application by that person until the person pays the past due amount in full.

**Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 776, effective April 15, 2011 with an automatic repeal date effective June 4, 2011; new Section made by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Amended by final expedited rulemaking at 29 A.A.R. 3478 (November 3, 2023), with an immediate effective date of October 13, 2023 (Supp. 23-4).

**R12-15-104. Applications and Filings Subject to Fixed Fee; Fixed Fee Schedule; Mileage Expenses; Costs for Legal Notices**

- A. The Department shall not accept or take action on the following applications and filings unless the fee shown for the application or filing is paid at the time the application or filing is submitted:

## 1. Wells:

Type of Application or Filing	Fee
a. Late registration of well	\$60.00
b. Well driller's license	\$50.00
c. Re-issuance, renewal, or amendment of well driller's license	\$50.00
d. Re-activation of expired well driller's license	\$50.00
e. Well assignment	\$30.00 per well
f. Notice of intention to abandon a well	\$150.00
g. Notice of intention to drill a well other than a well described in subsection (A)(1)(h) of this Section	\$150.00
h. Notice of intention to drill a well that will not be located in an active management area or irrigation non-expansion area, that will be used solely for domestic purposes and that will have a pump with a maximum capacity of not more than 35 gallons per minute	\$100.00
i. Re-issuance of drill card	\$120.00
j. Permit to drill non-exempt well in an active management area	\$150.00 application fee plus \$30.00 permit fee

## 2. Groundwater:

Type of Application or Filing	Fee
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a. Conveyance of farm's flexibility account balance	\$250.00
b. Conveyance of notice of authority to irrigate in an irrigation non-expansion area	\$500.00
c. Conveyance of groundwater withdrawal permit	\$500.00
d. Issuance of notice of authority to irrigate in an irrigation non-expansion area	\$75.00

## 3. Grandfathered rights:

Type of Application	Fee
a. Late application for certificate of grandfathered right in an initial Active Management Area	\$100.00
b. Conveyance of certificate of grandfathered right	\$500.00
c. Issuance of revised certificate of grandfathered right following partial extinguishment of grandfathered right for assured water supply extinguishment credits	\$120.00
d. Revised certificate of Type 2 non-irrigation grandfathered right to reflect new or additional points of withdrawal or the deletion of a point of withdrawal	\$250.00
e. Approval of development plan to retire irrigation grandfathered right for a Type 1 non-irrigation grandfathered right	\$500.00
f. Re-issuance of certificate of grandfathered right to reflect a change in family circumstances or a transfer of the right from the rightholder to a trust in which the rightholder is a beneficiary or from a trust to a beneficiary of the trust	\$120.00
g. Application for certificate of grandfathered right following the designation of a subsequent Active Management Area	\$75.00

## 4. Underground water storage, savings and replenishment:

Type of Application or Filing	Fee
a. Conveyance of storage facility permit	\$500.00
b. Conveyance of water storage permit	\$500.00
c. Assignment of long-term storage credits	\$250.00

## 5. Assured water supply:

Type of Application or Filing	Fee
a. Extinguishment of grandfathered right for extinguishment credits	\$250.00
b. Conveyance of extinguishment credits	\$250.00

## 6. Surface water:

Type of Application or Filing	Fee
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a. Re-issuance of a surface water permit or certificate (not associated with an assignment of the permit or certificate)	\$120.00
b. Claim of water right for a stockpond pursuant to A.R.S. § 45-273	\$10.00
c. Statement of claim for a water right pursuant to A.R.S. § 45-183	\$5.00
d. Assignment of application, permit, certificate or statement of claim	\$75.00
e. Certification of water right for a stockpond pursuant to A.R.S. § 45-275	\$120.00

## 7. Dams:

Type of Application	Fee
Approval of plans for construction, enlargement, repair, alteration or removal of dam	2 percent of the total project cost

## 8. Water Exchange:

Type of Filing	Fee
Notice of water exchange that does not require approval pursuant to A.R.S. § 45-1052(6)(b)	\$500.00

## 9. Weather modification:

Type of Application	Fee
a. License for weather control or cloud modification	\$100.00
b. Equipment license for weather control or cloud modification	\$10.00

- B.** In addition to the application or filing fee listed in subsection (A), an applicant shall pay any mileage expenses and the actual cost of mailing or publishing any legal notice of the application. This subsection shall not apply to applications listed in subsection (A)(2)(d) or (A)(3)(g).

**Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 776, effective April 15, 2011 with an automatic repeal date effective June 4, 2011; new Section made by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Amended by final expedited rulemaking at 29 A.A.R. 3478 (November 3, 2023), with an immediate effective date of October 13, 2023 (Supp. 23-4).

**R12-15-105. Fee for Dam Safety Inspection; Fee for Review of Dam Safety Inspection Report**

- A.** The owner of a high or significant hazard potential dam shall pay a fee for the Department's dam safety inspection pursuant to R12-15-1219(A). The fee shall be based on the total crest length of the dam plus appurtenant embankments and saddle dikes, as follows:

Length (feet)	Fee
0 up to and including 500	\$2,000.00
More than 500 up to and including 1,000	\$2,200.00

More than 1,000 up to and including 2,000	\$2,400.00
More than 2,000 up to and including 4,000	\$2,600.00
More than 4,000 up to and including 8,000	\$3,000.00
More than 8,000 up to and including 16,000	\$3,400.00
More than 16,000 up to and including 32,000	\$3,800.00
More than 32,000	\$4,200.00

- B.** The owner of a low or very low hazard potential dam shall pay a fee for the Department's dam safety inspection pursuant to R12-15-1219(A). The fee shall be \$250.00.
- C.** After conducting a dam safety inspection pursuant to R12-15-1219(A), the Director shall send to the dam owner a bill for the fee required by subsection (A) or (B) of this Section. The dam owner shall pay the fee by the date specified in the bill, which shall be at least 35 days from the date of the bill. Failure by a dam owner to pay a fee required by subsection (A) or (B) of this Section shall be considered a violation of R12-15-1219.
- D.** The owner of a dam who submits a dam safety inspection report pursuant to R12-15-1219(E) shall pay a fee of \$750.00 if the dam is a high or significant hazard potential dam or a fee of \$250 if the dam is a low or very low hazard potential dam. The Department shall not accept a dam safety inspection report unless the fee is submitted with the report.

**Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 776, effective April 15, 2011 with an automatic repeal date effective June 4, 2011; new Section made by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Section amended by final rulemaking at 23 A.A.R. 2375, effective October 10, 2017 (Supp. 17-3).

**R12-15-106. Fee for Well Capping**

The owner of a well that is capped by the Department pursuant to A.R.S. § 45-594(C) shall pay to the Department a fee of \$300.00, plus actual expenses over \$300.00. After capping an open well, the Department shall send the owner of the well a bill for the fee under this Section. The owner of the well shall pay the fee by the date specified in the bill, which shall be at least 35 days after the date of the bill.

**Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 776, effective April 15, 2011 with an automatic repeal date effective June 4, 2011; new Section made by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-107. Expired****Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by exempt rulemaking at 17 A.A.R. 776, effective April 15, 2011 with an automatic repeal date effective June 4, 2011 (Supp. 11-2). New Section made by exempt rulemaking at 17 A.A.R. 1769, effective August 10, 2011 with an automatic repeal

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date effective July 1, 2012 (Supp. 11-3). New Section made by final rulemaking at 18 A.A.R. 203, effective July 1, 2012 (Supp. 12-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3475, effective November 5, 2016 (Supp. 16-4).

R12-15-108. Reserved  
 R12-15-109. Reserved  
 R12-15-110. Reserved  
 R12-15-111. Reserved  
 R12-15-112. Reserved  
 R12-15-113. Reserved  
 R12-15-114. Reserved  
 R12-15-115. Reserved  
 R12-15-116. Reserved  
 R12-15-117. Reserved  
 R12-15-118. Reserved  
 R12-15-119. Reserved  
 R12-15-120. Reserved  
 R12-15-121. Reserved  
 R12-15-122. Reserved  
 R12-15-123. Reserved  
 R12-15-124. Reserved  
 R12-15-125. Reserved  
 R12-15-126. Reserved  
 R12-15-127. Reserved  
 R12-15-128. Reserved  
 R12-15-129. Reserved  
 R12-15-130. Reserved  
 R12-15-131. Reserved  
 R12-15-132. Reserved  
 R12-15-133. Reserved  
 R12-15-134. Reserved  
 R12-15-135. Reserved  
 R12-15-136. Reserved  
 R12-15-137. Reserved  
 R12-15-138. Reserved  
 R12-15-139. Reserved  
 R12-15-140. Reserved  
 R12-15-141. Reserved  
 R12-15-142. Reserved  
 R12-15-143. Reserved  
 R12-15-144. Reserved  
 R12-15-145. Reserved  
 R12-15-146. Reserved  
 R12-15-147. Reserved  
 R12-15-148. Reserved  
 R12-15-149. Reserved

**R12-15-150. Reserved****R12-15-151. Repealed****Historical Note**

Adopted effective October 8, 1982 (Supp. 82-5). Amended effective June 29, 1994 (Supp. 94-2). Amended effective March 3, 1995 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3). Section repealed by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). New Section made by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Section repealed by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-152. Expired****Historical Note**

Adopted effective October 8, 1982 (Supp. 82-5). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1647, effective May 31, 2006 (Supp. 07-2).

**ARTICLE 2. PROCEDURAL RULES****R12-15-201. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). The reference to R12-14-223 in subsection (C) corrected to read R12-15-223 (Supp. 93-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-202. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-203. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-204. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-205. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-206. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-207. Correction of Clerical Mistakes**



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Upon a motion or on the initiative of the Director, the Director may correct clerical mistakes in decisions, orders, rulings, any process issued by the Department, or other parts of the record, and errors in the record arising from oversight or omission. The Director shall give all parties and the Chief Counsel notice of any corrections made pursuant to this Section.

**Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3).

**R12-15-208. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-209. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-210. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-211. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-212. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-213. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-214. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-215. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section number corrected (Supp. 93-1). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-216. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-217. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-218. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-219. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-220. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-221. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-222. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-223. Expired****Historical Note**

Adopted effective June 13, 1984 (Supp. 84-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2159, effective February 28, 2001 (Supp. 01-2).

**R12-15-224. Ex Parte Communications**

- A.** During the course of a contested case or appealable agency action, a party shall not make an ex parte communication or knowingly cause an ex parte communication to be made to the Director or other Department employee or consultant who is or may reasonably be expected to be involved in the decision-making process of the contested case or appealable agency action.
- B.** During the course of a contested case or appealable agency action, the Department personnel listed in subsection (A) shall not make an ex parte communication or knowingly cause an ex parte communication to be made to a party or a person who will be materially and directly affected by the outcome of the contested case or appealable agency action.
- C.** Any of the Department personnel listed in subsection (A) of this Section who receives a written communication prohibited by this Section shall file a copy of the communication in the

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public docket and serve a copy on the Director, the Chief Counsel, and all parties to the contested case or appealable agency action. Any of the Department personnel listed in subsection (A) of this Section who receives an oral communication prohibited by this Section shall file a summary, stating the substance of the communication, in the public docket and serve a copy on the Director, the Chief Counsel, and all parties to the contested case or appealable agency action.

- D.** Upon receipt of an ex parte communication or a copy or summary of an ex parte communication made or knowingly caused to be made by a party in violation of this Section, the Director, to the extent consistent with the interests of justice and the policy of the underlying statutes and rules, may require the party to show cause why the party's claim or interest in the contested case or appealable agency action should not be dismissed, denied or disregarded because of the violation.
- E.** For purposes of this Section, "ex parte communication" means any written or oral communication relating to the merits of a contested case or appealable agency action, except:
1. Communications made in the course of official proceedings in the contested case or appealable agency action;
  2. Communications made in writing, if a copy of the communication is promptly served on the Director, the Chief Counsel, and all parties to the contested case or appealable agency action;
  3. Oral communications made after adequate notice, stating the substance of each communication, to all parties and the Chief Counsel;
  4. Communications relating solely to procedural matters; and
  5. As otherwise authorized by law.

**Historical Note**

Adopted effective June, 1984 (Supp. 84-3). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3).

**ARTICLE 3. STOCKPOND AND OTHER SURFACE WATER RULES****R12-15-301. Expired****Historical Note**

Adopted effective October 8, 1982 (Supp. 82-5). Amended effective April 3, 1987 (Supp. 87-2). Amended effective May 7, 1990 (Supp. 90-2). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2012, effective February 28, 2001 (Supp. 01-2).

**R12-15-302. Expired****Historical Note**

Adopted effective October 8, 1982 (Supp. 82-5). Amended effective May 7, 1990 (Supp. 90-2). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 2012, effective February 28, 2001 (Supp. 01-2).

**R12-15-303. Multiple Applications for Water Rights**

- A.** If two or more applications are filed with the Director pursuant to A.R.S. §§ 45-152 or 45-273 or both by or for the same applicant and for a right to use the same water, the Director shall consolidate the applications. If the applicant is otherwise entitled to both a permit to appropriate and a certificate of stockpond water right, the Director shall issue to the applicant either the permit to appropriate or the certificate of stockpond water right, whichever would give the applicant the higher priority.

- B.** If one or more applications are filed with the Director pursuant to A.R.S. §§ 45-152 or 45-273 or both by or for the same applicant and for a right to use the same water for which the applicant holds a permit to appropriate, a certificate of water right or a certificate of stockpond water right, the Director shall deny the application or applications unless the applicant relinquishes every permit to appropriate, certificate of water right and certificate of stockpond water right which the applicant holds for that same water. The applicant may relinquish every permit to appropriate, certificate of water right and certificate of stockpond water right on the condition that the Director issues a permit to appropriate or certificate of stockpond water right to the applicant for the same water. In that case, the relinquishment shall be effective when the Director issues the permit to appropriate or certificate of stockpond water right.
- C.** For purposes of this rule, "same water" means the same quantity of water from the same source for use at the same place for the same purpose. Water for which a right is applied or held pursuant to an application or permit to appropriate, certificate of water right or certificate of stockpond water right may be the same water in whole or in part as water for which a right is applied or held pursuant to a separate application or permit to appropriate, certificate of water right or certificate of stockpond water right.

**Historical Note**

Adopted effective April 3, 1987 (Supp. 87-2). Section R12-15-310 renumbered to R12-15-303 and amended effective May 7, 1990 (Supp. 90-2).

**R12-15-304. Reserved****R12-15-305. Reserved****R12-15-306. Reserved****R12-15-307. Reserved****R12-15-308. Reserved****R12-15-309. Reserved****R12-15-310. Renumbered****Historical Note**

Adopted effective April 3, 1987 (Supp. 87-2). Section R12-15-310 renumbered to R12-15-303 effective May 7, 1990 (Supp. 90-2).

**ARTICLE 4. LICENSING TIME-FRAMES****R12-15-401. Licensing Time-frames**

The following time-frames apply to licenses issued by the Department. In this Article, "license" has the meaning prescribed in A.R.S. § 41-1001. The licensing time-frames consist of an administrative completeness review time-frame, a substantive review time-frame, and an overall time-frame.

1. Within the administrative completeness review time-frames set forth in subsection (7), the Department shall notify the applicant in writing whether the application is complete or incomplete. If the application is incomplete, the notice shall specify what information or component is required to make the application complete.
2. An applicant with an incomplete application shall supply the missing information within 60 days from the date of the notice, or within such further time as the Director may specify, unless another time limit is specified by statute or applicable rule. If the applicant fails to complete the application within the specified time period, the Director

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may deny the application. Denial of an application under this provision does not preclude the applicant from filing a new application.

3. Within the overall time-frames set forth in subsection (7), unless extended by mutual agreement under A.R.S. § 41-1075, the Department shall notify the applicant in writing that the application is granted or denied. If the application is denied, the Department shall provide written justification for the denial and a written explanation of the applicant's right to a hearing or the applicant's right to appeal.
4. In computing any period of time prescribed by this rule, the day of the filing, notice or event from which the designated period of time begins to run shall not be included. The last day of the computed period shall be included, unless it is a Saturday, Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the prescribed administrative completeness review time-frame or substantive review time-frame is less than 11

days, intermediate Saturdays, Sundays and legal holidays shall be excluded from the computation. The overall time-frame is the sum of the administrative completeness review time-frame and the substantive review time-frame calculated as prescribed by this Section.

5. Except as otherwise noted, the licensing time-frames do not include time for hearings. Time-frames in cases where a hearing is held are increased by 120 days.
6. The licensing time-frame rules are effective after December 31, 1998, as prescribed by A.R.S. § 41-1073(A), and apply to all applications filed after that date.
7. The licensing time-frames are set forth in Table A.

**Historical Note**

Adopted effective December 31, 1998; filed with the Office of the Secretary of State July 28, 1998 (Supp. 98-3). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**Table A. Licensing Time-frames**

No.	License	Legal Authority	Completeness Review (Days)*	Substantive Review (Days)*	Overall Time-frame (Days)*
1	Filling a body of water with poor quality water	A.R.S. § 45-132(C)	30	60	90
2	Interim water use in body of water	A.R.S. § 45-133	30	60	90
3	Temporary emergency permit for use of surface water or groundwater in body of water	A.R.S. § 45-134	10	20	30
4	Permit to appropriate water (non-instream flow)	A.R.S. §§ 45-151, 45-152 and 45-153	30	420	450
5	Permit to appropriate water (instream flow)	A.R.S. §§ 45-151, 45-152.01 and 45-153	50	530	580
6	Change in use of water	A.R.S. § 45-156(B)	30	375	405
7	Exception to limitation on time of completion of construction	A.R.S. § 45-160	5	15	20
8	Primary reservoir permit	A.R.S. § 45-161	30	420	450
9	Secondary reservoir permit	A.R.S. § 45-161	30	420	450
10	Certificate of water right (non-instream flow)	A.R.S. § 45-162	20	100	120
11	Certificate of water right (instream flow)	A.R.S. § 45-162	20	190	210
12	Reissuance of permit or certificate held by the United States or State of Arizona	A.R.S. § 45-164(C)	10	80	90
13	Severance and transfer	A.R.S. § 45-172 (excluding § 172(A)(6))	30	390	420
14	Stockpond certificate	A.R.S. § 45-273	30	190	220
15	Transporting water from this state **	A.R.S. § 45-292	120	300	420
16	Waiver of water conserving plumbing fixture requirement	A.R.S. § 45-315	10	3	13
17	Irrigated acreage in an irrigation non-expansion area	A.R.S. § 45-437	30	90	120

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No.	License	Legal Authority	Completeness Review (Days)*	Substantive Review (Days)*	Overall Time-frame (Days)*
18	Substitution of acres in an irrigation non-expansion area/flood damage	A.R.S. § 45-437.02	30	90	120
19	Substitution of acres in an irrigation non-expansion area/impediments to efficient irrigation	A.R.S. § 45-437.03	30	90	120
20	Reversal of substitution of acres irrigated with Central Arizona Project water	A.R.S. § 45-452(F)	30	90	120
21	Type 1 non-irrigation grandfathered right associated with irrigation land retired 1965-1980	A.R.S. §§ 45-463, 45-476.01, and 45-476	30	60	90
22	Type 2 non-irrigation grandfathered right	A.R.S. §§ 45-464, 45-476.01, and 45-476	30	60	90
23	Irrigation grandfathered right	A.R.S. §§ 45-465, 45-476.01, and 45-476	30	60	90
24	Substitution of acres in an active management area/flood damaged acres	A.R.S. § 45-465.01	30	90	120
25	Substitution of acres in an active management area/impediments to efficient irrigation	A.R.S. § 45-465.02	30	90	120
26	Type 1 non-irrigation right retired after 6/12/80	A.R.S. § 45-469	30	90	120
27	Restoration of retired irrigation grandfathered right	A.R.S. § 45-469(O)	30	90	120
28	Revised certificate for new or additional points of withdrawal for a Type 2 right	A.R.S. § 45-471(C)	45	45	90
29	Conveyance of irrigation grandfathered right for electrical energy generation	A.R.S. § 45-472(B)(2)	30	90	120
30	Conveyance of irrigation grandfathered right for non-irrigation use within service area	A.R.S. § 45-472(C)	30	90	120
31	Contract to supply groundwater	A.R.S. § 45-492(C)	15	90	105
32	Extension of service area to provide disproportionately large amount of water to large user	A.R.S. § 45-493(A)(2)	15	90	105
33	Addition/exclusion of acres by irrigation district	A.R.S. § 45-494.01(A)	30	90	120
34	Delivery of groundwater from an irrigation district to a general industrial use permit holder	A.R.S. § 45-497(B)	15	60	75
35	Issuance/renewal/modification of dewatering permit	A.R.S. §§ 45-513 and 45-527	30	70	100
36	Issuance/renewal/modification of mineral extraction and metallurgical processing permit	A.R.S. §§ 45-514 and 45-527	30	70	100
37	Issuance/renewal/modification of general industrial use permit	A.R.S. §§ 45-515, 45-521, 45-522, 45-523, 45-524, and 45-527	30	70	100

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No.	License	Legal Authority	Completeness Review (Days)*	Substantive Review (Days)*	Overall Time-frame (Days)*
38	Issuance/renewal/modification of poor quality groundwater withdrawal permit	A.R.S. §§ 45-516 and 45-527	30	70	100
39	Issuance/renewal/modification of temporary permit for electrical energy generation	A.R.S. §§ 45-517 and 45-527	30	70	100
40	Issuance/extension/ modification of temporary dewatering permit	A.R.S. §§ 45-518 and 45-527	30	70	100
41	Emergency temporary dewatering permit	A.R.S. § 45-518(D)	3	7	10
42	Issuance/renewal/modification of drainage water withdrawal permit	A.R.S. §§ 45-519 and 45-527	30	70	100
43	Issuance/renewal/modification of hydrologic testing permit	A.R.S. §§ 45-519.01, 45-521, 45-522, 45-524, and 45-527	30	15	45
44	Change of location of use	A.R.S. §§ 45-520(A), 45-521, and 45-527	30	30	60
45	Conveyance of a groundwater withdrawal permit	A.R.S. § 45-520(B)	30	30	60
46	Transportation of groundwater withdrawn in McMullen Valley Basin to an active management area	A.R.S. § 45-552(B)	45	105	150
47	Transportation of groundwater withdrawn in Harquahala irrigation non-expansion area to an initial active management area	A.R.S. § 45-554(B)	45	105	150
48	Transportation of groundwater withdrawn in Big Chino subbasin to an initial active management area	A.R.S. § 45-555(B)	45	105	150
49	Well spacing requirements for withdrawing groundwater for transportation to an active management area	A.R.S. § 45-559	45	105	150
50	Groundwater replenishment district's preliminary or long-term replenishment plan **	A.R.S. § 45-576.03	As prescribed by A.R.S. § 45-576.03(A)	As prescribed by A.R.S. § 45-576.03 (B), (C), (D), and (E)	As prescribed by A.R.S. § 45-576.03
51	Conservation district or water district long-term replenishment plan **	A.R.S. §§ 45-576.03, 45-576.02(C), and 45-576.02(E)	As prescribed by A.R.S. § 45-576.03(I)	As prescribed by A.R.S. § 45-576.03(J), (K), (L), and (M)	As prescribed by A.R.S. § 45-576.03
52	Notice of intent to abandon a well	A.R.S. § 45-594 and A.A.C. R12-15-816	15	15	30
53	Well construction request for variance	A.R.S. §§ 45-594, 45-596(D), and A.A.C. R12-15-820	15	30	45
54	Well driller license	A.R.S. § 45-595(C)	25	65	90
55	Single well license	A.R.S. § 45-595(D)	25	65	90
56	Renewal or reactivation of well drilling license	A.R.S. § 45-595(C) A.A.C. R12-15-806	25	15	40
57	Notice of intent to drill	A.R.S. § 45-596, and A.A.C. R12-15-810	15	0	15
58	Well construction permit	A.R.S. § 45-599	30	60	90

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No.	License	Legal Authority	Completeness Review (Days)*	Substantive Review (Days)*	Overall Time-frame (Days)*
59	Alternative water measuring devices	A.R.S. § 45-604 and A.A.C. R12-15-909	15	60	75
60	Underground storage facility permit	A.R.S. §§ 45-811.01 and 45-871.01	As prescribed by A.R.S. § 45-871.01(B)	As prescribed by A.R.S. § 45-871.01(D), (G), and (H)	As prescribed by A.R.S. § 45-871.01
61	Groundwater savings facility permit	A.R.S. §§ 45-812.01 and 45-871.01	As prescribed by A.R.S. § 45-871.01(B)	As prescribed by A.R.S. § 45-871.01(D), (G), and (H)	As prescribed by A.R.S. § 45-871.01
62	Storage facility permit renewal/conveyance/ modification	A.R.S. §§ 45-814.01 and 45-871.01	As prescribed by A.R.S. § 45-871.01(B)	As prescribed by A.R.S. § 45-871.01(D), (G), and (H)	As prescribed by A.R.S. § 45-871.01
63	Water storage permit modification/conveyance	A.R.S. §§ 45-831.01 and 45-871.01	As prescribed by A.R.S. §§ 45-831.01(G) and 45-871.01(B) and (E)	As prescribed by A.R.S. §§ 45-831.01(G) and 45-871.01(D), (E), (G), and (H)	As prescribed by A.R.S. §§ 45-831.01(G) and 45-871.01
64	Recovery well permit	A.R.S. §§ 45-834.01 and 45-871.01	As prescribed by A.R.S. § 45-871.01(B)	As prescribed by A.R.S. § 45-871.01(F), (G), and (H)	As prescribed by A.R.S. § 45-871.01
65	Emergency temporary recovery well permit	A.R.S. § 45-834.01(D)	5	10	15
66	Issuance/renewal/modification of water exchange permit	A.R.S. §§ 45-1041, 45-1042, and 45-1045	As prescribed by A.R.S. § 45-1042(A)	As prescribed by A.R.S. § 45-1042(B), (C), and (D)	As prescribed by A.R.S. § 45-1042
67	Modification of previously enrolled or permitted water exchange/non-Colorado River	A.R.S. § 45-1041(B)	60	90	150
68	Construction, enlargement, repair, alteration, or removal of a dam	A.R.S. §§ 45-1203, 45-1206, and 45-1207	120	60	180
69	Weather modification license	A.R.S. § 45-1601	15	60	75
70	Certificate of Assured Water Supply (CAWS)	A.A.C. R12-15-704, A.R.S. §§ 45-576 and 45-578	150	60	210
71	Designation or Modification of Designation of Assured Water Supply (DAWS)	A.A.C. R12-15-710 and R12-15-714; A.R.S. § 45-576	150	60	210
72	Analysis of Assured Water Supply	A.A.C. R12-15-703, A.R.S. § 45-576(H)	150	30	180
73	Water Report	A.A.C. R12-15-713, A.R.S. § 45-108	75	45	120
74	Designation or Modification of Designation of Adequate Water Supply	A.A.C. R12-15-714 and R12-15-715; A.R.S. § 45-108	150	60	210
75	Analysis of Adequate Water Supply	A.R.S. § 45-108 A.A.C. R12-15-712	90	30	120
76	Final petition to establish new service area right by city, town, or private water company	A.R.S. § 45-492(A)	30	60	90
77	Application for permit to transport groundwater away from the Yuma groundwater basin	A.R.S. § 45-547	120	300	420
78	Application for substitution of acres to allow irrigation with Central Arizona Project in an active management area	A.R.S. § 45-452(B)	30	60	90

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No.	License	Legal Authority	Completeness Review (Days)*	Substantive Review (Days)*	Overall Time-frame (Days)*
79	Application for approval of development plan to retire irrigation grandfathered right for Type I non-irrigation grandfathered right	A.R.S. § 45-469(A)(2) and (B)	30	60	90
80	Application for assignment of Type A certificate of assured water supply	A.R.S. § 45-579; A.C.C. R12-15-705	90	30	120
81	Application for assignment of Type B certificate of assured water supply	A.R.S. § 45-579; A.C.C. R12-15-706	90	30	120
82	Application for classification of Type A certificate of assured water supply	A.C.C. R12-15-707	30	15	45
83	Application for new certificate of assured water supply pursuant to A.A.C. R12-15-704(G)	A.C.C. R12-15-704(G)	150	60	210
84	Application for letter stating that owner is not required to obtain a certificate of assured water supply	A.C.C. R12-15-704(M)	60	30	90
85	Application for extinguishment of grandfathered right for extinguishment credits	A.C.C. R12-15-723(A)	60	30	90
86	Application for conveyance of extinguishment credits	A.C.C. R12-15-723(G)	60	30	90
87	Application for exemption from adequate water supply requirements based on substantial capital investment	A.R.S. § 45-108.02	90	30	120
88	Application for exemption from adequate water supply requirements based on an adequate water supply within twenty years	A.R.S. § 45-108.03	90	30	120
89	Application for re-issuance of drill card to new driller	A.R.S. § 45-596	10	0	10
90	Application for equipment license for weather control or cloud modification	A.R.S. § 45-1605	15	60	75

\* The computation of days is prescribed by R12-15-401(4).

\*\* Hearing is required.

**Historical Note**

Adopted effective December 31, 1998; filed with the Office of the Secretary of State July 28, 1998 (Supp. 98-3). Table A amended by final rulemaking at 23 A.A.R. 2375, effective October 10, 2107 (Supp. 17-3). Table A amended by final expedited rulemaking at 28 A.A.R. 266 (January 28, 2022), with an immediate effective date of January 5, 2022 (Supp. 22-1).

**ARTICLE 5. RESERVED**

**ARTICLE 6. RESERVED**

**ARTICLE 7. ASSURED AND ADEQUATE WATER SUPPLY**

**R12-15-701. Definitions - Assured and Adequate Water Supply Programs**

In addition to any other definitions in A.R.S. Title 45 and the management plans in effect at the time of application, the following words and phrases in this Article shall have the following meanings, unless the context otherwise requires:

1. “Abandoned plat” means a plat for which a certificate or water report has been issued and that will not be developed because of one of the following:
  - a. The land has been developed for another use; or
  - b. Legal restrictions will preclude approval of the plat.
2. “ADEQ” means the Arizona Department of Environmental Quality.
3. “Adequate delivery, storage, and treatment works” means:
  - a. A water delivery system with sufficient capacity to deliver enough water to meet the needs of the proposed use;

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- b. Any necessary storage facilities with sufficient capacity to store enough water to meet the needs of the proposed use; and
- c. Any necessary treatment facilities with sufficient capacity to treat enough water to meet the needs of the proposed use.
- 4. "Adequate storage facilities" means facilities that can store enough water to meet the needs of the proposed use.
- 5. "Affiliate" means a person who, directly or indirectly through one or more intermediaries, controls, is controlled by or is under common control with the person specified.
- 6. "AMA" means an active management area as defined in A.R.S. § 45-402.
- 7. "Analysis" means an analysis of assured water supply or an analysis of adequate water supply.
- 8. "Analysis holder" means a person to whom an analysis of assured water supply or an analysis of adequate water supply is issued and any current owner of land included in the analysis.
- 9. "Analysis of adequate water supply" means a determination issued by the Director stating that one or more criteria required for a water report pursuant to R12-15-713 have been demonstrated for a development.
- 10. "Analysis of assured water supply" means a determination issued by the Director stating that one or more criteria required for a certificate of assured water supply pursuant to R12-15-704 have been demonstrated for a development.
- 11. "Annual authorized volume" means, for an approved remedial action project, the annual authorized volume specified in a consent decree or other document approved by ADEQ or the EPA, except that:
  - a. If no annual authorized amount is specified in a consent decree or other document approved by ADEQ or the EPA, the annual authorized volume is the largest volume of groundwater withdrawn pursuant to the approved remedial action project in any year prior to January 1, 1999.
  - b. If the Director increases the annual authorized volume pursuant to R12-15-729(C), the annual authorized volume is the amount approved by the Director.
- 12. "Annual estimated water demand" means the estimated water demand divided by 100.
- 13. "Approved remedial action project" means a remedial action project approved by ADEQ under A.R.S. Title 49, or by the EPA under CERCLA.
- 14. "Authorized remedial groundwater use" means, for any year, the amount of remedial groundwater withdrawn pursuant to an approved remedial action project and used by a municipal provider during the year, not to exceed the annual authorized volume of the project.
- 15. "Build-out" means a condition in which all water delivery mains are in place and active water service connections exist for all lots.
- 16. "CAP water" means:
  - a. All water from the Colorado River or from the Central Arizona Project works authorized in P.L. 90-537, excluding enlarged Roosevelt reservoir, which is made available pursuant to a subcontract with a multi-county water conservation district.
  - b. Any additional water not included in subsection 16(a) of this Section that is delivered by the United States Secretary of the Interior pursuant to an Indian water rights settlement through the Central Arizona Project.
- 17. "Central Arizona Groundwater Replenishment District" or "CAGRD" means a multi-county water conservation district acting in its capacity as the entity established pursuant to A.R.S. § 48-3771, et seq., and responsible for replenishing excess groundwater.
- 18. "Central distribution system" means a water system that qualifies as a public water system pursuant to A.R.S. § 49-352.
- 19. "CERCLA" or "Comprehensive Environmental Response, Compensation, and Liability Act of 1980" has the same meaning as prescribed in A.R.S. § 49-201.
- 20. "Certificate" means a certificate of assured water supply issued by the Director for a subdivision pursuant to A.R.S. § 45-576 et seq. and this Article.
- 21. "Certificate holder" means any person included on a certificate, except the following:
  - a. Any person who no longer owns any portion of the property included in the certificate, and
  - b. Any potential purchaser for whom the purchase contract has been terminated or has expired.
- 22. "Certificate of convenience and necessity" means a certificate required by the Arizona Corporation Commission, pursuant to A.R.S. § 40-281, which allows a private water company to serve water to customers within its certificated area.
- 23. "Colorado River water" means water from the main stream of the Colorado River. For purposes of this Article, Colorado River water does not include CAP water.
- 24. "Committed demand" means the 100-year water demand at build-out of all recorded lots that are not yet served water within the service area of a designation applicant or a designated provider.
- 25. "County water augmentation authority" means an authority formed pursuant to A.R.S. Title 45, Chapter 11.
- 26. "Current demand" means the 100-year water demand for existing uses within the service area of a designation applicant or designated provider, based on the annual report for the previous calendar year.
- 27. "Depth-to-static water level" means the level at which water stands in a well when no water is withdrawn by pumping or by free flow.
- 28. "Designated provider" means:
  - a. A municipal provider that has obtained a designation of assured or adequate water supply; or
  - b. A city or town that has obtained a designation of adequate water supply pursuant to A.R.S. § 45-108(D).
- 29. "Designation" means a decision and order issued by the Director designating a municipal provider as having an assured water supply or an adequate water supply.
- 30. "Determination of adequate water supply" means a water report, a designation of adequate water supply, or an analysis of adequate water supply.
- 31. "Determination of assured water supply" means a certificate, a designation of assured water supply, or an analysis of assured water supply.
- 32. "Development" means either a subdivision or an unplatted development plan.
- 33. "Diversion works" means a structure or well that allows or enhances diversion of surface water from its natural course for other uses.



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34. "Drought response plan" means a plan describing a variety of conservation and augmentation measures, especially the use of backup water supplies, that a municipal provider will utilize in operating its water supply system in times of a water supply shortage. The plan may include the following:
- An identification of priority water uses consistent with applicable public policies.
  - A description of sources of emergency water supplies.
  - An analysis of the potential use of water pressure reduction.
  - Plans for public education and voluntary water use reduction.
  - Plans for water use bans, restrictions, and rationing.
  - Plans for water pricing and penalties for excess water use.
  - Plans for coordination with other cities, towns, and private water companies.
35. "Drought volume" means 80% of the volume of a surface water supply, determined by the Director under R12-15-716 to be physically available on an annual basis to a certificate holder or a designated provider.
36. "Dry lot development" means a development or subdivision without a central water distribution system.
37. "EPA" means the United States Environmental Protection Agency.
38. "Estimated water demand" means:
- For a certificate or water report, the Director's determination of the 100-year water demand for all uses included in the subdivision;
  - For a designation, the sum of the following:
    - The Director's determination of the current demand;
    - The Director's determination of the committed demand; and
    - The Director's determination of the projected demand during the term of the designation; or
  - For an analysis, the Director's determination of the water demand for all uses included in the development.
39. "Existing municipal provider" means a municipal provider that was in operation and serving water for non-irrigation use on or before January 1, 1990.
40. "Extinguish" means to cause a grandfathered right to cease to exist through a process established by the Director pursuant to R12-15-723.
41. "Extinguishment credit" means a credit that is issued by the Director in exchange for the extinguishment of a grandfathered right and that may be used to make groundwater use consistent with the management goal of an AMA.
42. "Firm yield" means the minimum annual diversion for the period of record which may include runoff releases from storage reservoirs, and surface water withdrawn from a well.
43. "Gray water" has the same meaning as provided in A.R.S. § 49-201.
44. "Gray water reuse system" means a system constructed to reuse gray water that meets the requirements of the rules adopted by ADEQ for gray water systems.
45. "Management plan" means a water management plan adopted by the Director according to A.R.S. § 45-561 et seq.
46. "Mandatory adequacy jurisdiction" means a city, town, or county that requires an adequate water supply determination by the Director as a condition of approval of a plat according to A.R.S. § 9-463.01(J) or (O) or A.R.S. § 11--823(A).
47. "Master-planned community" has the same meaning as provided in A.R.S. § 32-2101.
48. "Median flow" means the flow which is represented by the middle value of a set of flow data that are ranked in order of magnitude.
49. "Member land" has the same meaning as provided in A.R.S. § 48-3701.
50. "Member service area" has the same meaning as provided in A.R.S. § 48-3701.
51. "Multi-county water conservation district" means a district established according to A.R.S. Title 48, Chapter 22.
52. "Municipal provider" has the same meaning as provided in A.R.S. § 45-561.
53. "New Alternative Water Supply" means a volume of water that is not groundwater withdrawn from an AMA and that was not served within the service area of the municipal provider in the calendar year 2023 for the Phoenix and Pinal AMAs. The Director shall use the annual report submitted by the municipal provider for calendar year 2023, as verified by the Director, for purposes of this paragraph.
54. "New municipal provider" means a municipal provider that began serving water for non-irrigation use after January 1, 1990.
55. "Owner" means:
- For an analysis, certificate, or water report applicant, a person who holds fee title to the land described in the application; or
  - For a designation applicant, the person who will be providing water service according to the designation.
56. "Perennial" means a stream that flows continuously.
57. "Persons per household" means a measure obtained by dividing the number of persons residing in housing units by the number of housing units.
58. "Physical availability determination" means a letter issued by the Director stating that an applicant has demonstrated all of the criteria in R12-15-702(C).
59. "Plat" means a preliminary or final map of a subdivision in a format typically acceptable to a platting entity.
60. "Potential purchaser" means a person who has entered into a purchase agreement for land that is the subject of an application for a certificate or an assignment of a certificate.
61. "Projected demand" means the 100-year water demand at build-out, not including committed or current demand, of customers reasonably projected to be added and plats reasonably projected to be approved within the designated provider's service area and reasonably anticipated expansions of the designated provider's service area.
62. "Proposed municipal provider" means a municipal provider that has agreed to serve a proposed subdivision.
63. "Purchase agreement" means a contract to purchase or acquire an interest in real property, such as a contract for purchase and sale, an option agreement, a deed of trust, or subdivision trust agreement.
64. "Remedial groundwater" means groundwater withdrawn according to an approved remedial action project, but

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does not include groundwater withdrawn to provide an alternative water supply according to A.R.S. § 49-282.03.

65. "Service area" means:
  - a. For an application for an analysis of adequate water supply, a water report, or a designation of adequate water supply, the area of land actually being served water for a non-irrigation use by the municipal provider and additions to the area that contain the municipal provider's operating distribution system for the delivery of water for a non-irrigation use;
  - b. For an application for a designation of adequate water supply according to A.R.S. § 45-108(D), the area of land actually being served water for a non-irrigation use by each municipal provider that serves water within the city or town, and additions to the area that contain each municipal provider's operating distribution system for the delivery of water for a non-irrigation use; or
  - c. For an application for a certificate or designation of assured water supply, "service area" has the same meaning as prescribed in A.R.S. § 45-402.
66. "Subdivision" has the same meaning as prescribed in A.R.S. § 32-2101.
67. "Superfund site" means the site of a remedial action undertaken according to CERCLA.
68. "Surface water" means any surface water as defined in A.R.S. § 45-101, including CAP water and Colorado River water.
69. "Unreplenished groundwater" means the volume of groundwater withdrawn within the service area of a municipal provider after subtracting the groundwater used consistent with the management goal of the AMA pursuant to R12-15-722.
70. "Water Quality Assurance Revolving Fund site" or "WQARF site" means a site of a remedial action undertaken according to A.R.S. Title 49, Chapter 2, Article 5.
71. "Water report" means a letter issued to the Arizona Department of Real Estate by the Director for a subdivision stating whether an adequate water supply exists according to A.R.S. § 45-108 and this Article.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Amended by emergency rulemaking at 11 A.A.R. 2706, effective June 29, 2005 for 180 days (Supp. 05-2). Emergency renewed for 180 days at 12 A.A.R. 144, effective December 23, 2005 (Supp. 05-4). Emergency expired. Amended by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by final expedited rulemaking at 28 A.A.R. 909 (May 6, 2022), with an immediate effective date of April 11, 2022 (Supp. 22-2). Amended by final rulemaking at 30 A.A.R. 3751 (December 13, 2024), with an immediate effective date of November 25, 2024 (Supp. 24-4).

**R12-15-702. Physical Availability Determination**

- A. A person may apply for a physical availability determination by submitting an application on a form prescribed by the Director with the initial fee required by R12-15-103(C), and providing the following information with the application:
  1. The proposed source of water for which the applicant is seeking a determination of physical availability,
  2. Evidence that the applicant has complied with subsection (C) of this Section, and

3. Any other information that the Director reasonably deems necessary to determine whether water is physically available in the area that is the subject of the application.
- B. Each applicant shall sign an application for a physical availability determination. If an applicant is not a natural person, the applicant's authorized officer, managing member, partner, trust officer, trustee or other person who performs similar decision-making functions for the applicant shall sign the application. If the applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the land to be included in the determination, the authorized representative may sign the application on the applicant's behalf.
- C. An applicant for a physical availability determination shall demonstrate the following:
  1. The volume of water that is physically available for 100 years in the area that is the subject of the application, according to the criteria in R12-15-716.
  2. That the proposed sources of water will be of adequate quality, according to the criteria in R12-15-719.
- D. After a complete application is submitted, the Director shall review the application and associated evidence to determine whether the applicant has demonstrated all of the criteria in subsection (C) of this Section. If the Director determines that the applicant has demonstrated all of the criteria in subsection (C) of this Section, the Director shall issue a physical availability determination.
- E. Any person applying for a determination of assured water supply or a determination of adequate water supply may use an existing physical availability determination for purposes of R12-15-716. The Director shall consider any changes in hydrologic conditions for purposes of R12-15-716.
- F. The issuance of a physical availability determination does not reserve any water for purposes of this Article.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-703. Analysis of Assured Water Supply**

- A. A person proposing to develop land that will not be served by a designated provider may apply for an analysis of assured water supply before applying for a certificate. An applicant for an analysis must be the owner of the land that is the subject of the application or have the written consent of the owner. The commissioner of the Arizona State Land Department may apply for an analysis for land owned by the state of Arizona or may consent to the inclusion of such land in an application.
- B. An applicant for an analysis shall submit an application on a form prescribed by the Director with the initial fee required by R12-15-103(C), and attach the following:
  1. A title report, condition of title report, limited search title report, or recorded deed, dated within 90 days of the date the application is submitted, demonstrating the ownership of the land that is the subject of the application;
  2. A description of the development, including:
    - a. A map of the land uses included in the development,

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- b. A list of water supplies proposed to be used by the development,
  - c. A summary of land use types included in the development, and
  - d. An estimate of the water demand for the land uses included in the development; and
- 3. Evidence that the applicant has complied with subsection (E) of this Section.
- C. An applicant shall sign the application for an analysis. If an applicant is not a natural person, the applicant's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant shall sign the application. If the applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the land to be included in the analysis, the authorized representative may sign the application on the applicant's behalf.
- D. After a complete application is submitted, the Director shall determine the estimated water demand of the development.
- E. The Director shall issue an analysis if an applicant demonstrates one or more of the following:
  - 1. Sufficient supplies of water are physically available to meet all or part of the estimated water demand of the development for 100 years, according to the criteria in R12-15-716.
  - 2. Sufficient supplies of water are continuously available to meet the estimated water demand of the development for 100 years, according to the criteria in R12-15-717.
  - 3. Sufficient supplies of water are legally available to meet the estimated water demand of the development for 100 years, according to the criteria in R12-15-718.
  - 4. The proposed sources of water are of adequate quality, according to the criteria in R12-15-719.
  - 5. Any proposed groundwater use is consistent with the management plan in effect at the time of the application, according to the criteria in R12-15-721.
  - 6. Any proposed groundwater use is consistent with the management goal, according to the criteria in R12-15-722.
- F. For 10 years after the Director issues an analysis, or a longer period allowed under subsections (H) or (I) of this Section:
  - 1. If groundwater is a source of supply in the analysis and the applicant demonstrates that groundwater is physically available under subsection (E)(1) of this Section, the Director shall consider that supply of groundwater reserved for the use of the proposed development in subsequent determinations of physical availability pursuant to R12-15-716(B).
  - 2. If an analysis holder applies for a certificate for a subdivision located on land included in the analysis, the Director shall presume that a criterion demonstrated in the analysis remains satisfied with respect to the subdivision, unless the Director has received new evidence demonstrating that the criterion is not satisfied. If the Director issues the certificate, the Director shall reduce the volume of groundwater reserved pursuant to subsection (F)(1) of this Section by the amount of the estimated water demand for the certificate that will be met with groundwater.
- G. The Director shall reduce the amount of groundwater considered reserved for use of the development upon request by the analysis holder. If the analysis holder requesting a reduction is not the person to whom the analysis was issued, the Director shall reduce the amount of reserved groundwater only if the person to whom the analysis was issued or that person's designee consents to the request for reduction. The person to whom the analysis was issued shall notify the Director in writing of the name of the person's designee for purposes of this subsection.
- H. The analysis holder may apply to the Director for a five-year extension of the time period in subsection (F) of this Section by submitting an application on a form prescribed by the Director no earlier than 36 months before the end of the time period and no later than 30 days before the end of the time period. If an extension is granted, the analysis holder may apply to the Director for an additional five-year extension by submitting an application on a form prescribed by the Director no earlier than 36 months before the end of the extended time period and no later than 30 days before the end of the extended time period. The Director shall extend the time period for no more than two successive five-year periods under this subsection if the analysis holder demonstrates one of the following:
  - 1. The analysis holder has made a substantial capital investment in developing the land included in the analysis.
  - 2. The analysis holder has made material progress in developing the land included in the analysis.
  - 3. Progress in developing the land included in the analysis has been delayed for reasons outside the control of the analysis holder.
- I. After the Director grants two five-year extensions pursuant to subsection (H) of this Section, the Director may extend the time period for additional five-year periods if the analysis holder files a timely application pursuant to subsection (H) of this Section and demonstrates one of the criteria in subsections (H)(1), (2), or (3) of this Section.
- J. The Director shall review an application for an analysis or an application for an extension pursuant to subsections (H) or (I) of this Section pursuant to the licensing time-frame provisions in R12-15-401.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Amended by emergency rulemaking at 11 A.A.R. 2706, effective June 29, 2005 for 180 days (Supp. 05-2). Emergency renewed for 180 days at 12 A.A.R. 144, effective December 23, 2005 (Supp. 05-4). Emergency expired. Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-703.01. Repealed****Historical Note**

New Section made by final rulemaking at 7 A.A.R. 3038, effective June 18, 2001 (Supp. 01-2). Section repealed by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-704. Certificate of Assured Water Supply**

- A. An application for a certificate shall be filed by the current owner of the land that is the subject of the application. Potential purchasers and affiliates may also be included as applicants.
- B. An applicant for a certificate shall submit an application on a form prescribed by the Director with the fee required by R12-15-103(C) and provide the following:

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1. One of the following forms of proof of ownership for each applicant to be listed on the certificate:
    - a. For an applicant that is the current owner, one of the following:
      - i. A title report, condition of title report, limited search title report, or recorded deed, dated within 90 days of the date the application is filed, demonstrating that the applicant is the owner of the land that is the subject of the application; or
      - ii. Evidence that the CAGRDR has reviewed and approved evidence that the applicant is the owner of the land that is the subject of the application.
    - b. For an applicant that is a potential purchaser, evidence of a purchase agreement;
    - c. For an applicant that is an affiliate of another applicant, a certification by the other applicant of the affiliate status;
  2. A plat of the subdivision;
  3. An estimate of the 100-year water demand for the subdivision;
  4. If the subdivision is enrolled as a member land in the CAGRDR and the applicant proposes to install gray water reuse systems in the subdivision, sufficient information for the Director to determine the appropriate reduction in demand;
  5. A list of all proposed sources of water that will be used by the subdivision;
  6. Evidence that the criteria in subsection (F) or (G) are met; and
  7. Any other information that the Director reasonably determines is necessary to decide whether an assured water supply exists for the subdivision.
- C.** Each applicant shall sign the application for a certificate. If an applicant is not a natural person, the applicant's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant shall sign the application. If an applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the land to be included in the certificate, the authorized representative may sign the application on the applicant's behalf.
- D.** The Director shall give public notice of an application for a certificate as provided in A.R.S. § 45-578.
- E.** After a complete application is submitted, the Director shall review the application and associated evidence to determine:
1. The estimated water demand of the subdivision. If the subdivision is enrolled in the CAGRDR and the applicant demonstrates that gray water reuse systems will be installed in the subdivision, the Director shall reduce the estimated water demand of the subdivision by the volume the Director determines is likely to be saved through the gray water reuse systems;
  2. The amount of the groundwater allowance for the subdivision, as provided in R12-15-724 through R12-15-727; and
  3. Whether the applicant has demonstrated all of the requirements in subsection (F) or (G).
- F.** Except as provided in subsection (G), the Director shall issue a certificate if the applicant demonstrates all of the following:
1. Sufficient supplies of water are physically available to meet the estimated water demand of the subdivision, according to the criteria in R12-15-716;
  2. Sufficient supplies of water are continuously available to meet the estimated water demand of the subdivision, according to the criteria in R12-15-717;
  3. Sufficient supplies of water are legally available to meet the estimated water demand of the subdivision, according to the criteria in R12-15-718;
  4. The sources of water are of adequate quality, according to the criteria in R12-15-719;
  5. The applicant has the financial capability to construct adequate delivery, storage, and treatment works for the subdivision, according to the criteria in R12-15-720;
  6. The proposed use of groundwater withdrawn within an AMA is consistent with the management plan in effect at the time of the application, according to the criteria in R12-15-721; and
  7. The proposed use of groundwater withdrawn within an AMA is consistent with the achievement of the management goal, according to the criteria in R12-15-722.
- G.** If the Director previously issued a certificate for the subdivision, the Director shall issue a new certificate to the applicant if the applicant demonstrates that all of the requirements in subsection (F) are met or that all of the following apply:
1. Any changes to the plat for which the previous certificate was issued are not material, according to the criteria in R12-15-708;
  2. If groundwater is a proposed source of supply for the subdivision, the proposed groundwater withdrawals satisfied the physical availability requirements in effect at the time the complete and correct application for the previous certificate was submitted;
  3. Any proposed sources of water, other than groundwater, are physically available to satisfy the estimated water demand that will not be satisfied with groundwater, according to the criteria in R12-15-716;
  4. Any proposed sources of water other than groundwater are continuously available to satisfy the estimated water demand that will not be satisfied with groundwater, according to the criteria in R12-15-717;
  5. The proposed uses of groundwater withdrawn within an AMA were consistent with the achievement of the management goal according to the criteria in effect at the time the complete and correct application for the previous certificate was submitted; and
  6. The applicant demonstrates that the requirements in subsections (F)(3) through (6) are met.
- H.** Before issuing a certificate, the Director shall classify the certificate for the purposes of R12-15-705 and R12-15-706 as follows:
1. Type A certificate. The Director shall classify the certificate as a Type A certificate if the applicant meets the criteria in R12-15-720(A)(1) and all of the subdivision's estimated water demand will be met with one or more of the following:
    - a. Groundwater served by a proposed municipal provider pursuant to an existing service area right;
    - b. Groundwater served by a proposed municipal provider pursuant to a pending service area right, if the proposed municipal provider currently holds or will hold the well permit;

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- c. CAP water served by a municipal provider pursuant to the proposed municipal provider's non-declining, long-term municipal and industrial subcontract;
  - d. Surface water served by a proposed municipal provider pursuant to the proposed municipal provider's surface water right or claim;
  - e. Effluent owned and served by a proposed municipal provider; or
  - f. A Type 1 grandfathered right appurtenant to the land on which the groundwater will be used and held by a proposed municipal provider.
- 2. Type B certificate. The Director shall classify all certificates that do not meet the requirements of subsection (H)(1) as Type B certificates.
- I. The Director shall review an application for a certificate pursuant to the licensing time-frame provisions in R12-15-401.
- J. An owner of six or more lots is not required to obtain a certificate if all of the following apply:
  - 1. The lots comprise a subset of a subdivision for which:
    - a. A plat was recorded before 1980; or
    - b. A certificate was issued before February 7, 1995;
  - 2. No changes were made to the plat since February 7, 1995; and
  - 3. Water service is currently available to each lot.
- K. A new owner of all or a portion of a subdivision for which a plat has been recorded is not required to obtain a certificate if all of the following apply:
  - 1. The Director previously issued a Type A certificate for the subdivision pursuant to subsection (H)(1) or R12-15-707;
  - 2. Water service is currently available to each lot; and
  - 3. There are no material changes to the plat for which the certificate was issued, according to the criteria in R12-15-708.
- L. An owner of six or more lots in the Pinal AMA is not required to obtain a certificate if all of the following apply:
  - 1. A plat for the subdivision was recorded before October 1, 2007;
  - 2. There have been no material changes to the plat according to the criteria in R12-15-708, since October 1, 2007;
  - 3. The proposed municipal provider was designated as having an assured water supply when the plat was recorded, but is no longer designated as having an assured water supply; and
  - 4. Water service is currently available to each lot.
- M. A person may request a letter stating that the owner is not required to obtain a certificate pursuant to subsection (J), (K), or (L) by submitting an application on a form prescribed by the Director and attaching evidence that the criteria of subsection (J), (K), or (L) are met. Upon receiving an application pursuant to this subsection, the Director shall:
  - 1. Review the application pursuant to the licensing time-frame provisions in R12-15-401.
  - 2. Determine whether the criteria of subsection (J), (K), or (L) are met.
  - 3. If the Director determines that the criteria of subsection (J) are met, issue a letter to the applicant and the Arizona Department of Real Estate stating that the current owner is not required to obtain a certificate.
  - 4. If the Director determines that the criteria of subsection (K) or (L) are met, issue a letter to the applicant and the Arizona Department of Real Estate stating that the current owner and any future owners are not required to obtain a certificate.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 1394, effective October 1, 2007 (Supp. 07-2). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Amended by final expedited rulemaking at 28 A.A.R. 909 (May 6, 2022), with an immediate effective date of April 11, 2022 (Supp. 22-2).

**R12-15-705. Assignment of Type A Certificate of Assured Water Supply**

- A. The certificate holder of a Type A certificate and the assignee may apply for approval of an assignment of the Type A certificate within the time allowed by A.R.S. § 45-579(A). The assignee may file the application if there is no certificate holder. The application shall be submitted on a form prescribed by the Director with the initial fee required by R12-15-103(C), and the applicant shall provide the following:
  - 1. One of the following forms of proof of ownership for each assignee:
    - a. A title report, condition of title report, limited search title report, or recorded deed, dated within 90 days of the date the application is submitted to the Director and demonstrating that the assignee is the owner of the land that is the subject of the proposed assignment; or
    - b. If the assignee is a potential purchaser, evidence of a purchase agreement;
  - 2. A current plat of the subdivision;
  - 3. An estimate of the 100-year water demand for the subdivision, based on the current plat;
  - 4. Certification by each applicant that:
    - a. The proposed municipal provider has not changed and has agreed to continue to serve the subdivision after the assignment; and
    - b. All water supplies listed on the current certificate are physically, continuously, and legally available to meet the estimated water demand of the subdivision after the assignment.
- B. Each applicant shall sign the application for an assignment of a Type A certificate. If an applicant is not a natural person, the entity's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant shall sign the application. If an applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the land included in the certificate, the authorized representative may sign the application on behalf of the applicant.
- C. Upon receiving an application for an assignment of a Type A certificate, the Director shall post the notice required by A.R.S. § 45-579(E).
- D. If the Director determines that the application meets the criteria of A.R.S. § 45-579(A), the Director shall issue a Type A certificate to each applicant. A Type A certificate issued under this subsection shall retain the issue date, the number of lots, and the estimated water demand shown on the original certificate, except as provided in subsection (E) of this Section. The

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Director shall determine that the application meets the criteria of A.R.S. § 45-579(A) if all of the following apply:

1. The application is submitted within the time allowed by A.R.S. § 45-579(A);
  2. The assignee is the owner or a potential purchaser of the portion of the subdivision that is the subject of the assignment;
  3. There have been no material changes to the plat for which the original certificate was issued, according to the criteria in R12-15-708;
  4. Neither the applicant nor a predecessor in interest has impaired the manner in which consistency with management goal requirements were satisfied when the original certificate was issued; and
  5. The applicant makes the certifications required in subsection (A)(4) of this Section.
- E.** In the case of a partial assignment, the Director shall determine whether changes to the plat are material according to R12-15-708. The Director shall issue a Type A certificate to the assignee for the portion of the subdivision that is the subject of the assignment and for the number of lots and the estimated water demand of the current plat of the portion of the subdivision that is the subject of the assignment. The Director shall issue a Type A certificate to the certificate holder for the portion of the subdivision retained by the certificate holder and for the remainder of the number of lots and the remainder of the estimated water demand. The sum of the number of lots and the sum of the amount of the estimated water demand shown on each certificate shall equal the total number of lots and the total estimated water demand shown on the certificate being assigned.
- F.** The Director shall review an application for an assignment of a Type A certificate of assured water supply pursuant to the licensing time-frame provisions in R12-15-401.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1).  
 Amended by final rulemaking at 8 A.A.R. 4390, effective November 22, 2002 (Supp. 02-3). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-706. Assignment of Type B Certificate of Assured Water Supply**

- A.** The certificate holder of a Type B certificate or a certificate issued before the effective date of this Section that has not been classified pursuant to R12-15-707 and the assignee may apply for approval of an assignment of the certificate to another person within the time allowed by A.R.S. § 45-579(A). The assignee may file the application if there is no certificate holder. The application shall be submitted on a form prescribed by the Director with the initial fee required by R12-15-103(C), and the applicant shall provide the following:
1. One of the following forms of proof of ownership for each assignee:
    - a. A title report, condition of title report, limited search title report, or recorded deed, dated within 90 days of the date the application is submitted to the Director and demonstrating that the assignee is the owner of the land that is the subject of the proposed assignment; or
    - b. If the assignee is a potential purchaser, evidence of a purchase agreement;
  2. A current plat of the subdivision;
  3. An estimate of the 100-year water demand for the subdivision, based on the current plat;
  4. Evidence that all necessary water rights, permits, licenses, contracts, and easements have been or will be assigned to the assignee of the certificate;
  5. Evidence that the assignee has the financial capability to construct adequate delivery, storage, and treatment works for the subdivision according to the criteria in R12-15-720;
  6. Evidence that all water supplies listed on the current certificate are physically, continuously, and legally available to meet the estimated water demand of the subdivision after the assignment;
  7. Evidence that the proposed municipal provider has not changed and has agreed to serve the subdivision after the assignment;
  8. If the applicant requests that the Director classify the certificate pursuant to subsection (E) of this Section, evidence that the requirements of R12-15-704(H)(1) are satisfied;
  9. Any other information that the Director reasonably deems necessary to determine whether the application meets the criteria of A.R.S. § 45-579.
- B.** Each applicant shall sign the application for an assignment of a certificate. If an applicant is not a natural person, the entity's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant shall sign the application. If an applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the land to be included in the certificate, the authorized representative may sign the application on the applicant's behalf.
- C.** Upon receiving an application for an assignment, the Director shall post the notice required by A.R.S. § 45-579(E).
- D.** Except as provided in subsection (E) of this Section, if the Director determines that the application meets the criteria of A.R.S. § 45-579(A), the Director shall issue a Type B certificate to each applicant. A Type B certificate issued under this subsection shall retain the issue date, the number of lots, and the estimated water demand shown on the original certificate, except as provided in subsection (F) of this Section. The Director shall determine that the application meets the criteria of A.R.S. § 45-579(A) if all of the following apply:
1. The application is submitted within the time allowed by A.R.S. § 45-579(A);
  2. The assignee is the owner or potential purchaser of the portion of the subdivision that is the subject of the assignment;
  3. There have been no material changes to the plat for which the original certificate was issued, according to the criteria in R12-15-708;
  4. The applicant demonstrates the financial capability to construct adequate delivery, storage, and treatment works for the subdivision according to the criteria in R12-15-720;

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5. All necessary water rights, permits, licenses, contracts, and easements have been or will be assigned to the assignee of the certificate;
  6. All water supplies listed on the current certificate are physically, continuously, and legally available to meet the estimated water demand of the subdivision after the assignment;
  7. Neither the applicant nor a predecessor in interest has impaired the manner in which consistency with management goal requirements were satisfied when the original certificate was issued; and
  8. The proposed municipal provider has agreed to serve the subdivision after the assignment.
- E.** The applicant may include in the application a request to classify the certificate as a Type A certificate. If the Director determines that the request meets the requirements of R12-15-704(H)(1), the Director shall classify the certificate as a Type A certificate.
- F.** In the case of a partial assignment, the Director shall determine whether changes to the plat are material according to R12-15-708. The Director shall issue a Type B certificate to the assignee for the portion of the subdivision that is the subject of the assignment and for the number of lots and the estimated water demand of the current plat of the portion of the subdivision that is the subject of the assignment. The Director shall issue a Type B certificate to the certificate holder for the portion of the subdivision retained by the certificate holder and for the remainder of the number of lots and the remainder of the estimated water demand. The sum of the number of lots and the sum of the amount of the estimated water demand shown on each certificate shall equal the total number of lots and the total estimated water demand shown on the certificate that is being assigned.
- G.** The Director shall review an application for an assignment of a Type B certificate pursuant to the licensing time-frame provisions in R12-15-401.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-707. Application for Classification of a Type A Certificate**

- A.** A holder of a Type B certificate or a certificate issued before the effective date of this Section may apply to the Director to classify the certificate as a Type A certificate by submitting an application on a form prescribed by the Director with the initial fee prescribed in R12-15-103(C), and attaching evidence that the certificate meets the requirements of R12-15-704(H)(1).
- B.** At least one certificate holder shall sign the application for classification of a certificate as a Type A certificate. If the applicant is not a natural person, the applicant's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant shall sign the application. If the applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the

land to be included in the certificate, the authorized representative may sign the application on behalf of the applicant.

- C.** If the applicant demonstrates that the requirements of R12-15-704(H)(1) are met, the Director shall classify the certificate as a Type A certificate and issue a Type A certificate to each certificate holder.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-708. Material Plat Change; Application for Review**

- A.** A certificate or a water report is applicable to the original plat for which the certificate or water report was issued and to a revised plat, unless the plat changes are material according to subsections (C) and (D).
- B.** If a plat is revised after the Director issues a certificate or a water report and the changes to the plat are material according to subsection (C) or (D), the holder may:
1. Apply for a new certificate or water report for the revised plat,
  2. Use the original plat for which the certificate or water report was issued, or
  3. Revise the plat so that any changes are not material according to subsections (C) and (D).
- C.** Changes to the plat for which a certificate or a water report has been issued are material if any of the following apply:
1. The 100-year water demand for the revised plat equals the 100-year water demand for the certificate or water report and the number of lots on the plat has increased by more than:
    - a. For subdivisions of six to 10 lots: one lot;
    - b. For subdivisions of 11 to 499 lots: 10%, rounding up to the nearest whole number; or
    - c. For subdivisions of 500 lots or more: 50 lots.
  2. The 100-year water demand for the revised plat exceeds the estimated water demand for the certificate or water report, unless all of the following apply:
    - a. The 100-year water demand for the revised plat does not exceed the estimated water demand for the certificate or water report by more than 10%, rounding to the nearest whole acre-foot, or by more than 25 acre-feet per year, whichever is less;
    - b. The 100-year water demand is not greater than the supply demonstrated to be physically, continuously, and legally available at the time of issuance of the certificate or water report, and that water supply remains physically, continuously, and legally available; and
    - c. For a certificate, one of the following applies:
      - i. The subdivision is enrolled as a member land in the CAGRD;
      - ii. Groundwater is not included as a source of supply; or
      - iii. The subdivision is located in the Pinal AMA and the 100-year water demand for the revised plat will not exceed the sum of the amount of the groundwater allowance and the amount of any extinguishment credits pledged to the cer-

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tificate, including extinguishment credits pledged after the certificate was issued.

- d. The number of lots on the revised plat has not increased by more than:
  - i. For subdivisions of six to 10 lots: one lot;
  - ii. For subdivisions of 11 to 499 lots: 10%, rounding up to the nearest whole number; or
  - iii. For subdivisions of 500 or more: 50 lots.
3. For a certificate, additional land is included in the plat, unless all of the following apply:
  - a. The land included in the original plat for which the certificate was issued is located in a master-planned community;
  - b. The outer boundaries of the master-planned community have not expanded;
  - c. If the land included in the original plat for which the certificate was issued is enrolled as a member land in the CAGR, the additional land has also been enrolled in the CAGR; and
  - d. A certificate has been issued for the additional land.
- D. Changes to a portion of a plat are not material if one of the following applies:
  1. The changes to the portion of the plat being reviewed are not material according to subsection (C) when compared to the equivalent portion of the plat for which the certificate was issued;
  2. The changes to the entire revised plat are not material according to subsection (C) when compared to the entire plat for which the certificate was issued; or
  3. For a partial assignment pursuant to R12-15-705 or R12-15-706, the plat for the portion of the subdivision retained by the certificate holder could be configured so that changes to the total number of lots and the estimated water demand for the entire subdivision, including the portion under consideration, are not material according to subsection (C). For purposes of this subsection, the Director may require the applicant to submit evidence demonstrating whether changes to the plat are material. However, the Director shall not require the applicant to submit a plat for the retained portion of a subdivision, unless the materiality of changes to the plat cannot be determined with any other evidence.
- E. A person may apply for a review of a revised plat to determine whether any changes to the plat are material as follows:
  1. The applicant shall submit an application on a form prescribed by the Director with the initial fee required by R12-15-103(C), and shall attach the revised plat.
  2. The Director shall review the revised plat and the plat for which the certificate or water report was originally issued to determine whether any changes are material according to the criteria in subsections (C) and (D).
  3. The Director shall issue a letter to the applicant stating whether any changes to the plat are material and identifying which changes, if any, are material. If the Director determines that the changes to the plat are not material, the Director's letter shall state that the certificate or water report is applicable to the revised plat.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective Septem-

ber 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

Amended by final expedited rulemaking at 28 A.A.R. 909 (May 6, 2022), with an immediate effective date of April 11, 2022 (Supp. 22-2).

**R12-15-709. Certificate of Assured Water Supply; Revocation**

- A. The Director may revoke a certificate if an assured water supply does not exist.
- B. The Director shall not revoke a certificate if any of the residential lots within the plat have been sold.
- C. If the Director determines that a certificate should be revoked, the Director shall provide for an administrative hearing, in accordance with A.R.S. Title 41, Chapter 6, Article 10. To determine whether a certificate should be revoked, the Director shall use the standards in place at the time the original application was submitted for the certificate.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-710. Designation of Assured Water Supply**

- A. A municipal provider applying for a designation of assured water supply shall submit an application on a form prescribed by the Director with the fee required by R12-15-103(C) and provide the following:
  1. The applicant's current demand;
  2. The applicant's committed demand;
  3. The applicant's projected demand for the proposed term of the designation;
  4. If the applicant is seeking a reduction in the estimated water demand because gray water reuse systems will be installed, sufficient information for the Director to determine the appropriate reduction in demand;
  5. The proposed term of the designation, which shall not be less than two years;
  6. Evidence that the criteria in subsection (E) are met; and
  7. Any other information that the Director determines is necessary to decide whether an assured water supply exists for the municipal provider.
- B. An application for a designation shall be signed by:
  1. If the applicant is a city or town, the city or town manager or a person employed in an equivalent position. The application shall also include a resolution of the governing body of the city or town, authorizing that person to sign the application; or
  2. If the applicant is a private water company, the applicant's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant.
- C. The Director shall give public notice of an application for designation in the same manner as provided for certificates in A.R.S. § 45-578. For an application to modify a designation of assured water supply to which subsection (G) applies, the physical availability of the groundwater and stored water to be recovered outside the area of impact of storage sought to be included in the designation shall not be grounds for an objection.
- D. After a complete application is submitted, the Director shall review the application and associated evidence to determine:
  1. The annual volume of water physically, continuously, and legally available for at least 100 years;



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2. The term of the designation, which shall not be less than two years;
  3. The applicant's estimated water demand. If the applicant demonstrates that gray water reuse systems will be installed, the Director shall reduce the estimated water demand for the subdivision by the volume the Director determines is likely to be saved through the gray water reuse systems;
  4. The applicant's groundwater allowance; and
  5. Whether the applicant has demonstrated compliance with all requirements in subsection (E).
- E.** The Director shall designate the applicant as having an assured water supply if the applicant demonstrates all of the following:
1. Sufficient supplies of water are physically available to meet the applicant's estimated water demand, according to the criteria in R12-15-716 or as provided in subsection (G), (H) or (I) of this Section;
  2. Sufficient supplies of water are continuously available to meet the applicant's estimated water demand, according to the criteria in R12-15-717;
  3. Sufficient supplies of water are legally available to meet the applicant's estimated water demand, according to the criteria in R12-15-718;
  4. The proposed sources of water are of adequate quality, according to the criteria in R12-15-719;
  5. The applicant has the financial capability to construct adequate delivery, storage, and treatment works in a timely manner according to the criteria in R12-15-720;
  6. Any proposed groundwater use is consistent with the management plan in effect at the time of the application, according to the criteria in R12-15-721; and
  7. Any proposed use of groundwater withdrawn within an AMA is consistent with the management goal, according to the criteria in R12-15-722.
- F.** The Director shall review an application for a designation of assured water supply pursuant to the licensing time-frame provisions in R12-15-401.
- G.** For an application seeking to modify a designation of assured water supply that does not include a volume of groundwater or stored water recovered outside the area of impact pursuant to subsection (H) or (I) of this Section, the Director shall not review the physical availability of the volume of groundwater and stored water to be recovered outside the area of impact sought to be included in the designation if the total volume of those sources sought to be included in the designation does not exceed the total volume of those sources included in the previous designation of assured water supply that are required to be accounted for pursuant to A.A.C. R12-15-716(B)(3)(c)(ii), minus the sum of the following:
1. The volume of groundwater withdrawn by the applicant since the previous designation of assured water supply order issuance date; and
  2. The volume of stored water recovered outside the area of impact by the applicant since the previous designation of assured water supply order issuance date.
- H.** For a new application for a designation of assured water supply in the Phoenix and Pinal Active Management Areas, a volume of groundwater and stored water recovered outside the area of impact, as calculated in subsection (H)(1), (2) and (3) of this Section, shall be deemed physically available if the Director determines that a New Alternative Water Supply included in the application meets the requirements in R12-15-716 through R12-15-720. The volume of groundwater and stored water recovered outside the area of impact shall be calculated as follows:
1. Add the total volume of groundwater withdrawn and stored water recovered outside the area of impact within the service area of applicant during the calendar year 2023 to the estimated groundwater and stored water recovered outside the area of impact demand for unbuilt portions of issued certificates of assured water supply as of 2023 that are or will be within the service area of the applicant, and multiply the sum by 100;
  2. Multiply 25 percent of each New Alternative Water Supply included in the designation by 100; and
  3. Subtract the total volume calculated in subsection (H)(2) of this Section from the total volume calculated in subsection (H)(1).
  4. The Director shall use the annual report submitted by the municipal provider for calendar year 2023, as verified by the Director, for purposes of this calculation.
- I.** For an application seeking to modify a designation of assured water supply that includes a volume of groundwater and stored water recovered outside the area of impact pursuant to subsection (H) of this Section, the following apply:
1. The 100-year volume calculated pursuant to subsection (H) of this Section shall be reduced by the volume of groundwater withdrawn and stored water recovered outside the area of impact by the applicant since the previous designation order issuance date; and
  2. The 100-year volume calculated pursuant to subsection (H) of this Section shall be further reduced by 25 percent of the 100-year volume of each New Alternative Water Supply included in any modified designation but not included in the previous designation.
- J.** The Director shall not include any additional sources of groundwater withdrawn from the AMA or stored water recovered outside the area of impact in the AMA in a designation of assured water supply that includes a volume of groundwater and stored water recovered outside the area of impact pursuant to subsection (H) or (I) of this Section.
- K.** An applicant that includes a volume of groundwater or stored water recovered outside the area of impact pursuant to subsection (H) or (I) of this Section must be enrolled as a member service area with the CAGR.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Amended by final expedited rulemaking at 28 A.A.R. 909 (May 6, 2022), with an immediate effective date of April 11, 2022 (Supp. 22-2). Amended by final rulemaking at 30 A.A.R. 3751 (December 13, 2024), with an immediate effective date of November 25, 2024 (Supp. 24-4).

**R12-15-711. Designation of Assured Water Supply; Annual Report Requirements, Review, Modification, Revocation**

- A.** A designated provider shall include in the annual report required by A.R.S. § 45-632 the following information for the preceding calendar year:
1. The designated provider's committed demand;

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2. The demand at build-out for customers with which the designated provider has entered into an agreement to serve water, other than committed demand;
  3. A report regarding the designated provider's compliance with water quality requirements;
  4. The depth-to-static water level of all wells from which the designated provider withdrew water; and
  5. Any other information the Director may reasonably require to determine whether the designated provider continues to meet the criteria for a designation of assured water supply.
- B.** If there is a change of ownership, the subsequent owner of a designated provider shall notify the Director in writing of the change in ownership within 90 days.
- C.** The Director shall review a designation at least every 15 years following issuance of the designation to determine whether the designation should be modified or revoked. To determine whether the designation should be modified or revoked, the Director shall use the standards in place at the time of review.
- D.** The Director may modify a designation for good cause, including a merger, division of the designated provider, or a change in ownership of the designated provider. A designation that includes a volume of groundwater pursuant to R12-15-710(H) or (I) shall be for an initial term of no greater than 15 years.
- E.** A designated provider may request a modification of the designation at any time pursuant to R12-15-710.
- F.** The Director may revoke a designation if:
1. After notifying the designated provider and initiating a review of the designated provider's status, the Director determines that the designated provider has less water, according to the criteria in R12-15-710(E), than the amount required for a 100-year supply for the provider's:
    - a. Current demand,
    - b. Committed demand, and
    - c. Projected demand during the next two calendar years;
  2. The designated provider fails to construct adequate delivery, storage, and treatment works in a timely manner;
  3. ADEQ or another governmental entity with equivalent jurisdiction has determined, after notice and an opportunity for a hearing, that the designated provider is in significant noncompliance with A.A.C. Title 18, Chapter 4 and is not taking action to resolve the noncompliance; or
  4. The designated provider has violated its management plan requirements for two or more consecutive calendar years, and one of the following applies:
    - a. The provider fails to amend its water use plan in a manner that the Director determines will achieve compliance, or
    - b. The provider fails to sign a stipulated agreement to remedy the violation.
- G.** If the Director determines that a designation of assured water supply should be revoked, the Director shall provide for an administrative hearing, in accordance with A.R.S. Title 41, Chapter 6, Article 10.
- H.** If a designated provider's designated status terminates, the provider may apply for re-designation at anytime after termination.
- I.** Notwithstanding any other provision in this Article, a decision and order of the Director designating a city, town, or private water company as having an assured water supply is not affected by this Article solely because the rule numbers cited

in the decision and order may have changed after the effective date of the decision and order.

- J.** During the term of the designation, a designated provider may request an expedited modification of the designation to include additional water supplies that do not include groundwater or stored water recovered outside the area of impact from an AMA. The Director shall review only the following for an expedited modification under this subsection:
1. The proposed current, committed and projected demands under the current term of the designation; and
  2. The assured water supply requirements for the additional water supply pursuant to R12-15-710(I), if applicable, and R12-15-716 through R12-15-722.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

Amended by final rulemaking at 30 A.A.R. 3751 (December 13, 2024), with an immediate effective date of November 25, 2024 (Supp. 24-4).

**R12-15-712. Analysis of Adequate Water Supply**

- A.** A person proposing to develop land outside an AMA that will not be served by a designated provider may apply for an analysis of adequate water supply before applying for a water report. An applicant for an analysis must be the owner of the land that is the subject of the application or have the written consent of the owner. The commissioner of the Arizona State Land Department may apply for an analysis for land owned by the state of Arizona outside an AMA or may consent to the inclusion of such land in an application.
- B.** An applicant for an analysis shall submit an application on a form prescribed by the Director with the initial fee required by R12-15-103(C), and attach the following:
1. A title report, condition of title report, limited search title report, or recorded deed, dated within 90 days of the date the application is submitted to the Director, demonstrating the ownership of the land that is the subject of the application;
  2. A description of the development, including:
    - a. A map of the land uses included in the development,
    - b. A list of water supplies proposed to be used by the development,
    - c. A summary of land use types included in the development, and
    - d. An estimate of the water demand for the land uses included in the development; and
  3. Evidence that the applicant has complied with subsection (E) of this Section.
- C.** An applicant shall sign the application for an analysis. If an applicant is not a natural person, the applicant's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant shall sign the application. If the applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the land that is the subject of the water report, the authorized representative may sign the application on the applicant's behalf.
- D.** After a complete application is submitted, the Director shall determine the estimated water demand of the development.
- E.** The Director shall issue an analysis if an applicant demonstrates one or more of the following:

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1. Sufficient supplies of water are physically available to meet all or part of the estimated water demand of the development for 100 years, according to the criteria in R12-15-716;
  2. Sufficient supplies of water are continuously available to meet the estimated water demand of the development for 100 years, according to the criteria in R12-15-717;
  3. Sufficient supplies of water are legally available to meet the estimated water demand of the development for 100 years, according to the criteria in R12-15-718;
  4. The proposed sources of water are of adequate quality, according to the criteria in R12-15-719.
- F.** For 10 years after the Director issues an analysis, or a longer period allowed under subsections (H) or (I) of this Section:
1. If groundwater is a source of supply in the analysis and the applicant demonstrates that groundwater is physically available under subsection (E)(1), the Director shall consider that supply of groundwater reserved for the use of the proposed development in subsequent determinations of physical availability pursuant to R12-15-716(B).
  2. If an analysis holder applies for a water report for a subdivision located on land included in the analysis, the Director shall presume that a criterion demonstrated in the analysis remains satisfied with respect to the subdivision, unless the Director has received new evidence demonstrating that the criterion is not satisfied. If the Director issues the water report, the Director shall reduce the volume of groundwater reserved pursuant to subsection (F)(1) of this Section by the amount of the estimated water demand for the water report that will be met with groundwater.
- G.** The Director shall reduce the amount of water considered reserved for use of the development upon request by the analysis holder. If the analysis holder requesting a reduction is not the person to whom the analysis was issued, the Director shall reduce the amount of reserved groundwater only if the person to whom the analysis was issued or that person's designee consents to the request for reduction. The person to whom the analysis was issued shall notify the Director in writing of the person's designee for purposes of this subsection.
- H.** The analysis holder may apply to the Director for a five-year extension of the time period in subsection (F) of this Section by submitting an application on a form prescribed by the Director no earlier than 36 months before the end of the time period and no later than 30 days before the end of the time period. If an extension is granted, the analysis holder may apply to the Director for an additional five-year extension by submitting an application on a form prescribed by the Director no earlier than 36 months before the end of the extended time period and no later than 30 days before the end of the extended time period. The Director shall extend the time period for no more than two successive five-year periods under this subsection if the analysis holder demonstrates one of the following:
1. The analysis holder has made a substantial capital investment in developing the land included in the analysis.
  2. The analysis holder has made material progress in developing the land included in the analysis.
  3. Progress in developing the land included in the analysis has been delayed for reasons outside the control of the analysis holder.
- I.** After the Director grants two five-year extensions pursuant to subsection (H) of this Section, the Director may extend the time period for additional five-year periods if the analysis holder files a timely application pursuant to subsection (H) of

this Section and demonstrates one of the criteria in subsections (H)(1), (2), or (3) of this Section.

- J.** The Director shall review an application for an analysis or an application for an extension pursuant to subsections (H) or (I) of this Section pursuant to the licensing time-frame provisions in R12-15-401.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-713. Water Report**

- A.** An application for a water report shall be filed by the current owner of the land that is the subject of the application.
- B.** An applicant for a water report shall submit an application on a form prescribed by the Director with the initial fee required by R12-15-103(C), and provide the following:
1. A title report, condition of title report, limited search title report, or recorded deed, dated within 90 days of the date the application is filed and demonstrating that the applicant is the owner of the land that is the subject of the application;
  2. A plat of the subdivision;
  3. An estimate of the 100-year water demand for the subdivision;
  4. A list of all proposed sources of water that will be used by the subdivision;
  5. If the applicant is seeking a finding that the subdivision has an adequate water supply, evidence that the criteria in subsection (E) are met; and
  6. Any other information that the Director reasonably determines is necessary to decide whether an adequate water supply exists for the subdivision.
- C.** Each applicant shall sign the application for a water report. If an applicant is not a natural person, the applicant's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant shall sign the application. If an applicant submits a letter, signed by the applicant and dated within 90 days of the date the application is submitted, authorizing a representative to submit applications for permits regarding the land to be included in the water report, the authorized representative may sign the application on the applicant's behalf.
- D.** After a complete application is submitted, the Director shall review the application and associated evidence to determine:
1. The estimated water demand of the subdivision,
  2. Whether the applicant has demonstrated all of the requirements in subsection (E).
- E.** The Director shall determine that the subdivision has an adequate water supply if the applicant demonstrates all of the following:
1. Sufficient supplies of water are physically available to meet the estimated water demand of the subdivision, according to the criteria in R12-15-716;
  2. Sufficient supplies of water are continuously available to meet the estimated water demand of the subdivision, according to the criteria in R12-15-717;

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3. Sufficient supplies of water are legally available to meet the estimated water demand of the subdivision, according to the criteria in R12-15-718;
  4. The proposed sources of water will be of adequate quality, according to the criteria in R12-15-719;
  5. The applicant has the financial capability to construct adequate delivery, storage, and treatment works for the subdivision according to the criteria in R12-15-720.
- F.** The Director shall issue a water report to the applicant that states whether the applicant has complied with the requirements in subsection (E).
- G.** The Director shall review an application for a water report pursuant to the licensing time-frame provisions in R12-15-401.
- H.** The Director may review or modify a water report if the Director receives new evidence regarding the criteria in subsection (E). The Director shall not modify a water report pursuant to this subsection if any of the residential lots included in the plat have been sold. To determine whether a water report should be modified pursuant to this subsection, the Director shall use the standards in place at the time the original application was submitted for the water report. If the Director modifies a water report, the Director shall:
1. Provide for an administrative hearing pursuant to A.R.S. Title 41, Chapter 6, Article 10; and
  2. Notify the Arizona Department of Real Estate.
- I.** An owner of land that is the subject of a water report may request a modification of the water report at any time by submitting an application in accordance with subsection (B). To determine whether a water report should be modified pursuant to this Section, the Director shall use the standards in place at the time of review.
- J.** A water report is subject to the provisions of R12-15-708.
- K.** An owner of a subdivision that is located within a mandatory adequacy jurisdiction and that will be served Colorado River water by a municipal provider may apply for an exemption from the requirement to obtain an adequate water supply determination from the director or a commitment of water service from a designated provider according to A.R.S. § 45-108.03(A)(1)(b) by submitting an application on a form prescribed by the Director and demonstrating that the criteria in subsection (K)(2) are met. Upon receiving an application according to this subsection, the Director shall:
1. Review the application according to the licensing time frame provisions in R12-15-401.
  2. Determine whether the applicant has demonstrated that all of the following apply:
    - a. Sufficient supplies of water will not be legally available to meet the estimated water demand of the subdivision in a timely manner because the municipal provider will serve Colorado River water to the subdivision and the municipal provider does not currently have the legal right to serve the Colorado River water to the subdivision;
    - b. The municipal provider currently has an entitlement to Colorado River water, according to the criteria in R12-15-718(G);
    - c. The municipal provider will have the legal right to serve the Colorado River water to the subdivision within 20 years;
    - d. An interim water supply will be used to serve the subdivision until the municipal provider has the legal right to serve the Colorado River water to the subdivision and the interim water supply meets all of the criteria in subsection (E), except that the supply will be available for the interim period and not for 100 years; and
  3. If the Director determines that the criteria of subsection (K)(2) are met, issue a letter to the applicant, the platting authority, and the Arizona Department of Real Estate stating that the owner is exempt from the requirement to obtain an adequate water supply determination from the director or a commitment of water service from a designated provider.
- L.** An owner of a subdivision that is located within a mandatory adequacy jurisdiction and that will be served by a water supply project under construction may apply for an exemption from the requirement to obtain an adequate water supply determination from the director or a commitment of water service from a designated provider according to A.R.S. § 45-108.03(A)(1)(a) by submitting an application on a form prescribed by the Director and demonstrating that the criteria in subsection (L)(2) are met. Upon receiving an application according to this subsection, the Director shall:
1. Review the application according to the licensing time frame provisions in R12-15-401.
  2. Determine whether the applicant has demonstrated that all of the following apply:
    - a. Sufficient supplies of water will not be available to meet the estimated water demand of the subdivision in a timely manner because the physical works for delivering water to the subdivision are not complete;
    - b. The physical works for delivering water to the subdivision are under construction and will be completed within 20 years;
    - c. An interim water supply will be used to serve the subdivision until the physical works for delivering water to the subdivision are fully constructed and the interim water supply meets all of the criteria in subsection (E), except that supply will be available for the interim period and not for 100 years; and
    - d. When the physical works for delivering water to the subdivision are fully constructed, the water supply will meet all of the criteria in subsection (E).
  3. If the Director determines that the criteria of subsection (L)(2) are met, issue a letter to the applicant, the platting authority, and the Arizona Department of Real Estate stating that the owner is exempt from the requirement to obtain an adequate water supply determination from the director or a commitment of water service from a designated provider.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2). Amended by final expedited rulemaking at 28 A.A.R. 909 (May 6, 2022), with an immediate effective date of April 11, 2022 (Supp. 22-2).

**R12-15-714. Designation of Adequate Water Supply**

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- A.** A municipal provider applying for a designation of adequate water supply shall submit an application on a form prescribed by the Director with the initial fee required by R12-15-103(C), and the following:
1. The applicant's current demand;
  2. The applicant's committed demand;
  3. The applicant's projected demand for the proposed term of the designation;
  4. The proposed term of the designation, which shall not be less than two years;
  5. Evidence that the criteria in subsection (E) of this Section are met; and
  6. Any other information that the Director determines is necessary to decide whether an adequate water supply exists for the municipal provider.
- B.** A city or town, other than a municipal provider, that is applying for a designation shall submit an application on a form prescribed by the Director with the initial fee required in R12-15-103(C), and provide the following:
1. The current demand of the applicant's service area;
  2. The committed demand of the applicant's service area;
  3. The projected demand of the applicant's service area for the proposed term of the designation;
  4. The proposed term of the designation, which shall not be less than two years; and
  5. Evidence that the requirements in A.R.S. § 45-108(D) are met.
- C.** An application for a designation shall be signed by:
1. If the applicant is a city or town, the city or town manager or a person employed in an equivalent position. The application shall also include a resolution of the governing body of the city or town, authorizing that person to sign the application; or
  2. If the applicant is a private water company, the applicant's authorized officer, managing member, partner, trust officer, trustee, or other person who performs similar decision-making functions for the applicant.
- D.** After a complete application is submitted, the Director shall review the application and associated evidence to determine:
1. The annual volume of water that is physically, continuously, and legally available for at least 100 years;
  2. The term of the designation, which shall not be less than two years;
  3. The estimated water demand for the applicant's service area for 100 years; and
  4. Whether the applicant has demonstrated compliance with all requirements in subsection (E) or (F) of this Section.
- E.** The Director shall designate the applicant has having an adequate water supply pursuant to subsection (A) of this Section if the applicant demonstrates all of the following:
1. Sufficient supplies of water are physically available to meet the applicant's estimated water demand, according to the criteria in R12-15-716;
  2. Sufficient supplies of water are continuously available to meet the applicant's estimated water demand, according to the criteria in R12-15-717;
  3. Sufficient supplies of water are legally available to meet the applicant's estimated water demand, according to the criteria in R12-15-718;
  4. The proposed sources of water are of adequate quality, according to the criteria in R12-15-719; and
  5. The applicant has the financial capability to construct adequate delivery, storage, and treatment works in a timely manner according to the criteria in R12-15-720.
- F.** The Director shall issue a designation pursuant to subsection (B) of this Section if the applicant demonstrates that the requirements of A.R.S. § 45-108(D) are met.
- G.** The Director shall review an application for a designation of adequate water supply pursuant to the licensing time-frame provisions in R12-15-401.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-715. Designation of Adequate Water Supply; Annual Report Requirements, Review, Modification, Revocation**

- A.** By March 31 of each calendar year, a designated provider shall submit the following information for the preceding calendar year on a form provided by the Director:
1. The designated provider's committed demand;
  2. The demand at build-out for customers with which the designated provider has entered into an agreement to serve water, other than committed demand;
  3. A report regarding the designated provider's compliance with water quality requirements;
  4. The depth-to static water level of all wells from which the designated provider withdrew water;
  5. A report regarding volume of water withdrawn, diverted, or received from each source for delivery to customers;
  6. Any other information the Director may reasonably require to determine whether the designated provider continues to meet the criteria for a designation of adequate water supply.
- B.** If there is a change of ownership, the subsequent owner of a designated provider shall notify the Director in writing of the change in ownership within 90 days.
- C.** The Director shall review a designation at least every 15 years following issuance of the designation to determine whether the designation should be modified or revoked.
- D.** The Director may modify a designation for good cause, including a merger, division of the designated provider, or a change in ownership of the designated provider. A designated provider may request a modification of the designation at any time pursuant to R12-15-714. To determine whether the designation should be modified, the Director shall use the standards in place at the time of review.
- E.** The Director may revoke a designation if:
1. After notifying the designated provider and initiating a review of the designated provider's status, the Director determines that the designated provider has less water, according to the criteria in R12-15-714(E), than the amount required for a 100-year supply for the provider's:
    - a. Current demand,
    - b. Committed demand, and
    - c. Projected demand for the next two calendar years;
  2. The designated provider fails to construct adequate delivery, storage, and treatment works in a timely manner; or
  3. ADEQ or another governmental entity with equivalent jurisdiction has determined, after notice and an opportunity for a hearing, that the designated provider is in sig-

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nificant noncompliance with A.A.C. Title 18, Chapter 4 and is not taking action to resolve the noncompliance.

- F. To determine whether the designation should be revoked, the Director shall use the standards in place at the time of review. If the Director determines that a designation of adequate water supply should be revoked, the Director shall provide for an administrative hearing, in accordance with A.R.S. Title 41, Chapter 6, Article 10.
- G. If a designated provider's designated status terminates, the provider may apply for re-designation at anytime after termination.
- H. Notwithstanding any other provision in this Article, a decision and order of the Director designating a city, town, or private water company as having an assured water supply is not affected by this Article solely because the rule numbers cited in the decision and order may have changed after the effective date of the decision and order.

**Historical Head**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-716. Physical Availability**

- A. The volume of a proposed source of water that is physically available to an applicant for a determination of assured water supply or a determination of adequate water supply is the amount determined by the Director to be physically available pursuant to subsections (B) through (L) of this Section.
- B. If the proposed source is groundwater, the applicant shall submit a hydrologic study, using a method of analysis approved by the Director, that accurately describes the hydrology of the affected area. Except as provided in subsection (D) of this Section, the Director shall determine that the proposed volume of groundwater will be physically available for the proposed use if both of the following apply:
  - 1. The groundwater will be withdrawn as follows:
    - a. Except as provided in subsection (B)(1)(b) of this Section, from wells owned by the applicant or the proposed municipal provider that are located within the service area of the applicant or the proposed municipal provider or from proposed wells that the Director determines are likely to be constructed for future uses of the applicant or the proposed municipal provider.
    - b. If the application is for a dry lot development, from wells that the Director determines are likely to be constructed on individual lots.
  - 2. Except as provided in subsection (C) of this Section, the groundwater will be withdrawn from depths that do not exceed the applicable maximum 100-year depth-to-static water level according to the following:

Type and location of development	Maximum 100-year depth-to-static water level
a. Developments in Phoenix, Tucson, or Prescott AMAs, except dry lot developments	1000 feet below land surface
b. Developments in Pinal AMA, except dry lot developments	1100 feet below land surface
c. Developments outside AMAs, except dry lot developments	1200 feet below land surface

d. Dry lot developments	400 feet below land surface
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- 3. The Director shall calculate the projected 100-year depth-to-static water level by adding the following for the area where groundwater withdrawals are proposed to occur:
  - a. The depth-to-static water level on the date of application.
  - b. The projected declines caused by existing uses, using the projected decline in the 100-year depth-to-static water level during the 100-year period after the date of application, calculated using records of declines for the maximum period of time for which records are available up to 25 calendar years before the date of application. If evidence is provided to the Director of likely changes in pumpage patterns and aquifer conditions, as opposed to those patterns and conditions occurring historically, the Director may determine projected declines using a model rather than evidence of past declines.
  - c. The projected decline in the depth-to-static water level during the 100-year period after the date of application, calculated by adding the projected decline from each of the following that are not accounted for in subsection (B)(3)(b) of this Section:
    - i. The estimated water demand of issued certificates and water reports that will be met with groundwater or stored water recovered outside the area of impact of the stored water, not including the demand of subdivided lots included in abandoned plats;
    - ii. The estimated water demand of designations that will be met with groundwater or stored water recovered outside the area of impact of the stored water; and
    - iii. The groundwater reserved for developments for which the Director has issued an analysis pursuant to R12-15-703 or R12-15-712.
  - d. The projected decline in depth-to-static water level that the Director projects will result from the applicant's proposed use over a 100-year period.
- C. The Director shall lower the maximum 100-year depth-to-static water level requirement specified in subsection (B)(2) of this Section for an applicant seeking a determination of adequate water supply if the applicant demonstrates both of the following:
  - 1. Groundwater is available at the lower depth; and
  - 2. The applicant has the financial capability to obtain the groundwater at the lower depth, according to the criteria in R12-15-720.
- D. If the proposed source is groundwater that will be withdrawn from a groundwater basin outside an AMA and transported into an AMA, the Director shall determine that the proposed volume of groundwater will be physically available if both of the following apply:
  - 1. The groundwater will be withdrawn from wells owned by the applicant or the proposed municipal provider or from proposed wells that the Director determines are likely to be constructed for the future uses of the applicant or the proposed municipal provider.
  - 2. Withdrawal of the groundwater will comply with any depth-to-static water level criteria, decline rate criteria, and volume limitation criteria prescribed by statute. If there are no applicable depth-to-static water level criteria prescribed by statute, withdrawal of the groundwater

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shall comply with the depth-to-static water level criteria in subsection (B)(2) of this Section.

- E.** Subject to subsection (L) of this Section, if the proposed source of water is surface water, other than CAP water, or Colorado River water, the Director shall determine the annual volume of water that is physically available for the proposed use, taking into consideration the priority date of the right or claim, by calculating 120% of the firm yield of the proposed source at the point of diversion as limited by the capacity of the diversion works; except that if the applicant demonstrates that an alternative source of water will be physically available during times of shortage in the proposed surface water supply, the Director shall determine the annual volume of water available by calculating 100% of the median flow of the proposed source at the point of diversion as limited by the capacity of the diversion works. The Director shall determine the firm yield or median flow as follows:
1. By calculating the firm yield or median flow at the point of diversion based on at least 20 calendar years of flow records from the point of diversion, unless 20 calendar years of records are unavailable and the Director determines that a shorter period of record provides information necessary to determine the firm yield or median flow; or
  2. By calculating the firm yield or median flow at the point of diversion using a hydrologic model that projects the firm yield or median flow, taking into account at least 20 calendar years of historic river flows, changes in reservoir storage facilities, and projected changes in water demand. The yield available to any applicant may be composed of rights to stored water, direct diversion, or normal flow rights. If the permit for the water right was issued less than five years before the date of application, the Director shall require the applicant to submit evidence, as applicable, in accordance with this subsection.
- F.** Subject to subsection (L) of this Section, if the proposed source of water is CAP water, the Director shall determine the annual volume of water that is physically available for the proposed use as follows:
1. If the applicant or the proposed municipal provider has a non-declining, long-term municipal and industrial subcontract for CAP water, calculate 100% of the annual amount of water established in the subcontract.
  2. If the applicant has a lease for Indian priority CAP water, calculate 100% of the annual amount of water established in the lease.
  3. If the applicant has a subcontract for CAP water other than a non-declining, long-term municipal and industrial subcontract or a lease for Indian priority CAP water:
    - a. If the applicant submits evidence of sufficient backup water supplies, calculate 100% of the annual amount of water established in the subcontract. The applicant may establish backup water supplies by one or more of the following:
      - i. A drought response plan;
      - ii. Long-term storage credits;
      - iii. A contract for water with a multi-county water conservation district; or
      - iv. Evidence of other backup supplies that are physically, continuously, and legally available.
    - b. If the applicant does not submit evidence of sufficient backup water supplies pursuant to subsection (F)(3)(a) of this Section, calculate the percentage of the annual amount of water established in the subcontract that reasonably reflects the reliability of the applicant's CAP water supply.
- G.** Subject to subsection (L) of this Section, if the proposed source of water is Colorado River water, the Director shall determine the annual volume of water that is physically available for the proposed use as follows:
1. If the priority of the contract for Colorado River water provides reliability equal to or better than CAP municipal and industrial water, calculate 100% of the annual amount of water established in the contract.
  2. If the contract for Colorado River water provides reliability that is less than CAP municipal and industrial water:
    - a. If the applicant submits evidence of sufficient backup water supplies, calculate 100% of the annual amount of water in the contract. The applicant may establish backup water supplies by one or more of the following:
      - i. A drought response plan;
      - ii. Long-term storage credits;
      - iii. A contract for water with a multi-county water conservation district; or
      - iv. Evidence of other backup supplies that are physically, continuously, and legally available.
    - b. If the applicant does not submit evidence of sufficient backup water supplies pursuant to subsection (G)(2)(a) of this Section, calculate the percentage of the annual amount of water established in the contract that reasonably reflects the reliability of the applicant's Colorado River water supply.
- H.** Subject to subsection (I) of this Section, if the proposed source of water is effluent, the Director shall determine the annual volume of water that will be physically available by evaluating the current, metered production or the projected production of effluent. The volume of effluent that is physically available shall not include the following:
1. If the effluent will be delivered directly from a wastewater treatment plant, the volume of effluent that exceeds the applicant's estimated water demand that will be met with effluent; and
  2. The volume of effluent that does not comply with any applicable water quality requirements for the proposed use of the effluent.
- I.** If the proposed source of water is stored water to be recovered from recovery wells, the Director shall determine the volume of water that is physically available for the proposed use as follows:
1. If the stored water is represented by long-term storage credits in existence on the date of application, the amount that is physically available is the amount that may be recovered pursuant to the credits in a manner consistent with A.R.S. Title 45, Chapter 3.1, subject to subsection (I)(3) of this Section.
  2. If the applicant proposes to use long-term storage credits that do not exist on the date of application or recover stored water on an annual basis pursuant to A.R.S. § 45-851.01, the Director shall evaluate the following in determining whether to include the proposed credits or the water proposed to be stored and recovered annually in the amount of water that is physically available for the applicant's proposed use:
    - a. The terms of a contract to obtain water to store in a storage facility;
    - b. The physical, continuous, and legal availability of the water proposed to be stored;

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- c. The presence of an existing storage facility that will be available for use for the proposed storage;
  - d. The existence of all required permits of an adequate duration; and
  - e. Whether recovery of the stored water will comply with subsection (I)(3) of this Section.
- 3. If the applicant proposes to recover the stored water from recovery wells located outside the area of impact of storage, the stored water will be considered physically available only if sufficient water exists for the withdrawals consistent with both of the following:
  - a. The maximum 100-year depth-to-static water level requirements established in subsection (B)(2) of this Section; and
  - b. Any criteria for the withdrawals prescribed in the management plan in effect at the time of the application.
- J. If the applicant will obtain the source of water through a water exchange agreement, the Director shall determine that the water is physically available for the proposed use if the applicant submits evidence that the source of water the applicant or the applicant's customers will use will be physically available in accordance with the terms of this Section.
- K. In the case of two or more pending, conflicting, complete and correct applications for determinations of assured water supply or determinations of adequate water supply, the Director shall give priority to the application with the earliest priority date. The priority date of an application for a determination of assured water supply or determination of adequate water supply shall be the date that a complete and correct application is filed with the Director. The Director shall consider an application complete and correct if it contains all the information required and the Director verifies that the information is accurate.
- L. For a certificate applicant that proposes to use surface water, the Director shall determine that the proposed source is physically available only if the applicant demonstrates one of the following:
  - 1. The land that is the subject of the application is a member land of the CAGRD.
  - 2. The applicant has independently obtained the surface water supply.
  - 3. The proposed municipal provider would satisfy the criteria in R12-15-722 if the municipal provider were subject to those requirements.
- C. If the proposed source of water is surface water other than CAP water or Colorado River water, the applicant shall demonstrate that a continuous supply will exist because of one or more of the following:
  - 1. The projected volume to be diverted from the source is perennial at the point of diversion;
  - 2. Adequate storage facilities will be available to the applicant in a timely manner to store water for use when a volume of surface water is not available at the point of diversion to satisfy the applicant's water demands;
  - 3. The applicant has presented evidence of supplies of other sources of water that the Director has determined will be physically, continuously, and legally available to supplement the applicant's proposed surface water supplies;
  - 4. The applicant or the proposed municipal provider will withdraw surface water from wells of sufficient capacity to meet the applicant's estimated water demand on a continuous basis for 100 years; or
  - 5. The applicant has submitted a drought response plan that the Director has determined will conserve or augment a volume of water equal to the volume of water that is subject to drought.
- D. If the proposed source of water is CAP water or Colorado River water, the applicant shall demonstrate that a continuous supply is available because of one or more of the following:
  - 1. Adequate storage facilities will be available to the applicant in a timely manner to store water when a volume of CAP water or Colorado River water is not available to meet the applicant's water demands;
  - 2. The applicant has presented evidence of supplies of other sources of water that the Director has determined will be physically, continuously, and legally available to the applicant to supplement the proposed CAP water or Colorado River water supplies; or
  - 3. The applicant has submitted a drought response plan that the Director has determined will conserve or augment a volume of water equal to the volume subject to drought.
- E. If the proposed source of water is effluent, the applicant shall demonstrate that the capability to use the effluent to meet the demands of the proposed use will not be affected by any fluctuations in the supply of the effluent.
- F. If the proposed source of water is stored water to be recovered from recovery wells, the applicant shall demonstrate that recovery wells of a sufficient capacity will be constructed in a timely manner to serve the proposed use on a continuous basis for 100 years.
- G. If an applicant will obtain the source of water through a water exchange agreement, the applicant shall demonstrate that the source of water the applicant or the applicant's customers will use will be continuously available in accordance with the terms of this Section.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-717. Continuous Availability**

- A. The Director shall determine that an applicant will have sufficient supplies of water that will be continuously available for 100 years if the applicant submits sufficient evidence that adequate delivery, storage, and treatment works will be in place in a timely manner to make the water available to the applicant or the applicant's customers for 100 years and the applicant meets any applicable requirements in subsections (B) through (G) of this Section.
- B. If the proposed source of water is groundwater, the applicant shall demonstrate that wells of a sufficient capacity will be constructed in a timely manner to serve the proposed uses on a continuous basis for 100 years.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Amended by emergency rulemaking at 11 A.A.R. 2706, effective June 29, 2005 for 180 days (Supp. 05-2). Emergency renewed for 180 days at 12 A.A.R. 144, effective December 23, 2005 (Supp. 05-4). Emergency expired. Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-718. Legal Availability**

- A. The Director shall determine that an applicant will have sufficient supplies of water that will be legally available for at least



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100 years if the applicant submits all of the applicable information required by this Section.

**B.** If the applicant is an applicant for a certificate or a water report, the applicant shall submit the following, as applicable:

1. A Notice of Intent to Serve agreement between the owner of the land to be included in the subdivision and the proposed municipal provider, stating the proposed municipal provider's intent to serve the subdivision;
2. If the proposed municipal provider is a city or town, evidence indicating that the proposed subdivision is located within the incorporated limits of the city or town or evidence of the legal right of the city or town to serve water to the subdivision outside the city or town's incorporated limits; or
3. If the proposed municipal provider is a private water company, one of the following:
  - a. Evidence that the proposed municipal provider has a certificate of convenience and necessity approved by the Arizona Corporation Commission and the subdivision is located within the geographic area described in the certificate of convenience and necessity or any other area in which the Arizona Corporation Commission authorizes the private water company to serve water;
  - b. Evidence that the proposed municipal provider has an order preliminary issued by the Arizona Corporation Commission authorizing the municipal provider to provide water service and the proposed subdivision is located within the area described in the order preliminary; or
  - c. Evidence that the proposed municipal provider is not a public service corporation regulated by the Arizona Corporation Commission.

**C.** If the applicant is a private water company applying for a designation, the applicant shall submit evidence that the applicant has a certificate of convenience and necessity approved by the Arizona Corporation Commission, or has been issued an order preliminary by the Arizona Corporation Commission for a certificate of convenience and necessity, authorizing the applicant to serve the proposed use.

**D.** If a proposed source of water is groundwater to be withdrawn within an AMA, the applicant shall submit evidence that the applicant or the proposed municipal provider has one or more of the following:

1. A service area right;
2. An applicable non-irrigation grandfathered right to withdraw groundwater, in an amount sufficient to serve the proposed use; or
3. A pending notice of intent to establish a new service area and all of the following apply:
  - a. The notice of intent to establish a new service area identifies the proposed subdivision,
  - b. The applicant or the proposed municipal provider has obtained a permit for any wells used to establish the service area right,
  - c. The proposed municipal provider has obtained a water right or recovery well permit to establish the service area right, and
  - d. The water right is of sufficient volume and duration to meet the estimated water demand of the proposed subdivision until the anticipated date of issuance of a service area right.

**E.** If a proposed source of water is surface water other than CAP water or Colorado River water:

1. The applicant shall submit evidence that the applicant or the proposed municipal provider has a certificated surface water right, decreed water right, or a pre-1919 claim for the proposed source. If the applicant or the proposed municipal provider does not hold a surface water right or claim, but will receive water pursuant to a water right or claim that is appurtenant to the land that is the subject of the application, the applicant shall submit evidence of the water right or claim and evidence that the water right or claim may neither be legally withheld nor severed and transferred by the right holder or claimant.
  2. If the certificated surface water right or decreed water right pre-dates the date of application by at least five years, or the applicant submits a pre-1919 claim, the applicant shall submit one of the following:
    - a. Evidence that the surface water supply has been used pursuant to the applicable water right or claim within the five years before the date of application;
    - b. Evidence that a court has determined that the right has not been abandoned; or
    - c. Evidence that the non-use would not have resulted in an abandonment of the right pursuant to A.R.S. § 45-189.
  3. The Director shall determine that the volume of water that is legally available pursuant to a certificated surface water right, a decreed water right, or a pre-1919 claim is equal to the face value of the right or claim. If the right or claim is subsequently adjudicated, the Director shall determine the volume of water that is legally available based on the adjudicated amount of water.
- F.** Subject to subsections (M) and (N) of this Section, if a proposed source of water is CAP water, the applicant shall submit evidence that the applicant or the proposed municipal provider has entered into a subcontract with a multi-county water conservation district for the proposed volume of CAP water. The Director shall presume that a 50-year long-term, non-declining municipal and industrial subcontract is sufficient evidence of the legal availability of the volume of CAP water specified in the subcontract for 100 calendar years.
- G.** Subject to subsections (M) and (N) of this Section, if a proposed source of water is Colorado River water, the applicant shall submit evidence of one of the following:
1. The applicant or the proposed municipal provider has a contract with the United States Secretary of the Interior for the proposed supply; or
  2. The applicant has obtained an allocation of Colorado River water from an entity to which all of the following apply:
    - a. The entity holds a contract for Colorado River water with the United States Secretary of the Interior;
    - b. The entity provides Colorado River water to the proposed municipal provider;
    - c. The entity has allocated a sufficient volume of the Colorado River water to the subdivision; and
    - d. The area that the entity may serve, described in the contract with the United States Secretary of the Interior, includes the subdivision.
- H.** If a proposed source of water is effluent, the applicant shall submit evidence that the applicant or the proposed municipal provider has the legal right to use the effluent.
- I.** If the applicant will obtain a proposed source of water through a written contract other than a water exchange agreement, a contract between a certificate applicant and the municipal provider proposed to serve the applicant, a contract with the

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United States Secretary of the Interior for Colorado River water, or a subcontract with a multi-county water conservation district, the applicant shall submit evidence that the person providing the water under the contract has a legal right to the water in accordance with the terms of this Section and that the terms of the contract will ensure that the proposed source of water will be delivered to the applicant or to the proposed subdivision. The Director shall determine the term of years for which the proposed source of water is legally available based on the term of years remaining in the contract. The Director shall determine the quantity of water legally available based on the volume established in the contract.

- J. If the applicant will obtain a proposed source of water through a water exchange agreement, the applicant shall submit evidence that the water exchange agreement satisfies the requirements of A.R.S. Title 45, Chapter 4.
- K. If the Director can determine the proposed source of water to be physically and continuously available only because of the use of storage facilities by the applicant or by the proposed municipal provider, the applicant shall submit evidence of the applicant's or the proposed municipal provider's legal right to store water in the storage facilities.
- L. If the applicant proposes to use long-term storage credits, the applicant shall submit evidence that the applicant or the proposed municipal provider has the legal right to use the credits under A.R.S. Title 45, Chapter 3.1.
- M. If a proposed supply of water is Colorado River water or CAP water leased from an Indian community, the applicant shall submit evidence that the water leased has a priority equal to or higher than CAP municipal and industrial water, evidence that the Indian community is expressly authorized by an Act of Congress to lease the water for use off Indian community lands, evidence of the lease, and evidence of one of the following:
  - 1. The proposed water supply is available under the lease for at least 100 years from any time during the year in which the applicant submits the application.
  - 2. The term of the lease has less than 100 years remaining in the year in which the applicant submits the application and a supplemental water supply, together with the leased water, provides a 100-year water supply. The applicant shall demonstrate that the supplemental water supply is physically, continuously, and legally available and, if such supplemental supply is groundwater, that use of the groundwater is consistent with the management goal of the AMA. If the supplemental supply is water recovered through the use of long-term storage credits, the applicant shall also submit the following, as applicable:
    - a. If the applicant is to use the long-term storage credits before the beginning of the lease term, evidence that the applicant or the proposed municipal provider has obtained a recovery well permit that allows the applicant or the proposed municipal provider to recover water pursuant to the long-term storage credits; or
    - b. If the long-term storage credits will be accrued in the future, evidence that the applicant or the proposed municipal provider will accrue the long-term storage credits within 20 years after the effective date of the designation, certificate, or water report by storing the water under an issued water storage permit at a permitted storage facility and that no more than 20 years of the applicant's supplemental water supply will be provided by the long-term storage credits.

- N. If the Director previously determined that Colorado River water or CAP water leased from an Indian community was legally available to a designated provider for 100 years, the Director shall determine that the designated provider continues to have a legally available supply of water for 100 years for the annual amount of water available under the lease if:
  - 1. The lease has at least 50 years remaining in its term or the lease has at least 40 years remaining in its term and the designated provider submits evidence to the Director of active and ongoing negotiations with the Indian community to renew or re-negotiate the lease; and
  - 2. One of the following applies:
    - a. No more than 15% of the total water supplies that the designated provider establishes as physically, continuously, and legally available during any year are obtained through leases with Indian communities;
    - b. Groundwater will be physically, continuously, and legally available to the designated provider at the end of the lease term to substitute for the leased water for the remainder of the 100-year period, and the projected use of groundwater is consistent with the management goal of the AMA. For purposes of this subsection, the designated provider may demonstrate that the proposed use is consistent with the management goal by entering into a written agreement with the Director under which the designated provider agrees to replace through replenishment or underground storage any groundwater used at the end of the lease term if groundwater use is not consistent with the management goal. The written agreement shall provide that specific performance is the only remedy in the event of default;
    - c. A non-groundwater source of water will be physically, continuously, and legally available at the end of the lease term to substitute for the leased water for the remainder of the 100-year period; or
    - d. The designated provider's governing board or council submits a resolution requesting that the designated provider be allowed to increase its projected use of Indian lease water from 15%, as allowed by subsection (N)(2)(a) of this Section, to 20%, and the Director finds that all of the following apply:
      - i. No more than 20% of the total water supplies that the designated provider establishes as physically, continuously, and legally available during any year are obtained through leases with Indian communities;
      - ii. No more than 15% of the total water supplies that the designated provider establishes as physically, continuously, and legally available during any year are obtained through any single lease with an Indian community; and
      - iii. The designated provider does not meet the requirements of subsections (N)(2)(a), (b), or (c) of this Section.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-719. Water Quality**

- A. Except as provided in subsection (B) of this Section, when reviewing an application for a determination of assured water

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supply or a determination of adequate water supply, the Director shall determine that the water supply is of adequate quality if one of the following applies:

1. The applicant certifies on the application that the applicant or the proposed municipal provider will be regulated by ADEQ, or another governmental entity with equivalent jurisdiction, as a public water system pursuant to A.R.S. § 49-351, et seq., unless ADEQ, or another governmental entity with equivalent jurisdiction, has determined, after notice and an opportunity for a hearing, that the public water system is in significant noncompliance with A.A.C. Title 18, Chapter 4 and is not taking action to resolve the noncompliance; or
  2. The applicant has submitted results of a lab analysis demonstrating that the water meets water quality requirements in accordance with A.A.C. Title 18, Chapter 4, or that the water will meet these requirements after treatment that is required by law. The lab analysis shall be based on water withdrawn from a well representative of the well or wells from which water will be withdrawn for the proposed use, conducted in compliance with sample collection and analysis requirements in A.A.C. Title 18, Chapter 4, and completed within 60 days of the date the application is submitted to the Director. If ADEQ waives any of the water quality or sample collection and analysis requirements in A.A.C. Title 18, Chapter 4, the Director shall not require the applicant to meet the waived requirements.
- B.** If a well or a proposed well from which water will be withdrawn for the proposed use is located within one mile of a WQARF site or Superfund site, the Director shall determine that the water supply is of adequate quality only if the applicant submits a contaminant migration and mitigation analysis, demonstrating that the water supply will continue to meet the requirements in A.A.C. Title 18, Chapter 4 for 100 years. The contaminant migration and mitigation analysis may include the impact of any mitigation or treatment, including mitigation or treatment required pursuant to a consent decree.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-720. Financial Capability**

- A.** The Director shall determine that an applicant for a certificate or a water report has the financial capability to construct adequate delivery, storage, and treatment works if the applicant demonstrates one or more of the following:
1. The applicant will submit its final plat to a qualified platting authority;
  2. The applicant has constructed adequate delivery, storage, and treatment works, and water service is available to each lot; or
  3. The applicant has posted a performance bond with the platting authority for the entire cost of adequate delivery, storage, and treatment works.
- B.** Upon receiving evidence that a platting authority has established standards for proof of financial capability to construct adequate delivery, storage, and treatment works, pursuant to A.R.S. § 9-463.01(C)(8) or A.R.S. § 11-806.01(G), the Director shall classify the platting authority as a qualified platting authority. The Director shall maintain a list of qualified platting authorities.

- C.** The Director shall determine that an applicant for a designation has the financial capability to construct adequate delivery, storage, and treatment works if the applicant demonstrates one or more of the following for each of those facilities:
1. The applicant has constructed adequate delivery, storage, and treatment works;
  2. The applicant has entered into written agreements requiring a potential developer to construct adequate delivery, storage, and treatment works;
  3. The applicant has submitted evidence demonstrating that financing mechanisms are in place to construct adequate delivery, storage, and treatment works in a timely manner;
  4. If the applicant is a city or town, the applicant has adopted a five year capital improvement plan that provides for the construction, or the commencement of construction, of adequate delivery, storage, and treatment works in a timely manner, and has submitted a certification by the applicant's chief financial officer that finances are available to implement that portion of the five-year plan; or
  5. If the applicant is a private water company, the applicant has received approval from the Arizona Corporation Commission for financing the construction of adequate delivery, storage, and treatment works.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by final rulemaking at 30 A.A.R. 3751 (December 13, 2024), with an immediate effective date of November 25, 2024 (Supp. 24-4).

**R12-15-721. Consistency with Management Plan**

- A.** The Director shall determine whether a designation applicant's projected use of groundwater withdrawn within an active management area is consistent with the management plan as follows:
1. If the applicant is providing water to customers as of the date of application, the applicant's projected water use is consistent with the management plan if either of the following apply:
    - a. The applicant is in compliance with its applicable management plan requirements in the most recent calendar year for which data is available before the date of application; or
    - b. The applicant has signed a stipulation and consent order that is in effect on the date of the application, or that becomes effective during the time of review of the application, to remedy non-compliance with the management plan requirements and the applicant is in compliance with the terms of the stipulation and consent order.
  2. If the applicant has not commenced serving water to customers as of the date of application, the applicant shall submit a water use plan that demonstrates to the Director that compliance with management plan requirements will be achieved through the use of conservation or augmentation measures.
  3. If the applicant has a pending request for an administrative review or variance from its management plan requirements, the Director shall not make a finding regarding compliance with this Section until the Director

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has issued a final decision and order on the request or the request has been withdrawn.

- B.** The Director shall determine that a certificate applicant's projected use of groundwater withdrawn within an AMA is consistent with the management plan if the applicant submits a water use plan for the subdivision that includes both of the following:
1. Information demonstrating that compliance with management plan requirements will be achieved through conservation or augmentation measures; and
  2. All information required to calculate the water requirements for each proposed water use.
- C.** A certificate applicant for a subdivision of 50 or fewer lots is exempt from the requirements of this rule.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-722. Consistency with Management Goal**

- A.** For the Phoenix, Prescott, or Tucson AMAs, the Director shall calculate the volume of groundwater that may be used consistent with the management goal of the AMA in which the proposed use is located for at least 100 years by adding the following:
1. The amount of the groundwater allowance, according to R12-15-724(A), R12-15-726(A), or R12-15-727(A).
  2. The amount of any extinguishment credits pledged to the certificate or designation, according to R12-15-724(B), R12-15-726(B), or R12-15-727(B).
  3. Any groundwater that is consistent with the achievement of the management goal pursuant to A.R.S. Title 45, Chapter 2.
- B.** The Director shall determine that a proposed groundwater use in the Phoenix, Prescott, or Tucson AMA is consistent with the management goal of the AMA if the volume calculated in subsection (A) is equal to or greater than the portion of the applicant's estimated water demand to be met with groundwater.
- C.** For a certificate in the Pinal AMA, the Director shall calculate the volume of groundwater that may be used consistent with the management goal of the AMA for at least 100 years by adding the following:
1. The amount of the groundwater allowance, according to R12-15-725(A)(1).
  2. The amount of any extinguishment credits pledged to the certificate for a grandfathered right that was extinguished on or after January 1, 2019, according to R12-15-725(B), except that annual reported use of such extinguishment credits to make groundwater use consistent with the management goal is limited to the following percentages of groundwater use from the sixth year after certificate issuance:

Years After Certificate Issuance	Percentage of Total Groundwater Use that May Be Made Consistent with the Pinal AMA Management Goal with Extinguishment Credits Pledged to Certificate
Years Six through Ten	75%
Years Eleven through Fifteen	50%
Years Sixteen through Twenty	25%

Years Twenty-one and After	0%
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3. The amount of any extinguishment credits pledged to the certificate for a grandfathered right that was extinguished on or after October 1, 2007 and before January 1, 2019.
  4. The amount of any extinguishment credits pledged to the certificate for a grandfathered right that was extinguished before October 1, 2007. The Director shall calculate the amount of the extinguishment credits by multiplying the annual amount of the credits by 100.
  5. Any groundwater that is consistent with achievement of the management goal pursuant to A.R.S. Title 45, Chapter 2.
- D.** For a certificate in the Pinal AMA, the Director shall determine that the proposed groundwater use is consistent with the management goal of the AMA if the volume calculated in subsection (C) is equal to or greater than the portion of the applicant's estimated water demand to be met with groundwater.
- E.** For a designation in the Pinal AMA, the Director shall calculate the volume of groundwater that may be used consistent with the management goal of the Pinal AMA on an annual basis for at least 100 years by adding the following for each year during the 100-year period:
1. The amount of the groundwater allowance, according to R12-15-725(A)(2). If any of the groundwater allowance is not used during a year, the unused groundwater allowance shall not be added to the volume calculated under this subsection for the following year.
  2. The amount of any extinguishment credits pledged to the designation for a grandfathered right that was extinguished on or after January 1, 2019, divided by the number of years remaining in which the credits may be used pursuant to R12-15-725(B). These credits shall be included in the calculation only for those years in which the credits may be used. If any of the extinguishment credits were originally pledged to a certificate and are being used to support the municipal provider's designation pursuant to R12-15-723(G)(2), the extinguishment credits shall not be limited by the percentages in subsection (C)(2) of this section.
  3. The amount of any extinguishment credits pledged to the designation for a grandfathered right that was extinguished on or after October 1, 2007 and before January 1, 2019, divided by 100. Extinguishment credits for a grandfathered right that was extinguished on or after October 1, 2007 and before January 1, 2019 may be used in any year.
  4. The annual amount of any extinguishment credits pledged to the designation for a grandfathered right that was extinguished before October 1, 2007. The following shall apply if any of the extinguishment credits are not used during a calendar year:
    - a. If the extinguishment credits were pledged to the designation before October 1, 2007, any extinguishment credits not used during a calendar year shall be added to the volume calculated under this subsection for the following calendar year.
    - b. If the extinguishment credits are pledged to the designation on or after October 1, 2007, any of the extinguishment credits not used during a calendar year shall not be added to the volume calculated under this subsection for the following calendar year, except that if the extinguishment credits were originally pledged to a certificate before October 1, 2007 and are used to support the municipal pro-

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vider's designation pursuant to R12-15-723(G)(2), any of the extinguishment credits not used during a calendar year shall be added to the volume calculated under this subsection for the following calendar year.

5. Any groundwater that is consistent with the achievement of the management goal pursuant to A.R.S. Title 45, Chapter 2.
- F. For a designation in the Pinal AMA, the Director shall determine that the proposed groundwater use is consistent with the management goal of the Pinal AMA if the volume calculated in subsection (E) for each year during the 100-year period is equal to or greater than the portion of the applicant's annual estimated water demand to be met with groundwater.
- G. Upon application, the following volumes of groundwater used by an applicant are considered consistent with the management goal:
  1. If the Director determines that a surface water supply is physically available under R12-15-716 and the volume of the supply actually available during a calendar year is equal to or less than the drought volume for the supply, the volume of groundwater, other than the groundwater that is accounted for under subsection (A), (C), or (E), withdrawn within the AMA that, when combined with the available surface water supply, is equal to or less than the drought volume.
  2. Any volume of groundwater withdrawn within a portion of an AMA that is exempt from conservation requirements under A.R.S. Title 45 due to waterlogging. The Director shall review the application of this exclusion on a periodic basis, not to exceed 15 years.
  3. Remedial groundwater that is consistent with the management goal according to the requirements of R12-15-729.
- H. An applicant for a certificate of assured water supply for a dry lot subdivision of 20 lots or fewer is exempt from the requirements of this Section.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 1394, effective October 1, 2007 (Supp. 07-2). Amended by final rulemaking at 24 A.A.R. 3578, effective January 1, 2019 (Supp. 18-4). At the request of the Department R12-15-722(A)(2) through (5) have been removed since they were not part of the amendments made to this Section in Supp. 18-4; subsections R12-15-722(A)(2) through (3) as amended at 13 A.A.R. 1394 have been restored (Supp. 19-2).

**R12-15-723. Extinguishment Credits**

- A. Except as provided in subsection (D), the owner of a grandfathered right may extinguish the right in exchange for extinguishment credits by submitting the following:
  1. A notarized statement of extinguishment of a grandfathered right on a form provided by the Director;
  2. The grandfathered right number;
  3. If the right being extinguished is a Type 1 non-irrigation grandfathered right or an irrigation grandfathered right, evidence of ownership of the land to which the grandfathered right is appurtenant;
  4. If the grandfathered right is located in the Prescott AMA, evidence that all of the following conditions are met:
    - a. The land to which the right is appurtenant has not been and will not be subdivided pursuant to a preliminary plat or a final plat that was approved by a city, town, or county before August 21, 1998; and
    - b. The land to which the right is appurtenant is not and will not be the location of a subdivision for which a complete and correct application for a certificate of assured water supply was submitted to the Director before August 21, 1998;
5. If the right being extinguished is an irrigation grandfathered right, evidence that the development of the land to which the right is appurtenant is not completed; and
6. Any additional information the Director may reasonably require to process the extinguishment.
- B. The Director shall calculate the amount of extinguishment credits pursuant to R12-15-724(B), R12-15-725(B), R12-15-726(B) or R12-15-727(B). The Director shall notify the owner of the amount of extinguishment credits in writing. If the owner is extinguishing only a portion of the right, the Director shall issue a new certificate of grandfathered right for the remainder of the right.
- C. A Type 1 non-irrigation grandfathered right or an irrigation grandfathered right may be extinguished in whole or in part. A Type 2 non-irrigation grandfathered right may be extinguished only in whole.
- D. The following rights may not be extinguished in exchange for extinguishment credits:
  1. An irrigation grandfathered right that is appurtenant to land that has been physically developed for a non-irrigation use. The Director shall not consider the land to be physically developed until the development is completed.
  2. A Type 1 non-irrigation grandfathered right, if the Director determines that the holder is likely to continue to receive groundwater from an undesignated municipal provider for the same use pursuant to the provider's service area right or pursuant to a groundwater withdrawal permit.
  3. A Type 2 non-irrigation grandfathered right that was issued based on the withdrawal of groundwater for mineral extraction or processing or for the generation of electrical energy.
  4. On or after January 1, 2025, any grandfathered right that is in the Phoenix, Prescott, or Tucson AMAs.
  5. A Type 1 non-irrigation grandfathered right that was requested to be included by a city or town in the Tucson AMA in the determination made under A.R.S. § 45-463(F).
- E. The owner of extinguishment credits may pledge the credits to a certificate or to a designation before the certificate or designation is issued by submitting with the application for the certificate or designation a notice of intent to pledge extinguishment credits on a form provided by the Director. The extinguishment credits shall be pledged to the certificate or designation upon issuance of the certificate or designation.
- F. The owner of extinguishment credits may pledge the credits to a certificate or to a designation after the certificate or designation is issued by submitting a notice of intent to pledge extinguishment credits on a form provided by the Director. The Director shall notify the owner of the extinguishment credits and the certificate holder or designated provider that the credits have been pledged to the certificate or designation.
- G. Extinguishment credits that have not been pledged to a certificate or designation may be conveyed within the same AMA.

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Extinguishment credits pledged to a certificate or designation shall not be conveyed to another person, except that:

1. If extinguishment credits are pledged to a certificate that is later assigned or reissued, any unused credits are transferred, by operation of this subsection, to the assigned or reissued certificate. If the certificate is partially assigned or reissued, a pro rata share of the unused extinguishment credits is transferred to each assigned or reissued certificate according to the estimated water demand.
  2. If extinguishment credits are pledged to a certificate for a subdivision that is later served by a designated provider or a municipal provider that is applying for a designation:
    - a. Any unused extinguishment credits may be used to support the municipal provider's designation as long as the municipal provider serves the subdivision and remains designated;
    - b. For a designation in the Pinal AMA that is issued pursuant to R12-15-710(H) or (I), the extinguishment credits may only be applied to groundwater delivered to the subdivision that is the subject of the certificate;
    - c. If the municipal provider is no longer serving the subdivision or if the municipal provider loses its designated status, any unused extinguishment credits shall revert, by operation of this subsection, to the certificate to which they were originally pledged.
- H.** The Director shall review a statement of extinguishment of a grandfathered right and a notice of intent to pledge extinguishment credits pursuant to the licensing time-frame provisions in R12-15-401.
- I.** A person may apply to the Director on or before December 31, 2015 for the restoration of all or a portion of an irrigation grandfathered right extinguished under this Section during calendar year 2005, 2006 or 2007 if all of the following conditions are met:
1. The person owns the land to which the right or portion of the right was appurtenant;
  2. The land to which the right or portion of the right was appurtenant is physically capable of being irrigated and the infrastructure for delivering water to the land for irrigation purposes remains intact and is operable;
  3. The person holds extinguishment credits that were issued for the extinguishment of a grandfathered right in the AMA in which the land is located and that have not been pledged to a certificate or designation under subsection (E) or (F) in the following amount, as applicable:
    - a. If the person seeks to restore the entire irrigation grandfathered right, an amount of extinguishment credits equal to the amount of extinguishment credits issued by the Director in exchange for extinguishment of the irrigation grandfathered right; or
    - b. If the person seeks to restore a portion of the irrigation grandfathered right, an amount of extinguishment credits equal to the result obtained by multiplying the percentage of the right sought to be restored by the amount of extinguishment credits issued by the Director in exchange for the extinguishment of the right.
- J.** An application to restore all or a portion of an irrigation grandfathered right under subsection (I) shall be on a form provided by the Director and include all of the following:
1. A fee of \$250.00;
  2. The irrigation grandfathered right number of the right sought to be restored;
  3. If a certificate of extinguishment credits was issued by the Director for the extinguishment credits described in subsection (I)(3), the original certificate or an affidavit stating that the certificate is lost;
  4. A copy of a deed showing that the applicant owns the land to which the right or portion of the right sought to be restored was appurtenant and, if the application seeks to restore only a portion of the right, the legal description of the land to which that portion of the right was appurtenant;
  5. A certification by the applicant that the conditions described in subsection (I) are met; and
  6. An agreement in writing that if the right or portion of the right is restored, the flexibility account for the land to which the right or portion of the right is appurtenant shall have an account balance of zero at the beginning of the calendar year in which the right or portion of the right is restored and that any credits registered to the flexibility account after the right is restored may not be conveyed or sold to any person, including the applicant.
- K.** The Director shall approve an application to restore all or a portion of an irrigation grandfathered right submitted under subsection (I) if the application includes the fee and the information required under subsection (J) and the Director determines that the information is correct. If the Director approves an application to restore all or a portion of an irrigation grandfathered right, all of the following apply:
1. The irrigation water duty for the land to which the right or portion of the right is restored shall be the same as it was when the right was extinguished, unless the irrigation water duty is changed in a management plan adopted after the right was extinguished or is modified pursuant to A.R.S. § 45-575;
  2. The flexibility account for the land to which the right or portion of the right is appurtenant shall have an account balance of zero at the beginning of the calendar year in which the right or portion of the right is restored and any credits registered to the flexibility account after the right is restored may not be conveyed or sold to any person, including the applicant.
  3. The applicant shall forfeit the extinguishment credits described in subsection (I)(3); and
  4. The restored irrigation grandfathered right may be extinguished in exchange for extinguishment credits under this Section. For purposes of calculating the amount of extinguishment credits under R12-15-724(B), R12-15-725(B), R12-15-726(B) or R12-15-727(B), the calendar year of extinguishment is the calendar year in which the restored irrigation grandfathered right is extinguished.
- L.** The Director shall review an application to restore an irrigation grandfathered right under subsection (I) pursuant to the licensing time-frame provisions in R12-15-401. The application shall have an administrative completeness review time-frame of 30 days, a substantive review time-frame of 90 days, and an overall time-frame of 120 days.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by final rulemaking at 13 A.A.R. 1394, effective October 1, 2007 (Supp. 07-2). Amended by final rulemaking at 17 A.A.R. 1989, effective September 13, 2011 (Supp. 11-3). Amended by final rulemaking at 24 A.A.R. 3578, effective January 1, 2019 (Supp. 18-4).

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Amended by final rulemaking at 30 A.A.R. 3751  
(December 13, 2024), with an immediate effective date of  
November 25, 2024 (Supp. 24-4).

**R12-15-724. Phoenix AMA Calculation of Groundwater Allowance and Extinguishment Credits**

A. The Director shall calculate the groundwater allowance for a certificate or designation in the Phoenix AMA as follows:

1. If the application is for a certificate, multiply the applicable allocation factor in the table below by the annual estimated water demand for the proposed subdivision.

MANAGEMENT PERIOD	ALLOCATION FACTOR
Third	4
Fourth	2
Fifth	1
After Fifth	0

2. If the application is for a designation and the applicant provided water to its customers prior to February 7, 1995, multiply 7.5 by the total volume of water provided by the applicant to its customers from any source during calendar year 1994, consistent with the municipal conservation requirements established for the applicant pursuant to Section 5-103(A)(1) of the Second Management Plan for the Phoenix AMA.
3. If the application is for a designation and the applicant commenced providing water to its customers on or after February 7, 1995, the applicant's groundwater allowance is zero acre-feet, except as provided in subsection (A)(4) of this Section.
4. If the application is for a designation that includes a volume of groundwater or stored water recovered outside the area of impact pursuant to R12-15-710(H), the groundwater allowance shall be calculated as follows:
  - a. The applicant may select either of the following calculations if the volume does not exceed the applicant's 2023 unreplenished groundwater deliveries multiplied by 100:
    - i. Multiply 30 by the total groundwater deliveries during the calendar year 2023 to customers not enrolled as a member land in the CAGRD; or
    - ii. Multiply 20 by the total water deliveries from any source during the calendar year 2023 to customers not enrolled as a member land in the CAGRD.
  - b. Add the remaining groundwater allowance for each issued certificate of assured water supply that is or will be within the service area of the applicant to the volume calculated under subsection (A)(4)(a) of this Section.
  - c. The Director shall use the annual report submitted by the municipal provider for calendar year 2023, as verified by the Director, for purposes of this calculation.
5. For each calendar year of a designation, the Director shall calculate the volume of incidental recharge for a designated provider within the Phoenix AMA and add that volume to the designated provider's groundwater allowance. The Director shall calculate the volume of incidental recharge by multiplying the provider's total water use from any source in the previous calendar year by the standard incidental recharge factor of 4%. A designated provider may apply for a variance from the standard

incidental recharge factor as provided in A.R.S. § 45-566.01(E)(1). The Director may establish a different incidental recharge factor for the designated provider if the provider demonstrates to the satisfaction of the Director that the ratio of the average annual amount of incidental recharge expected to be attributable to the provider during the management period, to the average amount of water expected to be withdrawn, diverted, or received for delivery by the provider for use within its service area during the management period, is different than 4%.

B. The Director shall calculate the extinguishment credits for the extinguishment of a grandfathered right in the Phoenix AMA as follows:

1. For the extinguishment of a type 2 non-irrigation grandfathered right, multiply the number of acre-feet indicated on the certificate by the difference between 2025 and the calendar year of extinguishment.
2. For the extinguishment of all or part of an irrigation grandfathered right, or all or part of a type 1 non-irrigation grandfathered right, multiply 1.5 acre-feet per acre by the number of irrigation acres associated with the extinguished irrigation grandfathered right or the number of acres to which the extinguished type 1 non-irrigation grandfathered right is appurtenant, and then multiply the product by the difference between 2025 and the calendar year of extinguishment, except that:
  - a. If only a portion of an irrigation grandfathered right or a type 1 non-irrigation grandfathered right is extinguished, the Director shall include in the calculation only those acres associated with the portion of the right that is extinguished; and
  - b. If an extinguished irrigation grandfathered right has a debit balance in the corresponding flexibility account established under A.R.S. § 45-467, the Director shall subtract the amount of the debit from the amount of the extinguishment.

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

Amended by final rulemaking at 30 A.A.R. 3751  
(December 13, 2024), with an immediate effective date of  
November 25, 2024 (Supp. 24-4).

**R12-15-725. Pinal AMA Calculation of Groundwater Allowance and Extinguishment Credits**

A. The Director shall calculate the groundwater allowance for a certificate or designation in the Pinal AMA as follows:

1. If the application is for a certificate:
  - a. If the certificate application is filed before January 1, 2019, multiply the annual estimated water demand for the proposed subdivision by 10.
  - b. If the certificate application is filed on or after January 1, 2019, the groundwater allowance shall be zero.
2. If the application is for a designation:
  - a. If the applicant was designated as having an assured water supply as of October 1, 2007:
    - i. Multiply the applicant's service area population as of October 1, 2007 by 125 gallons per capita per day and multiply the product by 365 days. The service area population shall be determined using the methodology set forth in Section 5-

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- 103(D) of the Third Management Plan for the Pinal AMA.
- ii. Convert the number of gallons determined in subsection (A)(2)(a)(i) into acre-feet by dividing the number by 325,851 gallons.
  - iii. Determine the number of residential lots within plats that were recorded as of October 1, 2007 but not served water as of that date, and to which the applicant commenced water service by January 1, 2010.
  - iv. Multiply the number of lots determined in subsection (A)(2)(a)(iii) by 0.35 acre-foot per lot.
  - v. Add the volume from subsection (A)(2)(a)(ii) and the volume from subsection (A)(2)(a)(iv) of this Section.
- b. If the applicant provided water to its customers before October 1, 2007 but was not designated as having an assured water supply as of that date, and a complete and correct application for designation was filed before January 1, 2012, multiply the applicant's service area population as of October 1, 2007 by 125 gallons per capita per day and multiply the product by 365 days. The service area population shall be determined using the methodology in Section 5-103(D) of the Third Management Plan for the Pinal AMA.
  - c. If the applicant provided water to its customers before October 1, 2007 but was not designated as having an assured water supply as of that date, and a complete and correct application for designation was filed on or after January 1, 2012, the applicant's groundwater allowance is zero acre-feet, except as provided in subsection (A)(2)(e) of this Section.
  - d. If the applicant commenced providing water to its customers on or after October 1, 2007, the applicant's groundwater allowance is zero acre-feet, except as provided in subsection (A)(2)(e) of this Section.
  - e. If the application is for a designation that includes a volume of groundwater or stored water recovered outside the area of impact pursuant to R12-15-710(H), the groundwater allowance shall be calculated as follows: The applicant may select either of the following calculations if the volume does not exceed the applicant's 2023 unreplenished groundwater deliveries multiplied by 100:
    - i. Multiply 30 by the total groundwater deliveries during the calendar year 2023 to customers not enrolled as a member land in the CAGRD;
    - ii. Multiply 20 by the total water deliveries from any source during the calendar year 2023 to customers not enrolled as a member land in the CAGRD;
    - iii. Add the remaining groundwater allowance for each issued certificate of assured water supply that is or will be withdrawn within the service area of the applicant to the volume calculated under subsection (A)(2)(e)(i) or (A)(2)(e)(ii) of this Section; or
    - iv. The Director shall use the annual report submitted by the municipal provider for calendar year 2023, as verified by the Director, for purposes of this calculation.
3. For each calendar year of a designation, the Director shall calculate the volume of incidental recharge for a designated provider within the Pinal AMA and add that volume to the designated provider's groundwater allowance. The Director shall calculate the volume of incidental recharge by multiplying the provider's total water use from any source in the previous calendar year by the standard incidental recharge factor of 4%. A designated provider may apply for a variance from the standard incidental recharge factor by submitting a hydrologic study demonstrating, to the satisfaction of the Director, that the ratio of the average annual amount of incidental recharge expected to be attributable to the designated provider during the management period to the average annual amount of water expected to be withdrawn, diverted or received for delivery by the designated provider for use within its service area during the management period is different than 4%. The hydrologic study shall include the amount of water withdrawn, diverted or received for delivery by the designated provider for use within its service area during each of the preceding five years and the amount of incidental recharge that was attributable to the designated provider during each of those years. The Director may establish a different incidental recharge factor for the designated provider upon such demonstration.
- B. The Director shall calculate the extinguishment credits for extinguishing a grandfathered right in the Pinal AMA as follows.
    1. The Director shall calculate the initial volume of extinguishment credits for the extinguishment of a grandfathered right in the Pinal AMA as follows:
      - a. For the extinguishment of a type 2 non-irrigation grandfathered right, multiply the number of acre-feet indicated on the certificate of grandfathered right by 100.
      - b. For the extinguishment of all or part of an irrigation grandfathered right, or all or part of a type 1 non-irrigation grandfathered right, multiply 1.5 acre-feet by the number of irrigation acres associated with the extinguished irrigation grandfathered right or the number of acres to which the extinguished type 1 non-irrigation grandfathered right is appurtenant, and then multiply that product by 100, except that:
        - i. If only a portion of an irrigation grandfathered right or a type 1 non-irrigation grandfathered right is extinguished, only those acres associated with the portion of the right that is extinguished shall be included in the calculation; and
        - ii. If an extinguished irrigation grandfathered right has a debit balance in the corresponding flexibility account established under A.R.S. § 45-467, the amount of the debit shall be subtracted from the amount of the extinguishment credits.
    2. For grandfathered rights extinguished in the Pinal active management area on or after January 1, 2019, if the amount of the extinguishment credits remaining unused in the fifth, tenth, fifteenth, and twentieth year after the year of extinguishment is greater than an amount calculated by multiplying the initial volume of extinguishment credits by the applicable percentage shown in the table below, the amount of unused credits shall be reduced to



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an amount calculated by multiplying the initial volume of extinguishment credits by the applicable percentage:

Year After Extinguishment	Percentage
Fifth	75%
Tenth	50%
Fifteenth	25%
Twentieth	0%

3. For purposes of subsection (B)(2), the amount of extinguishment credits remaining unused shall be the initial volume of extinguishment credits issued for the extinguishment of the right, less:
  - a. The amount of any of the extinguishment credits previously pledged to a certificate of assured water supply or designation of assured water supply pursuant to R12-15-723, subsections (E) or (F) and reported to the Department as having been used; and
  - b. The amount of any previous reductions made to the extinguishment credits pursuant to subsection (B)(2).

**Historical Note**

Adopted effective February 7, 1995 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1394, effective October 1, 2007 (Supp. 07-2). Amended by final rulemaking at 15 A.A.R. 1979, effective January 2, 2010 (Supp. 09-4). Amended by final rulemaking at 19 A.A.R. 4174, effective December 3, 2013 (Supp. 13-4). Amended by final rulemaking at 24 A.A.R. 3578, effective January 1, 2019 (Supp. 18-4). Amended by final rulemaking at 30 A.A.R. 3751 (December 13, 2024), with an immediate effective date of November 25, 2024 (Supp. 24-4).

**R12-15-725.01. Repealed****Historical Note**

New Section made by final rulemaking at 19 A.A.R. 4174, effective December 3, 2013; with automatic repeal date of September 15, 2014 (Supp. 13-4). Section amended with automatic repeal, removed by final rulemaking at 20 A.A.R. 2673; effective September 12, 2014 (Supp. 14-3). Repealed by final rulemaking at 24 A.A.R. 3578, effective January 1, 2019 (Supp. 18-4).

**R12-15-725.02. Repealed****Historical Note**

New Section made by final rulemaking at 19 A.A.R. 4174, effective September 15, 2014 (Supp. 13-4). Repealed by final rulemaking at 20 A.A.R. 2673, effective September 12, 2014 (Supp. 14-3).

**R12-15-726. Prescott AMA Calculation of Groundwater Allowance and Extinguishment Credits**

- A. The Director shall calculate the groundwater allowance for a certificate or designation in the Prescott AMA as follows:
  1. If the application is for a certificate of assured water supply, the Director shall:
    - a. Subtract the year of application from 2025,
    - b. Multiply the number determined in subsection (A)(1)(a) by the applicant's annual estimated water demand, and

- c. Divide that product by two. The minimum volume that may be calculated in this subsection is zero acre-feet.
2. If the application is for a designation of assured water supply:
  - a. Except as provided in subsections (A)(3) and (A)(5), if the applicant was in existence as of January 12, 1999, and the application is filed before calendar year 2026, the Director shall:
    - i. Multiply by 100 the largest volume of groundwater determined by the Director to have been withdrawn by the applicant from within the Prescott AMA for use within the applicant's service area in any calendar year from 1995 through 1998, consistent with the municipal conservation requirements applicable under the second management plan for the Prescott active management area;
    - ii. Determine the volume of the applicant's total water demand, from any source, for 1999, consistent with the municipal conservation requirements established for the applicant in the management plan in effect on the date of application;
    - iii. Determine the volume of the applicant's total water demand, from any source, for 2014, consistent with the municipal conservation requirements established for the applicant in the management plan in effect on the date of application;
    - iv. Subtract the volume calculated in subsection (A)(2)(a)(ii) from the volume calculated in subsection (A)(2)(a)(iii) and then multiply the difference by 26;
    - v. Divide the product obtained in subsection (A)(2)(a)(iv) by two;
    - vi. If any residential groundwater uses, including residential groundwater uses served by an exempt well, in existence on August 21, 1998, have been replaced by permanent water service from the applicant after August 21, 1998, multiply one-half acre-foot of groundwater by the number of housing units receiving the service and then multiply that product by 100;
    - vii. Determine the volume of groundwater withdrawn by the applicant from within the Prescott active management area during the period beginning January 1, 1999, and ending December 31 of the calendar year before the date of the application;
    - viii. Multiply the volume of groundwater withdrawn by the applicant from within the Prescott active management area in 1999 by the number of calendar years in the period beginning with 1999 and ending with the calendar year before the date of application;
    - ix. Subtract from the volume calculated in subsection (A)(2)(a)(vii) the volume calculated in subsection (A)(2)(a)(viii). The volume calculated in this subsection shall not be less than zero; and
    - x. Add the volumes calculated in subsections (A)(2)(a)(i), (A)(2)(a)(v), and (A)(2)(a)(vi),

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- and then subtract from the sum the volume calculated in subsection (A)(2)(a)(ix).
- b. If the applicant did not exist as of January 12, 1999, or the date of application occurs after calendar year 2025, the groundwater allowance is zero acre-feet, except that if any residential groundwater uses, including residential groundwater uses served by an exempt well, in existence on August 21, 1998, have been replaced by permanent water service from the applicant after August 21, 1998, the groundwater allowance is a volume of groundwater computed by multiplying one-half acre-foot of groundwater by the number of housing units receiving the service and multiplying that product by 100.
  3. For the purpose of determining the groundwater allowance under subsection (A)(2)(a), at the request of the applicant, the Director shall replace the volume of groundwater calculated in subsection (A)(2)(a)(ii) through (v) with the amount of groundwater necessary for the applicant to serve the residential lots described in subsection (A)(4):
    - a. To compute this amount of groundwater, the Director shall:
      - i. Determine the average dwelling occupancy within the applicant's service area and multiply that average occupancy by an amount of groundwater, calculated by multiplying 150 gallons per capita per day by 365 days; and
      - ii. Multiply the product in subsection (A)(3)(a)(i) by the number of residential lots described in subsection (A)(4), and then multiply that product by 100.
    - b. The Director shall not include the amount computed in subsection (A)(3)(a) within the amount of groundwater that the applicant may use under subsection (A)(2)(a) until a final plat for the lots has been recorded.
  4. The Director shall include residential lots that will be served by the applicant in the calculation made under subsection (A)(3) if the lots meet all of the following criteria:
    - a. A preliminary plat for the lots was submitted to the city, town, or county on or before August 21, 1998, and the final plat is subsequently recorded;
    - b. The lots were not being served water on or before August 21, 1998; and
    - c. Any one of the following applies:
      - i. The lots were included within an application for certificate of assured water supply that was filed before August 21, 1998, the Director determined that the application was complete and correct as of August 21, 1998, and the Director subsequently issued a certificate of assured water supply for the lots.
      - ii. A preliminary plat for the lots was approved by a city, town, or county on or before August 21, 1998. At the time the preliminary plat was approved, the subdivider of the lots obtained a written commitment of water service from a municipal provider that was designated as having an assured water supply and the provider demonstrated to the satisfaction of the Director that sufficient water is physically available to serve the lots under the criteria in R12-15-716.
  5. For the purpose of determining the groundwater allowance under subsection (A)(2)(a), if the applicant makes the request described in subsection (A)(3), the Director shall replace the volume of groundwater calculated in subsection (A)(2)(a)(viii) with an amount of groundwater calculated as follows. The Director shall:
    - a. Determine the number of calendar years in the period beginning with 1999 and ending with the calendar year before the date of application and multiply that number of years by the largest volume of groundwater determined by the Director to have been withdrawn by the applicant from within the Prescott active management area for use within the applicant's service area in any calendar year from 1995 through 1998, consistent with the municipal conservation requirements applicable under the second management plan for the Prescott active management area;
    - b. Determine the average dwelling occupancy within the applicant's service area and multiply that average dwelling occupancy by an amount of groundwater calculated by multiplying 150 gallons per capita per day by 365 days;
    - c. For each year in the period beginning with 1999 and ending with the calendar year before the date of application, determine the number of the residential lots that meet the criteria in subsection (A)(4) and were served water by the applicant as of July 1 of the relevant year and add the number of these residential lots determined for each year;
    - d. Multiply the volume of groundwater calculated in subsection (A)(5)(b) by the number of residential lots in subsection (A)(5)(c); and
    - e. Add the volumes of groundwater from subsections (A)(5)(a) and (A)(5)(d).
  - B. The Director shall calculate the extinguishment credits for extinguishing a grandfathered right in the Prescott AMA as follows:
    1. For the extinguishment of a type 2 non-irrigation grandfathered right, multiply the number of acre-feet indicated on the certificate by the difference between 2025 and the calendar year of extinguishment.
    2. For the extinguishment of an irrigation grandfathered right or a type 1 non-irrigation grandfathered right:
      - a. Through December 31, 2010:
        - i. If the irrigation acres associated with the extinguished right were irrigated for at least four of the six calendar years preceding January 1, 2000, multiply 1.5 acre-feet per acre by the number of irrigation acres associated with the extinguished right or the number of acres to which the extinguished right is appurtenant and multiply that product by 25.
        - ii. If the irrigation acres associated with the extinguished right were not irrigated for at least four of the six calendar years preceding January 1, 2000, multiply 1.5 acre-feet per acre by the number of irrigation acres associated with the extinguished right or the number of acres to which the extinguished right is appurtenant and multiply the product by the difference between 2025 and the year in which the statement of intent to extinguish is filed.

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- b. After December 31, 2010, multiply 1.5 acre-feet per acre by the number of irrigation acres associated with the extinguished right or the number of acres to which the extinguished right is appurtenant and multiply the product by the difference between 2025 and the year in which the statement of intent to extinguish is filed.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-727. Tucson AMA Calculation of Groundwater Allowance and Extinguishment Credits**

A. The Director shall calculate the groundwater allowance for a certificate or designation in the Tucson AMA as follows:

1. If the application is for a certificate, multiply the applicable allocation factor in the table below by the annual estimated water demand for the proposed subdivision.

MANAGEMENT PERIOD	ALLOCATION FACTOR
Third	8
Fourth	4
Fifth	2
After Fifth	0

2. If the application is for a designation and the applicant provided water to its customers before February 7, 1995, multiply 15 by the total volume of water provided by the applicant to its customers from any source during calendar year 1994, consistent with the municipal conservation requirements established for the applicant pursuant to Section 5-103(A)(1) of the Second Management Plan for the Tucson AMA.
3. If the application is for a designation and the applicant commenced providing water to its customers on or after February 7, 1995, the applicant's groundwater allowance is zero acre-feet.
4. For each calendar year of the designation, the Director shall calculate the volume of incidental recharge for a designated provider within the Tucson AMA and add that volume to the designated provider's groundwater allowance. The Director shall calculate the volume of incidental recharge by multiplying the provider's total water use from any source in the previous calendar year by the standard incidental recharge factor of 4%. A designated provider may apply for a variance from the standard incidental recharge factor as provided in A.R.S. § 45-566.01(E)(1). The Director may establish a different incidental recharge factor for the designated provider if the provider demonstrates to the satisfaction of the Director that the ratio of the average annual amount of incidental recharge expected to be attributable to the provider during the management period, to the average amount of water expected to be withdrawn, diverted, or received for delivery by the provider for use within its service area during the management period, is different than 4%.

B. The Director shall calculate the extinguishment credits for the extinguishment of a grandfathered right in the Tucson AMA as follows:

1. For the extinguishment of a type 2 non-irrigation grandfathered right, multiply the number of acre-feet indicated on the certificate by the difference between 2025 and the calendar year of extinguishment.

2. For the extinguishment of all or part of an irrigation grandfathered right, or all or part of a type 1 non-irrigation grandfathered right, multiply 1.5 acre-feet per acre by the number of irrigation acres associated with the extinguished irrigation grandfathered right or the number of acres to which the extinguished type 1 non-irrigation grandfathered right is appurtenant, and then multiply the product by the difference between 2025 and the calendar year of extinguishment, except that:

- a. If only a portion of an irrigation grandfathered right or a type 1 non-irrigation grandfathered right is extinguished, the Director shall include in the calculation only those acres associated with the portion of the right that is extinguished; and
- b. If an extinguished irrigation grandfathered right has a debit balance in the corresponding flexibility account established under A.R.S. § 45-467, the Director shall subtract the amount of the debit from the amount of the extinguishment.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3).

**R12-15-728. Reserved****R12-15-729. Remedial Groundwater; Consistency with Management Goal**

A. Use of remedial groundwater by a municipal provider before January 1, 2050, is deemed consistent with the management goal of the AMA in which the remedial groundwater is withdrawn and is excluded when determining compliance with management goal requirements in this Article if all of the following apply:

1. The Director determines that the remedial groundwater use is consistent with the management goal under subsection (F) or (H) or the remedial groundwater use is consistent with the management goal under subsection (J); and
2. The municipal provider complies with the metering and reporting requirements in subsection (K).

B. A municipal provider that is using remedial groundwater or that has agreed in a consent decree or other document approved by ADEQ or the EPA to use remedial groundwater may apply to the Director for a determination that the municipal provider's use of the remedial groundwater is consistent with the management goal of the active management area by submitting an application on a form provided by the Director with the information required in subsection (D) before January 1, 2010.

C. A municipal provider filing an application under subsection (B) for remedial groundwater use associated with a treatment plant in operation before June 15, 1999, may request an increase in the project's annual authorized volume at the time the application is filed. The Director shall grant the request and increase the annual authorized volume up to the maximum treatment capacity of the treatment plant if the municipal provider submits evidence that an increase in the annual authorized volume is necessary to further the purpose of the remedial action project and that the increase is not in violation of the consent decree or other document approved by ADEQ or the EPA for the remedial action project.

D. An applicant shall provide the following with an application submitted under subsection (B):

1. A document evidencing ADEQ's or EPA's approval of the municipal provider's withdrawal and use of remedial

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groundwater, such as a remedial action plan, record of decision, or consent decree;

2. The volume of remedial groundwater that will be withdrawn and used annually by the municipal provider and the purpose for which the remedial groundwater will be used;
  3. The time period during which the remedial groundwater will be withdrawn and used by the municipal provider;
  4. A reference to the annual authorized volume provided in the document submitted pursuant to subsection (D)(1) or, if the document submitted pursuant to subsection (D)(1) does not specify the annual authorized volume for the project, the annual authorized volume claimed by the municipal provider and a written justification for that volume;
  5. If the approved remedial action project is currently operating, the volume of remedial groundwater withdrawn pursuant to the project for each year before the year in which the application is filed;
  6. The designated provider or certificate to which the remedial groundwater will be pledged;
  7. If the municipal provider is requesting an increase in the annual authorized volume of the project pursuant to subsection (C), evidence that the increase is necessary to further the purpose of the remedial action project and that the increase is not in violation of the consent decree or other document approved by ADEQ or the EPA for the project;
  8. The name and telephone number of a person the Department may contact regarding the application; and
  9. Any other information reasonably required to assist the Director in making the determination under subsection (F).
- E. After receiving an application under subsection (B), the Director shall determine that the application is complete and correct if it contains all the information required in subsection (D) and the Director verifies that the information is accurate. If the Director determines that the application is complete and correct, the Director shall assign a priority date to the application according to the following:
1. If the Director determines that the application was complete and correct when filed, the priority date of the application is the date the application was filed.
  2. If the Director determines that the application was not complete or correct when filed because of minor deficiencies, the Director shall notify the applicant of the deficiencies in writing and give the applicant 30 days to correct the deficiencies. If the applicant submits the necessary information to correct the deficiencies within 30 days after the date of the notice, the priority date of the application is the date the application was filed.
  3. If the Director determines that the application was not complete or correct when filed and that the deficiencies are not minor, the Director shall notify the applicant of the deficiencies and give the applicant at least 60 days to submit the necessary information to correct the deficiencies. If the applicant submits the necessary information to correct the deficiencies within the time allowed by the Director, the priority date of the application is the date the applicant submits the necessary information to correct the deficiencies.
- F. The Director shall approve a complete and correct application filed under subsection (B) if the Director determines that the applicant will use remedial groundwater before January 1, 2050. If the Director approves a municipal provider's application, the Director shall calculate the amount of remedial groundwater use that is consistent with the management goal of the AMA as follows:
1. The Director shall determine the total annual amount of remedial groundwater use in all AMAs that is deemed to be consistent with the management goal under this subsection and subsections (H) and (I) for applications with a priority date earlier than the priority date of the municipal provider's application.
  2. If the amount determined in subsection (F)(1) is less than 65,000 acre-feet and the difference between those amounts is equal to or greater than the municipal provider's authorized remedial groundwater use during the year, the amount of remedial groundwater use by the municipal provider that is deemed to be consistent with the management goal during the year is the amount of the municipal provider's authorized remedial groundwater use during the year.
  3. If the amount determined in subsection (F)(1) is less than 65,000 acre-feet and the difference between those amounts is less than the municipal provider's authorized remedial groundwater use during the year, the amount of remedial groundwater use by the municipal provider that is deemed consistent with the management goal during the year is the amount of the municipal provider's authorized remedial groundwater use during the year up to the difference between the amount determined in subsection (F)(1) and 65,000 acre-feet, plus a percentage of the municipal provider's authorized remedial groundwater use during the year that exceeds the difference. The percentage is 50 percent for calendar years 2000 through 2009, 25 percent for calendar years 2010 through 2019, and 10 percent for calendar years 2020 through 2024.
  4. If the amount determined in subsection (F)(1) is equal to or greater than 65,000 acre-feet, the amount of remedial groundwater use by the municipal provider that is deemed consistent with the management goal during the year is a percentage of the municipal provider's authorized remedial groundwater use during the year. The percentage is 50 percent for calendar years 2000 through 2009, 25 percent for calendar years 2010 through 2019, and 10 percent for calendar years 2020 through 2024.
- G. If the Director determines that remedial groundwater use by a municipal provider is consistent with the management goal of the active management area under subsection (F), the determination shall apply to remedial groundwater used by the municipal provider between the priority date of the application and January 1, 2050.
- H. If, before the effective date of this Section, a municipal provider filed an application with the Director requesting that the Director determine that the provider's use of remedial groundwater according to an approved remedial action project is consistent with the management goal of the active management area under Laws 1997, Ch. 287, § 52, as amended by Laws 1999, Ch. 295, § 50, the following shall apply:
1. If the Director approved the application before the effective date and determined the annual amount of remedial groundwater use by the applicant that will be considered consistent with the management goal, the Director's determination shall apply after the effective date and the Director shall include the annual amount of remedial groundwater use determined by the Director to be consis-

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tent with the management goal in the total amount of remedial groundwater determined in subsection (F)(1).

2. If the Director did not approve the application before the effective date, the Director shall process the application under subsections (E) and (F). If the Director approves the application, the Director's determination shall apply to remedial groundwater withdrawn and used by the municipal provider according to the approved remedial action project from the priority date of the application until January 1, 2050.
- I. A municipal provider that is using remedial groundwater that has been determined by the Director to be consistent with the management goal under subsection (F) or (H) may apply to the Director for an increase in the annual authorized volume of the approved remedial action project as follows:
  1. The applicant shall submit an application on a form provided by the Director.
  2. The Director shall determine that the application is complete and correct if it contains all of the required information and the Director verifies that the information is accurate.
  3. If the Director determines that an application filed under this subsection is complete and correct, the Director shall assign a priority date to the application using the criteria in subsection (E).
  4. The Director shall approve the application if the municipal provider submits information that demonstrates one of the following:
    - a. The annual authorized volume of the approved remedial action project has been increased in a consent decree or other document approved by ADEQ or the EPA; or
    - b. An increase is necessary to further the purpose of the approved remedial action project, and the increase is not in violation of the consent decree or other document approved by ADEQ or the EPA for the project.
  5. If the Director approves the application, the Director shall determine the additional annual amount of remedial groundwater use by the municipal provider that is deemed consistent with the management goal of the active management area, using the criteria in subsections (F) and (G). The Director shall include the annual amount of remedial groundwater use determined by the Director to be consistent with the management goal under this subsection in the total amount of remedial groundwater determined in subsection (F)(1).
- J. Until January 1, 2050, use of remedial groundwater by a municipal provider during a year is deemed consistent with the management goal of the AMA in which the remedial groundwater was withdrawn without approval of the Director under subsection (F) or (H) if:
  1. The total annual amount of remedial groundwater withdrawn from all wells according to the approved remedial action project does not exceed 250 acre-feet; and
  2. If remedial groundwater withdrawals according to the approved remedial action project commenced before June 15, 1999, the municipal provider notified the Director in writing of the volume and duration of the anticipated withdrawals on or before August 15, 1999. If remedial groundwater withdrawals according to the approved remedial action project commenced on or after June 15, 1999, the municipal provider gave written notice of the volume and duration of the anticipated withdrawals on or before August 15, 1999, or before the date the withdraw-

als commenced, whichever is later. If the municipal provider gives notice after the effective date of this Section, the municipal provider shall include or attach all of the following:

- a. A copy of a document evidencing ADEQ's or EPA's approval of the municipal provider's withdrawal and use of remedial groundwater, such as a remedial action plan, record of decision, or consent decree;
  - b. The volume of remedial groundwater that will be withdrawn and used annually by the municipal provider and the purpose for which the remedial groundwater will be used;
  - c. The time period during which the remedial groundwater will be withdrawn and used by the municipal provider;
  - d. If the approved remedial action project is currently operating, the volume of remedial groundwater withdrawn according to the project for each year before the year in which the application is filed;
  - e. The designated provider or certificate of assured water supply to which the remedial groundwater will be pledged; and
  - f. The name and telephone number of a person the Department may contact regarding the exemption.
- K. A municipal provider withdrawing remedial groundwater that has been determined to be consistent with the management goal under subsection (F) or (H) or that is consistent with the management goal under subsection (J) shall meter the remedial groundwater withdrawals separately from groundwater withdrawn pursuant to another groundwater withdrawal authority. The municipal provider shall include in its annual reports, filed under A.R.S. § 45-632, the amount of remedial groundwater withdrawn during the reporting year that is consistent with the management goal under this Section and the purposes for which the remedial groundwater was used.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Amended by final expedited rulemaking at 28 A.A.R. 909 (May 6, 2022), with an immediate effective date of April 11, 2022 (Supp. 22-2).

**R12-15-730. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 3475, effective September 12, 2006 (Supp. 06-3). Section repealed by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). New Section made by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Section repealed by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**ARTICLE 8. WELL CONSTRUCTION AND LICENSING OF WELL DRILLERS****R12-15-801. Definitions**

In addition to the definitions set forth in A.R.S. §§ 45-101, 45-402, and 45-591 and in R12-15-202, the following words and phrases in this Article shall have the following meanings, unless the context otherwise requires:

1. "Annular space" means the space between the outer well casing and the borehole wall. An annular space also means the space between an inner well casing and outer well casing.

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2. "Aquifer" means an underground formation capable of yielding or transmitting usable quantities of water.
3. "Artesian aquifer" means an aquifer which is overlain by a confining formation and which contains groundwater under sufficient pressure for the water to rise above the top of the aquifer.
4. "Artesian well" means a well that penetrates an artesian aquifer.
5. "Bentonite" means a colloidal clay composed mainly of sodium montmorillonite, a hydrated aluminum silicate.
6. "Cap" means a tamper-resistant, watertight steel plate of at least one-quarter inch thickness on the top of all inside and outside casings of a well.
7. "Casing" means the tubing or pipe installed in the borehole during or after drilling to support the sides of the well and prevent caving.
8. "Confining formation" means the relatively impermeable geologic unit immediately overlying an artesian aquifer.
9. "Consolidated formation" means a naturally occurring geologic unit through or into which a well is drilled, having a composition, density, and thickness which will provide a natural hydrologic barrier.
10. "Department" means the Arizona Department of Water Resources.
11. "Director" means the Director of the Arizona Department of Water Resources.
12. "Drilling card" means a card which is issued by the Director to the well drilling contractor or single well licensee designated in the notice of intent or permit, authorizing the well drilling contractor or licensee to drill the specific well or wells in the specific location as noticed or permitted.
13. "Exploration well" means a well drilled in search of geophysical, mineralogical or geotechnical data.
14. "Flowing artesian well" means an artesian well in which the pressure is sufficient to cause the water to rise above the land surface.
15. "Grout" or "cement grout" means cement mixed with no more than 50% sand by volume, and containing no more than six gallons of water per 94 pound sack of cement.
16. "Mineralized water" means any groundwater containing over 3000 milligrams per liter (mg/l) of total dissolved solids or containing any of the following chemical constituents above the indicated concentrations:
 

Constituent	Concentration (mg/l)
Arsenic	0.05
Barium	1.0
Cadmium	0.01
Chromium (total)	0.05
Fluoride	4.0
Lead	0.05
Mercury	0.002
Nitrate (as N)	10.0
Selenium	0.01
Silver	0.05
17. "Monitor well" means a well designed and drilled for the purpose of monitoring water quality within a specific depth interval.
18. "Open well" means a well which is not equipped with either a cap or a pump.
19. "Perforations" means a series of openings in a casing, made either before or after installation of the casing, to permit the entrance of water into the well.
20. "Piezometer well" means a well that is designed and drilled for the purpose of monitoring water levels within a specific depth interval.
21. "Pitless adaptor" means a commercially manufactured watertight unit or device designed for attachment to a steel well casing which permits discharge from the well below the land surface and allows access into the well casing while preventing contaminants from entering the well.
22. "Polluted water" means water whose chemical, physical, biological, or radiological integrity has been degraded through the artificial or natural infusion of chemicals, radionuclides, heat, biological organisms, or mineralogical or other extraneous matter.
23. "Pressure grouting" means a process by which a grout is confined within the borehole or casing of a well by the use of retaining plugs, packers, or a displacing fluid by which sufficient pressure is applied to drive the grout into and within the annular space or interval to be grouted.
24. "Qualifying party" means a partner, officer, or employee of a well drilling contractor, who has significant supervisory responsibilities and who has been designated to take the licensing examination for that well drilling contractor.
25. "Single well license" means a license issued to a person which allows the drilling or modification of a single exempt well on land owned by that person.
26. "Vadose zone well" means a well constructed in the interval between the land surface and the top of the static water level.
27. "Vault" means a tamper-resistant watertight structure used to complete a well below the land surface.
28. "Well abandonment" means the modification of the structure of a well by filling or sealing the borehole so that water may not be withdrawn or obtained from the well.
29. "Well drilling" means the construction or repair of a well, or the modification, except for abandonment, of a well, regardless of whether compensation is involved, including any deepening or additional perforating, any addition of casing or change to existing casing construction, and any other change in well construction not normally associated with well maintenance, pump replacement, or pump repair.
30. "Well drilling contractor" means an individual, public or private corporation, partnership, firm, association, or any other public or private organization or enterprise that holds a well driller's license pursuant to A.R.S. § 45-595(B).

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-802. Scope of Article**

This Article shall apply to man-made openings in the earth through which water may be withdrawn or obtained from beneath the surface of the earth, including all water wells, monitor wells and piezometer wells. It shall also apply to geothermal wells to the extent provided by A.R.S. § 45-591.01, and all exploration wells and grounding or cathodic protection holes greater than 100 feet in depth. However, this Article shall not apply to the following:

1. Man-made openings in the earth not commonly considered to be wells, such as construction and mining blast

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holes, underground mines and mine shafts, open pit mines, tunnels, septic tank systems, caissons, basements, and natural gas storage cavities.

2. Injection wells and vadose zone wells which are subject to regulation by the Arizona Department of Environmental Quality.
3. Oil, gas, and helium wells drilled pursuant to the provisions of A.R.S. Title 27.
4. Drilled boreholes in the earth less than 100 feet in depth which are made for purposes other than withdrawing or encountering groundwater, such as exploration wells and grounding or cathodic protection holes; except that in the event that groundwater is encountered in the drilling of a borehole, this Article shall apply.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-803. Well Drilling and Abandonment Requirements; Licensing and Supervision Requirements**

- A. A person shall not drill or abandon a well, or cause a well to be drilled or abandoned, in a manner which is not in compliance with A.R.S. Title 45, Chapter 2, Article 10, and the rules adopted thereunder.
- B. A person, other than a single well licensee or a bona fide employee of a well drilling contractor, shall not engage in well drilling or abandonment without first securing a well drilling license in accordance with R12-15-804, R12-15-805 and R12-15-806.
- C. A qualifying party of a well drilling contractor shall provide direct and personal supervision of the contractor's employees to ensure that all wells are constructed and abandoned in accordance with this Article.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Section 12-15-803 amended and the text of former Section R12-15-804 renumbered to subsections (B) and (C) and amended effective June 18, 1990 (Supp. 90-2).

**R12-15-804. Application for well drilling license**

- A. An applicant for a well drilling license shall submit a verified application of a form prescribed and furnished by the Director which contains the following information:
  1. A designation of the classification of license sought by the applicant.
  2. If the applicant is an individual, the individual's name, address and telephone number.
  3. If the applicant is a partnership, the names, addresses, and telephone numbers of all partners, with a designation of any limited partners.
  4. If the applicant is a corporation, association or other organization, the names, addresses and telephone numbers of the directors and of the president, vice president, secretary and treasurer, or the names, addresses and telephone numbers of the functional equivalent of such officers.
  5. The address or location of the applicant's place of business, the mailing address if it is different from the applicant's place of business, and if applicant is a corporation, the state in which it is incorporated.
  6. The name, address and telephone number of each qualifying party, the qualifying party's relationship to the applicant, and a detailed history of each qualifying party's supervisory responsibilities and well drilling experience,

including previous employers, job descriptions, duties and types of equipment utilized.

7. The names, addresses and telephone numbers of three persons not members of each qualifying party's immediate family, who can attest to each qualifying party's good character and reputation, experience in well drilling, and qualifications for licensing.
8. Such additional information relevant to the applicant's or qualifying party's experience and qualifications in well drilling as the Director may require.
- B. An applicant shall notify the Director in writing of any change in the information contained in the application within 30 days after such change.
- C. The Director shall not issue a license under this Article if the applicant or a qualifying party lacks good character and reputation.
- D. Prior to the issuance of a license, a qualifying party shall demonstrate three years of experience, dealing specifically with the type of drilling for which the applicant is applying for a license. This experience requirement may be reduced if the Director finds that the qualifying party has clearly and convincingly demonstrated a high degree of understanding and knowledge of well drilling techniques for the type of drilling for which the applicant is applying for a license. In no case, however, shall the practical experience requirement be less than two years.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Former Section R12-15-804 renumbered to R12-15-803(B) and (C), new Section R12-15-804 adopted effective June 18, 1990 (Supp. 90-2).

**R12-15-805. Examination for Well Drilling License**

- A. The Director shall offer an examination for a well drilling license no less than six times yearly. The examination shall be administered to those eligible applicants whose applications were submitted at least 20 days prior to the date of the examination. The examination shall consist of a section on legal requirements, a section on general knowledge and one or more of six specialized sections. The section on legal requirements shall test the qualifying party's knowledge of A.R.S. Title 45, Chapter 2, Article 10, and the rules adopted thereunder. The section on general knowledge shall test the qualifying party's knowledge of general hydrologic concepts, principles, and practices in the well construction industry, and shall test knowledge of groundwater protection, pollution, water quality and public health effects. The specialized sections shall test the qualifying party's knowledge in the following classifications:
  1. Cable tool drilling in rock and unconsolidated material.
  2. Air rotary drilling in rock and unconsolidated material.
  3. Mud rotary drilling in rock and unconsolidated material.
  4. Reverse rotary drilling in rock and unconsolidated material.
  5. Jetting and driving wells in unconsolidated material.
  6. Boring and augering in unconsolidated material.
- B. Only the qualifying party, Department personnel, and persons having the express permission of the Director shall be permitted in the examination room while the examination is in progress. The qualifying party shall not bring books or notes into the examination room, or communicate by any means whatsoever while the examination is in progress without the express permission of the presiding examiner. The qualifying party shall not leave the examination room while the examination is in progress without first obtaining the permission of the pre-

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siding examiner. The Director may disqualify an applicant for violation of this subsection.

- C. To obtain a well drilling license, a qualifying party of the applicant shall pass the section on legal requirements, the section on general knowledge, and one or more specialized sections. Each section of the examination shall be graded separately. The passing grade on each section shall be 70 percent.
- D. No person may take the examination more than twice during any 12 months.
- E. The Director may exempt a qualifying party from taking the section on general knowledge, and one or more of the specialized sections, if the qualifying party provides proof of passing an equivalent examination given by the National Ground Water Association.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Section repealed, new Section adopted effective June 18, 1990 (Supp. 90-2). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3).

**R12-15-806. License Fee; Issuance and Term of Licenses; Renewal; Display of License**

- A. The fee for a well driller's license shall be \$50.00.
- B. Upon submittal of the license fee and satisfactory completion of an examination, the Director shall issue the applicant a well drilling license. The license shall be numbered and shall state the specialized classifications of drilling activities for which the applicant is qualified and licensed. The applicant shall be licensed in only those classifications for which the qualifying party has passed the specialized sections of the examination. If the qualifying party subsequently passes other specialized sections, the applicant's license shall be amended. The applicant shall pay a fee of \$50.00 for the amendment of a well driller's license.
- C. A well drilling contractor shall notify the Director in writing within 30 days of the date on which the well drilling contractor no longer has a qualifying party for one or more of its specialized drilling classifications. Upon such notification, the Director may revoke or suspend part or all of the well drilling license of the well drilling contractor and require a new qualifying party to take and pass the examination.
- D. A well drilling license shall expire each year on June 30th, unless renewed pursuant to subsection (E).
- E. A person may renew a well drilling license by submitting an application for renewal on forms prescribed and furnished by the Director and a fee of \$50.00. If the application and renewal fee are postmarked on or before June 30, the well drilling contractor may operate as a licensee until actual issuance of the renewal license. A license which has expired may be reactivated and renewed within one year of its expiration by filing the required application and a reactivation fee of \$50.00. If a license has been expired for one or more years for failure to renew, the well drilling contractor shall apply for a new license and repeat the examination.
- F. A well drilling contractor shall prominently display the well drilling license number on all well drilling rigs owned or operated by the contractor in this state. Good quality paint or commercial decal numbers shall be used in placing each identification number on the drilling rig. The license number shall not be inscribed in crayon, chalk, pencil, or other temporary markings.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended

effective June 18, 1990 (Supp. 90-2). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-807. Single Well License**

- A. An applicant for a single well license pursuant to A.R.S. § 45-595(D) shall submit a verified application on forms prescribed and furnished by the Director, which shall include:
  1. The name and address of the applicant.
  2. The location of the well and whether the applicant owns the land.
  3. The type of drill rig to be used and the owner of the rig.
  4. The proposed design of the well or method of abandonment.
  5. The names of any people who will be assisting the applicant in the drilling or abandonment of the well, and whether the applicant will compensate them for their efforts.
  6. The applicant's experience, if any, in well drilling or abandonment.
  7. Such other information as the Director may require relevant to the applicant's experience and qualifications in well drilling or abandonment.
- B. The Director shall offer the single well examination no less than six times yearly and shall administer the examination to those eligible applicants whose applications were submitted at least 20 days prior to the date of the examination.
- C. The single well examination shall be of a form prescribed and furnished by the Director and shall test the applicant's knowledge of abandonment techniques, or those minimum well construction requirements and drilling techniques applicable to the proposed design of the well. The passing grade on the sections of the examination dealing with construction requirements and drilling techniques, respectively, shall be 70 percent.
- D. Rule R12-15-805 relating to testing procedures shall be fully applicable.
- E. Applicants who twice fail the examination shall wait a minimum of 90 days before re-testing.
- F. Upon passing the examination, the applicant shall be issued a single well license, authorizing the applicant to drill or abandon one exempt well at the location specified in the application. The license shall be valid for a period of one year from issuance.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-808. Revocation of License**

The Director may revoke, suspend, or place on probationary status a well drilling license issued pursuant to R12-15-806, or a single well license, for good cause, including:

1. Intentionally making a misstatement of fact on any filing with the Department.
2. Violating any provision of A.R.S. Title 45, Chapter 2, Article 10, and the rules promulgated thereunder, or aiding and abetting in such a violation.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2). Section number



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corrected (Supp. 93-1).

**R12-15-809. Notice of Intention to Drill**

A notice of intention to drill required to be filed pursuant to A.R.S. § 45-596 shall be signed by the owner or lessee of the property upon which the well is to be drilled.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2).

**R12-15-810. Authorization to Drill**

- A. A well drilling contractor or single well licensee may commence drilling a well only if the well drilling contractor or licensee has possession of a drilling card at the well site issued by the Director in the name of the well drilling contractor or licensee, authorizing the drilling of the specific well in the specific location.
- B. In extraordinary situations not requiring a permit but only a notice of intention to drill, the Director may grant a request by telephone for emergency authorization of commencement of drilling prior to the actual receipt by the well driller of the drilling card. Within seventy-two hours after such a request is granted, the well driller shall file a written statement indicating the nature and reasons for the request, and the date, time and Department employee granting the request, and the well owner shall file a notice of intent to drill if such a notice has not previously been filed.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2). Amended to correct typographical error under A.A.C. R1-1-109 (Supp. 01-2). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3).

**R12-15-811. Minimum Well Construction Requirements**

- A. Well casing
  1. Casing shall be of a sufficient strength and wall thickness to hold the borehole open and survive any necessary grouting. A person shall use only steel or thermoplastic casing in the construction of a well, unless the person has received a variance from the Director pursuant to R12-15-820. The well casing or an extension of the casing shall extend a minimum of one foot above ground level. When installing a pitless adaptor, the casing may be terminated below ground level for aesthetic reasons or freeze protection purposes. Casing made of, or which has been exposed to, hazardous or potentially harmful materials, such as asbestos, shall not be used.
  2. All well casing joints or overlaps shall be made watertight to prevent the degradation of the water supply by the migration of inferior quality water. Except as provided in subsection (H), any openings in the casing that will be above the water level in the well, such as bar holes, cracks or perforations, shall be completely plugged or sealed.
  3. Thermoplastic casing shall be installed in an oversized drillhole without driving. Thermoplastic casing shall conform with ATSM International Standard Specification F480-14 (2014), which is incorporated herein by reference and is on file with the Department. Rivets or screws used in the casing joints shall not penetrate the inside of the casing.
  4. Steel casing shall be new or in like-new condition, free from pits or breaks, and shall conform with ASTM International Standard Specification A53/53M-20 (2020), A139/139M-16 (2016) or A312/312M-20 (2021), which-ever is applicable, all of which are incorporated herein by reference and are on file with the Department.
5. Copies of the ASTM International standard specifications references to in subsections (B)(3) and (4) may be obtained from the Department of Water Resources, 1110 W. Washington Street, Suite 300, Phoenix, AZ 85007; and from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959. This Section does not include any later amendments or editions of those standard specifications.
- B. Surface seal
  1. Except as provided in subsections (B)(2) and (4), and R12-15-817(B)(1), all wells shall be constructed with a surface seal as herein provided. The seal shall consist of steel casing, one foot of which shall extend above ground level, and cement grout placed in one continuous application from the bottom of the zone to be grouted to the land surface. If a pitless adaptor is utilized, the cement grout may terminate at the bottom of the pitless adaptor. The minimum length of the steel casing shall be 20 feet. The minimum annular space between the casing and the borehole for placement of grout shall be one and one-half inches. Curing additives, such as calcium chloride, shall not exceed ten percent of the total volume of grout. Bentonite as an additive shall not exceed five percent of the total volume. The minimum length of the surface seal shall be 20 feet. Any annular space between the outer casing and an inner casing shall be completely sealed to prevent contamination of the well.
  2. All hand-dug wells shall be constructed with a watertight curbing extending, at a minimum, from one foot above the natural ground level to the static water level, or into the confining formation if the aquifer is artesian. The curbing shall consist of poured cement grout or casing surrounded by cement grout. Concrete block with cement grout and rock with cement grout may also be used. The poured cement grout shall not be less than six inches thick. If casing is to be used, the minimum annular space between the casing and the borehole shall be three inches. Hand-dug wells shall be sealed at the surface with a watertight, tamper-resistant cover to prevent contaminants from entering the well.
  3. All wells constructed by jetting or driving shall have cement grout placed in the annular space to a minimum depth of six feet. The minimum annular space between the casing and the borehole for placement of the grout shall be one and one-half inches.
  4. All horizontal wells, to prevent leakage, shall be constructed with a surface seal consisting of steel casing and cement grout extending a minimum of ten feet into the land surface.
- C. Access port. Every well with casing four inches in diameter or larger shall be equipped with a functional watertight access port with a minimum diameter of one-half inch so that the water level or pressure head in the well can be monitored at all times.
- D. Gravel packed wells
  1. If a gravel pack has been installed, the annular space between the outer casing and the inner casing shall be sealed, either by welding a cap at the top or by filling with cement grout from the bottom of the outer casing to the surface.
  2. If a gravel tube is installed, it shall be sealed with a cap.

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- E. Vents. All vents installed in the well casing shall open downward and be screened to prevent the entrance of foreign material.
- F. Removal of drilling materials
  1. In constructing a water well, the well driller shall take all reasonable precautions to protect the producing aquifer from contamination by drilling materials. Upon completion of the well, the well driller shall remove all foreign substances and materials introduced into the aquifer or aquifers during well construction. For purposes of this subsection, "substances and materials" means all drilling fluids, filter cake, lost circulation materials, and any other organic or inorganic substances.
  2. Materials known to present a health hazard, such as chrome-based mud thinners, asbestos products, and petroleum-based fluids, shall not be used as construction, seal or fill materials or drilling fluids.
  3. Drilling fluids and cuttings shall be contained in a manner which prevents discharge into any surface water.
- G. Repair of existing wells
  1. If, in the repair of a well, the old casing is withdrawn, the well shall be recased in conformance with these rules.
  2. If an inner casing is installed to prevent leakage of undesirable water into a well, the annular space between the casings shall be completely sealed by packers, casing swedging, pressure grouting or other methods which will prevent the movement of water between the casings.
- H. Monitor wells
  1. A monitor well may be screened up to ten feet above the highest seasonal static water level of record for the purpose of monitoring contaminants.
  2. A monitor well shall be identified as such on the vault cover or at the top of the steel casing. Identification information shall include the well registration number.
- I. Completion at the surface. In areas of traffic or public rights-of-way, wells may be constructed below the land surface in a vault. All other requirements in this Article shall apply.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2). The reference to R12-14-817(B)(1) in subsection (B)(1) corrected to read R12-15-817(B)(1) (Supp. 93-1). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4). Amended by final expedited rulemaking at 28 A.A.R. 266 (January 28, 2022), with an immediate effective date of January 5, 2022 (Supp. 22-1).

**R12-15-812. Special Aquifer Conditions**

- A. Artesian wells
  1. The well casing shall extend into the confining formation immediately overlying the artesian aquifer and shall be grouted from a minimum of ten feet into the confining formation to the land surface to prevent surface leakage into and subsurface leakage from the artesian aquifer.
  2. If leaks occur adjacent to the well or around the well casing, within 30 days the well shall be completed with the seals, packers, or casing and grouting necessary to eliminate such leakage or the well shall be abandoned according to R12-15-816.
  3. If the well flows at land surface, the well shall be equipped with a control valve, or suitable alternative means of completely controlling the flow, which must be available for inspection at the well site at all times.

- B. Mineralized or polluted water. In all water-bearing geologic units containing mineralized or polluted water as indicated by available data, the borehole shall be cased and grouted so that contamination of the overlying or underlying groundwater zones will not occur.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-813. Unattended Wells**

All wells, when unattended during well drilling, shall be securely covered for safety purposes and to prevent the introduction of foreign substances into the well.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Section number corrected (Supp. 93-1).

**R12-15-814. Disinfection of Wells**

A well drilling contractor shall disinfect any well from which the water to be withdrawn is intended to be utilized for human consumption or culinary purposes without prior treatment before removing the drill rig from the well site in accordance with the requirements contained in Engineering Bulletin No. 8, "Disinfection of Water Systems," issued by the Arizona Department of Health Services in August 1978, and Engineering Bulletin No. 10, "Guidelines for the Construction of Water Systems," issued by the Arizona Department of Health Services in May 1978, both of which are incorporated by reference and are on file with the Office of the Secretary of State. Copies of the Engineering Bulletins referred to in this Section may be obtained with this Chapter at the Office of the Secretary of State of the State of Arizona, State Capitol, West Wing, Phoenix, Arizona 85007, and from the Department of Water Resources, 1110 W. Washington Street, Suite 300, Phoenix, AZ 85007. This Section does not include any later amendments or editions of those Bulletins.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4). Amended by final expedited rulemaking at 28 A.A.R. 266 (January 28, 2022), with an immediate effective date of January 5, 2022 (Supp. 22-1).

**R12-15-815. Removal of Drill Rig from Well Site**

The drilling rig shall not be removed from the well site unless the well is in one of the following conditions:

1. Constructed in full conformance with R12-15-811 and R12-15-812 and either sealed with a cap or equipped with a pump.
2. Abandoned in accordance with R12-15-816.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-816. Abandonment**

- A. Well abandonment shall be performed only by a licensed well drilling contractor or single well licensee.
- B. Except as provided in subsection (F) of this Section, the owner of a well shall file a notice of intent to abandon the well prior to abandonment, on a form prescribed and furnished by the Director, which shall include:
  1. The name and mailing address of the person filing the notice.

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2. The legal description of the land upon which the well proposed to be abandoned is located and the name and mailing address of the owner of the land.
  3. The legal description of the location of the well on the land.
  4. The depth, diameter and type of casing of the well.
  5. The well registration number.
  6. The materials and methods to be used to abandon the well.
  7. When abandonment is to begin.
  8. The name and well drilling license number of the well drilling contractor or single well licensee who is to abandon the well.
  9. The reason for the abandonment.
  10. Such other information as the Director may require.
- C.** The Director shall, upon receipt of a proper notice of intent to abandon, mail a well abandonment authorization card to the designated well drilling contractor or single well licensee.
- D.** Except as described in subsection (F) of this Section, a well drilling contractor or single well licensee may commence abandoning a well only if the driller has possession of an abandonment card at the well site, issued by the Director in the name of the driller, authorizing the abandonment of that specific well or wells in that specific location.
- E.** Within 30 days after a well is abandoned pursuant to this Section, the well drilling contractor or single well licensee shall file with the Director a Well Abandonment Completion Report on a form prescribed and furnished by the Director which shall include the date the abandonment of the well was completed and such other information as the Director may require.
- F.** In the course of drilling a new well, the well may be abandoned without first filing a notice of intent to abandon and without an abandonment card. If the well is abandoned pursuant to this subsection without first filing a notice of intent to abandon and without an abandonment card, the well drilling contractor or single well licensee shall provide the following information in the Well Abandonment Completion Report:
1. The legal description of the land upon which the well was abandoned and the name and mailing address of the owner of the land.
  2. The legal description of the location of the well on the land.
  3. The depth, diameter and type of casing of the well prior to abandonment.
  4. The well registration number.
  5. The materials and methods used to abandon the well.
  6. The name and well drilling license number of the well drilling contractor or single well licensee who abandoned the well.
  7. The date of completion of the abandonment of the well.
  8. The reason for the abandonment.
  9. Such other information as the Director may require.
- G.** The abandonment of a well shall be accomplished through filling or sealing the well so as to prevent the well, including the annular space outside the casing, from being a channel allowing the vertical movement of water.
- H.** A well drilling contractor or single well licensee shall construct a surface seal for a well that does not penetrate an aquifer, as follows:
1. If the casing is removed from the top 20 feet of the well, a cement grout plug shall be set extending from two feet below the land surface to a minimum of 20 feet below the land surface, and the well shall be backfilled above the top of the cement grout plug to the original land surface.
  2. If the casing is not removed from the top 20 feet of the well, a cement grout plug shall be set extending from the top of the casing to a minimum of 20 feet below the land surface and the annular space outside the casing shall be filled with cement from the land surface to a minimum of 20 feet below the land surface.
- I.** In addition to the surface seal required in subsection (H):
1. A well penetrating a single aquifer system with no vertical flow components shall be filled with cement grout, concrete, bentonite drilling muds, clean sand with bentonite, or cuttings from the well.
  2. A well penetrating a single or multiple aquifer system with vertical flow components shall be sealed with cement grout or a column of bentonite drilling mud of sufficient volume, density, and viscosity to prevent fluid communication between aquifers.
- J.** Materials containing organic or toxic matter shall not be used in the abandonment of a well.
- K.** The owner or operator of the well shall notify the Director in writing no later than 30 days after abandonment has been completed. The notification shall include the well owner's name, the location of the well, and the method of abandonment.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3).

**R12-15-817. Exploration Wells**

- A.** Notification. Prior to drilling one or more exploration wells, the well owner, lessee, or exploration firm shall file a notice of intention to drill on forms provided by the Director. If the notice of intention to drill is filed for the project as a whole, the drilling card shall be issued for the project as a whole.
- B.** Construction and abandonment.
1. If an exploration well which is to be left open for re-entry at a later date encounters groundwater, it shall be cased and capped in accordance with R12-15-811, R12-15-812, and R12-15-822. The minimal length of surface seal shall be either 20 feet, or five feet into the first encountered consolidated formation, whichever is less. If no groundwater is encountered, the well shall be cased, grouted and capped in such a manner so as to prevent contamination of the well bore from the surface.
  2. Exploration wells not left open for re-entry shall be abandoned in accordance with R12-15-816.
- C.** Completion report. Within 30 days of project completion, the well owner, lessee, or exploration firm shall submit a project completion report on forms provided by the Director. The report shall include:
1. The exact number of wells drilled.
  2. The depth to water encountered or detected, with reference to specific wells.
  3. The abandonment method utilized, or construction details if completed for re-entry.
  4. Any other information which the Director may require.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-818. Well Location**

Except for monitor wells and piezometer wells, no well shall be drilled within 100 feet of any septic tank system, sewage disposal area, landfill, hazardous waste facility, storage area of hazardous

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materials or petroleum storage areas and tanks, unless authorized in writing by the Director.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-819. Use of Well as Disposal Site**

No well may be used as a storage or disposal site for sewage, toxic industrial waste, or other materials that may pollute the groundwater, except as authorized by the Arizona Department of Environmental Quality.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-820. Request for Variance**

- A. If extraordinary or unusual conditions exist, a well drilling contractor or owner may request a variance from the provisions of this Article.
- B. The request for variance shall be in writing and shall set forth the location of the well site, the reasons for the request, and the recommended requirements to be applied. The Director may approve the request only if the well drilling contractor or owner has clearly demonstrated that the variance will not adversely affect other water users or the local aquifers.
- C. A variance shall not be effective until the well drilling contractor or owner receives from the Director a written approval of the variance and a new drilling card stamped "variance issued."

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-821. Special Requirements**

If the Director determines that the literal application of the minimum well construction requirements contained in this Article would not adequately protect the aquifer or other water users, the Director may require that further additional measures be taken, such as increasing the length of the surface seal or increasing the well's minimum distance from a potential source of contamination.

**Historical Note**

Adopted effective March 5, 1984 (Supp. 84-2). Amended effective June 18, 1990 (Supp. 90-2).

**R12-15-822. Capping of Open Wells**

- A. The owner of an open well shall either install a cap on the well or abandon the well in accordance with R12-15-816. Within five days after capping the well, the owner of the well shall file with the Department a notice of well capping on a form approved by the Director which shall include the following information:
  1. The name and address of the well owner.
  2. The name and address of the person installing the cap.
  3. The well registration number.
  4. The legal description of the location of the well.
  5. The date the well was capped.
  6. The method of capping.
  7. The type and diameter of casing.
- B. If no casing exists in an open well, or if the integrity of the existing casing is insufficient to allow installation of a cap, the well owner shall install a surface seal in accordance with R12-15-811(B) prior to capping.
- C. The owner of a well on which a cap is installed shall make the cap tamper resistant by welding the cap to the top of the casing

by the electric arc method of welding, except that the owner of a well may make the cap tamper resistant by securing the cap to the top of the casing with a lock during temporary periods of well maintenance, modification or repair, not to exceed 30 days, or at any time if the well is a monitor well or piezometer well.

**Historical Note**

Adopted as an emergency effective March 2, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Readopted without change as an emergency effective June 2, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-2). Emergency expired. Readopted without change as an emergency effective September 5, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-3). Emergency expired. Readopted without change as an emergency effective December 1, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-4). Emergency expired. Readopted without change as an emergency effective March 23, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-1). Permanent rule adopted with changes effective June 18, 1990 (Supp. 90-2). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3).

**R12-15-823. Reserved**

**R12-15-824. Reserved**

**R12-15-825. Reserved**

**R12-15-826. Reserved**

**R12-15-827. Reserved**

**R12-15-828. Reserved**

**R12-15-829. Reserved**

**R12-15-830. Reserved**

**R12-15-831. Reserved**

**R12-15-832. Reserved**

**R12-15-833. Reserved**

**R12-15-834. Reserved**

**R12-15-835. Reserved**

**R12-15-836. Reserved**

**R12-15-837. Reserved**

**R12-15-838. Reserved**

**R12-15-839. Reserved**

**R12-15-840. Reserved**

**R12-15-841. Reserved**

**R12-15-842. Reserved**

**R12-15-843. Reserved**

**R12-15-844. Reserved**

**R12-15-845. Reserved**

**R12-15-846. Reserved**

**R12-15-847. Reserved**

**R12-15-848. Reserved**

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**R12-15-849. Reserved****R12-15-850. Evaluation of Notices of Intention to Drill; Notification of Registered Site Locations; Vertical Cross-Contamination Evaluation**

- A. The Director shall, upon receipt of a complete and correct notice of intention to drill form required under A.R.S. § 45-596, or upon receipt of an application for a permit under A.R.S. § 45-597 through 45-599, identify whether the proposed well will be drilled within a groundwater basin or subbasin in which there exists a site listed on the registry established under A.R.S. § 49-287.01(D). If the proposed well is situated within such a groundwater basin or subbasin, the Director shall notify the applicant and the authorized well drilling contractor in writing of the existence of the site and shall enclose a map indicating the boundaries of all listed sites within the groundwater basin or subbasin. The notification letter shall include the name, address, and telephone number of a Department contact person, along with a reference to the provision in R12-15-851 that requires the applicant to notify the Department in advance of the date drilling of the well will commence. The Department shall also specify in the notification letter whether the applicant is subject to the requirements of R12-15-851.
- B. The Director shall, upon receipt of a complete and correct notice of intention to drill form required under A.R.S. § 45-596, or upon receipt of an application for a permit under A.R.S. § 45-597 through 45-599, identify whether the proposed well will be drilled within an area where existing or anticipated future groundwater contamination presents a risk of vertical cross-contamination, as defined in A.R.S. § 49-281(15). If the Director determines that the proposed well will be drilled in such an area, and if the Director finds that the requirements of R12-15-811 are insufficient to prevent the risk of vertical cross-contamination, the Director shall establish site-specific requirements pursuant to R12-15-812 and R12-15-821.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 469, effective January 3, 2000 (Supp. 00-1).

**R12-15-851. Notification of Well Drilling Commencement**

A well owner who has been issued a drilling card for a notice of intent to drill authorizing the drilling of a well located within a site listed on the registry established under A.R.S. § 49-287.01, shall provide written notice to the Director indicating the date drilling will commence. The well owner shall coordinate with the contracted well driller to ensure that the Department receives proper notification under this Section. This notification shall consist of a letter or facsimile transmission received by the Department at least 2 business days before drilling commences at the well site. The Department shall use notification letters required by R12-15-850(A) to inform well owners whether they are subject to the requirements of this Section.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 469, effective January 3, 2000 (Supp. 00-1).

**R12-15-852. Notice of Well Inspection; Opportunity to Comment**

- A. At least 30 days before the beginning of a well inspection under A.R.S. § 45-605(A), the Director shall notify in writing all potentially affected well owners of record within a community involvement area established under A.R.S. § 49-289.02 or within other areas that the Director has selected for inspection

of wells that may be contributing to vertical cross-contamination. The notices shall include a map of the community involvement area, remedial site, or a subsection of either, that the Department intends to inspect, indicating the location of affected wells of record. The notice shall indicate the approximate date the inspection will start, the approximate duration of the inspection, an access agreement defining what specific activities will occur during a well inspection, and the name, address, and telephone number of a Department contact person.

- B. Once the Director has given notice of a well inspection under A.R.S. § 45-605(A), potentially affected well owners have 30 days from the date the letter is postmarked to comment on the proposed inspection. The Director, upon receiving a written request, may extend the comment period for a maximum of 30 additional days.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 469, effective January 3, 2000 (Supp. 00-1).

**ARTICLE 9. WATER MEASUREMENT****R12-15-901. Definitions**

In addition to the definitions set forth in A.R.S. §§ 45-101 and 45-402, the following words and phrases shall have the following meanings, unless the context otherwise requires:

1. "Approved measuring device" means an instrument, approved by the Director pursuant to R12-15-903 or R12-15-909(A) which measures the volume or flow rate of water withdrawn, delivered, received, transported, recharged, stored, recovered, or used, and which measurements, when used with an approved measuring method, allow for accurate computation of a volume of water.
2. "Approved measuring method" means a procedure, approved by the Director in R12-15-903 or R12-15-909(A), which, when used with an approved measuring device, will accurately calculate a volume of water.
3. "Flow rate" or "discharge" means the volume of water, including any sediment or other solids that may be dissolved or mixed with it, which passes through a particular reference section in a unit of time.
4. "Measured system" means a system through which water passes for the purpose of withdrawal, delivery, receipt, transportation, recharge, storage, replenishment, recovery or use.
5. "Responsible party" means an irrigation district or a person required by A.R.S. Title 45 or by a permit, rule, or order issued pursuant to A.R.S. Title 45, to use a measuring device or method approved by the Director.

**Historical Note**

Adopted effective December 27, 1982 (Supp. 82-6). Amended effective June 15, 1995 (Supp. 95-2). Amended to correct typographical error under A.A.C. R1-1-109 (Supp. 01-2).

**R12-15-902. Installation of Approved Measuring Devices**

- A. A responsible party shall install an approved measuring device to monitor the volume of water withdrawn, delivered, transported, recharged, stored, replenished, recovered, and used.
- B. A responsible party shall install and use a sufficient number of approved measuring devices to allow for the separate monitoring and reporting of the volume of water passing through the measured system pursuant to the following categories of rights:

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1. Irrigation grandfathered rights,
2. Non-irrigation grandfathered rights,
3. Service area rights,
4. Groundwater withdrawal permits, and
5. Recovery well permits or water storage permits.

This subsection does not require separate measuring devices for rights within each category unless otherwise required by A.R.S. Title 45, a permit, rule, or order pursuant to that Title.

- C. An approved measuring device which measures groundwater withdrawals shall be installed as close to the wellhead as is practical, consistent with the manufacturer's instructions. An approved measuring device which measures another point in the measured system shall be installed as close as is practical to the point of delivery, receipt, transportation, recharge, storage, replenishment, recovery, or use which the device is intended to measure, consistent with the manufacturer's instructions.

**Historical Note**

Adopted effective December 27, 1982 (Supp. 82-6).  
Amended effective June 15, 1995 (Supp. 95-2). Amended  
to correct typographical error under A.A.C. R1-1-109  
(Supp. 01-2).

**R12-15-903. Approved Water Measuring Devices and Methods**

- A. Any measuring device is approved by the Director if it is installed, maintained, and used in accordance with the manufacturer's recommendations, and if it meets the accuracy requirements set forth in R12-15-905(A).
- B. An approved measuring device shall be used with an approved measuring method set forth in R12-15-903(C) or an alternative measuring method approved by the Director as provided in R12-15-909(A).
- C. The following water measuring methods are approved by the Director:
  1. Totalizing measuring method: This method requires an approved measuring device which continuously records the volume of water passing through the measured system;
  2. Electrical consumption measuring method: This method requires measurements of either pipeflow rates or open-channel flow rates used in combination with electrical energy records;
  3. Natural gas consumption measuring method: This method requires measurements of either pipe flow rates or open channel flow rates used in combination with natural gas energy records;
  4. Hour meter measuring method: This method requires measurements of either pipe flow rates or open-channel flow rates used in combination with hour meter readings;
  5. Elapsed time of flow method: This method requires measurements of flow rates used in combination with elapsed time of the flow. This method may be used only by a responsible party who receives water from an open channel or by a person or entity who delivers water in an open channel to one or more grandfathered rightholders or permit holders, if it is not possible to use the electrical or gas consumption measurement methods or hour meter measuring method.

**Historical Note**

Adopted effective December 27, 1982 (Supp. 82-6).  
Amended effective June 15, 1995 (Supp. 95-2).

**R12-15-904. Water Measuring Method Reporting Require-****ments**

- A. A responsible party using one of the water measuring methods described in R12-15-903 shall file, with the annual report required by A.R.S. Title 45 and on a form prescribed by the Director, the following information, unless that information has not changed from that submitted in the annual report filed in the previous calendar year.
  1. The approved measuring method used;
  2. The type of approved measuring device used;
  3. The make, model, and size of the approved measuring device used.
- B. Except as provided in R12-15-904(B)(5) and R12-15-909(B) and (D), a responsible party shall file with the annual report the information required in subsection (A) of this Section and the following information on a form prescribed by the Director:
  1. Totalizing measuring method:
    - a. The initial totalizing meter reading for the reporting year taken prior to the first use of the measured system during the reporting year;
    - b. The end totalizing meter reading for the year taken subsequently to the last use of the measured system during the reporting year;
    - c. The units in which the water is measured;
    - d. Whether the power meter serves uses other than the pump motor or engine;
    - e. An estimate of the amount of any water passing through the measured system during measuring device malfunctions;
    - f. If the well is in operation for more than a 30-day period, the results of a minimum of two flow-rate measurements per reporting year taken under normal system operating conditions. The responsible party shall not submit the results of the flow-rate measurements with the annual report unless a meter malfunction continues longer than 72 hours during the reporting year;
    - g. The installation or overhaul date of the totalizing meter; and
    - h. The name of the energy company supplying energy to the responsible party's measured system, its power account number, meter number, total energy consumption for the year, and the type of energy unit.
  2. Electrical consumption measuring method:
    - a. The results of a minimum of two flow-rate measurements per reporting year taken at least 30 days apart and under normal system operating conditions or, if the measured system is used during a single period of 30 days or less during the year, the result of one flow-rate measurement taken during that single period in that year under normal system operating conditions;
    - b. The dates of the measurements;
    - c. The discharges in gallons per minute;
    - d. The time, in seconds, of ten cycles of the electric meter disk, power indicator pulse, or an alternative measurement, provided that the alternative means of measurement is approved in advance by the Director;
    - e. The inside diameter of the discharge pipe;
    - f. The multiplier ( $K_r$ ) and disk constant ( $K_h$ ) of the electric meter; and

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- g. The name of the energy company supplying energy to the responsible party's measured system, its power account number, meter number, total energy consumption for the year, and the type of energy unit.
- 3. Natural gas consumption measuring method:
  - a. The results of a minimum of two flow-rate measurements per reporting year taken at least 30 days apart and under normal system operating conditions or, if the measured system is used during a single period of 30 days or less during the year, the result of one flow-rate measurement taken during that single period in that year under normal system operating conditions;
  - b. The dates of the measurements;
  - c. The discharges in gallons per minute;
  - d. The amounts of gas per second in cubic feet indicated by the gas meter;
  - e. The billing factors (F);
  - f. The inside diameter of the discharge pipe; and
  - g. The name of the energy company supplying energy to the responsible party's measured system, its power account number, meter number, total energy consumption for the year, and the type of energy unit.
- 4. Hour meter measuring method:
  - a. The results of a minimum of two flow-rate measurements per reporting year taken at least 30 days apart and under normal system operating conditions or, if the measured system is used during a single period of 30 days or less during the year, the result of one flow-rate measurement taken during that single period in that year under normal system operating conditions;
  - b. The dates of the measurements;
  - c. The discharges in gallons per minute;
  - d. The initial hour meter reading for the reporting year taken prior to the first use of the measured system during the reporting year;
  - e. The end hour meter reading taken subsequently to the last use of the measured system during the reporting year;
  - f. Whether the energy meter serves uses other than the pump motor or engine;
  - g. The installation or overhaul date of the hour meter; and
  - h. The name of the energy company supplying energy to the responsible party's measured system, its power account number, meter number, total energy consumption for the year, and the type of energy unit.
- 5. Elapsed time of flow measuring method: A responsible party using this measuring method shall not be required to submit the following information with the annual report but instead shall record and retain it for three years after the reporting year.
  - a. The responsible party or agent shall measure and record an initial flow rate taken at the start of flow for each delivery of water;
  - b. If the flow rate continues for more than eight hours, a subsequent measured flow-rate measurement shall be taken. If any subsequently measured flow-rate differs by more than 10% from the initial flow rate, and the delivery is not adjusted to conform with the initial flow rate, the responsible party or agent shall record the subsequent flow rate;
  - c. The time the flow begins and the time the flow ends for each delivery of water; and
  - d. The dates of the measurements.
- C. A responsible party or person or entity who uses an approved measuring method or an approved alternative water measurement method shall save the records required by subsections (A) and (B) of this Section for three years after the reporting year.

**Historical Note**

Adopted effective December 27, 1982 (Supp. 82-6). Former Section R12-15-904 renumbered to R12-15-905, new Section adopted effective June 15, 1995 (Supp. 95-2). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-905. Accuracy of Approved Measuring Devices**

- A. A responsible party shall install, maintain, and use an approved measuring device and method in a manner which will ensure that its measurement error does not exceed 10% of the actual flow rate.
- B. All measured systems shall be installed or constructed and thereafter maintained so as to allow the Director, using another measuring device, to check readily the accuracy of the measuring device utilized by the responsible party.

**Historical Note**

Adopted effective December 27, 1982 (Supp. 82-6). Former Section R12-15-905 renumbered to R15-15-906, new Section R12-15-905 renumbered from R12-15-904 and amended effective June 15, 1995 (Supp. 95-2).

**R12-15-906. Repair and Replacement of Approved Measuring Devices**

If an approved measuring device fails to perform its designated function for more than 72 hours, the responsible party shall notify the Director of the failure, in writing, within seven calendar days after the discovery of the failure of the device. The reason for such failure shall be stated, as well as the estimated date of return to service of the device. If the malfunction is discovered by the Director and the malfunction does not appear to be the result of an attempt to render the device inaccurate, the Director shall notify the responsible party of the malfunction. The responsible party shall return the measuring device to full service within 30 days of either original notice by the responsible party to the Director or by the Director to the responsible party, unless repair or replacement service or parts are not available. In such case, the responsible party shall notify the Director of the delay within seven days and the reasons for it. The responsible party shall take corrective action in such cases as soon as practical. In all cases, the responsible party shall notify the Director within seven days when the measuring device is returned to full service and shall submit on a form prescribed by the Director estimates of the volume of water, if any, passing through the measured system during the period the measuring device was out of service and a description of the method used to calculate the estimates.

**Historical Note**

Section R12-15-906 renumbered from R12-15-905 and amended effective June 15, 1995 (Supp. 95-2).

**R12-15-907. Calculation of Irrigation Water Deliveries**

If one or more irrigation grandfathered rights receive water by a common distribution system where water is measured with an approved device or method at the point of delivery to the common distribution system, but not at a point of delivery to each irrigation

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grandfathered right, each irrigation grandfathered rightholder or agent shall report the water used by either of the following methods:

1. Estimate the amount of water used based on a pro rata share of the acres irrigated, or
2. Estimate the amount of water used based on a combination of the pro rata share of the acres irrigated and the consumptive use of each crop grown.

**Historical Note**

Adopted effective June 15, 1995 (Supp. 95-2).

**R12-15-908. Measurement of Water by One Person on Behalf of Another**

A responsible party shall be liable for any fines, penalties, or other sanctions resulting from the installation, monitoring, use, or accuracy of any measuring device, method, or recordkeeping, notwithstanding that the installation, monitoring, use, or recordkeeping may have been done by an agent of the responsible party.

**Historical Note**

Adopted effective June 15, 1995 (Supp. 95-2).

**R12-15-909. Alternative Water Measuring Devices, Methods, and Reporting**

- A. A responsible party may use an alternative water measuring device or method that differs from those described in R12-15-903 provided the device or method is approved in advance by the Director. The Director shall approve an alternative water measuring device or method if the device meets the requirements of R12-15-905. The Director may require from the responsible party such information as may be necessary to demonstrate that the alternative device or method meets the requirements of R12-15-905.
- B. Responsible parties may substitute equivalent information for the information required on the annual report form or use reporting formats that differ from that required in R12-15-904, provided the substituted information or format is approved in advance by the Director.
- C. Responsible parties may use estimation methods that differ from those described in R12-15-907 provided they are approved in advance by the Director.
- D. A municipal provider is exempted from the reporting requirements under R12-15-904 and the provisions under R12-15-906 pertaining to notification to the Director of measuring device malfunctions regarding metered service connections, unless required to report by A.R.S. Title 45 or by a permit, rule, or order issued pursuant to A.R.S. Title 45.
- E. Municipal providers and irrigation districts may notify the Director of measuring device malfunctions at the time of filing the annual report and in a manner that differs from the requirements of R12-15-906, provided the municipal provider or irrigation district implements a schedule of regular maintenance of measuring devices, repairs or replaces malfunctioning measuring devices within seven days of discovery of the malfunction, and the alternative notification is approved in advance by the Director.

**Historical Note**

Adopted effective June 15, 1995 (Supp. 95-2).

**ARTICLE 10. REPORTING REQUIREMENTS FOR  
ANNUAL REPORTS, ANNUAL ACCOUNTS, OPERATING  
FLEXIBILITY ACCOUNTS, AND CONVEYANCES OF  
GROUNDWATER RIGHTS**

**R12-15-1001. Definitions**

In addition to the definitions in A.R.S. §§ 45-101 and 45-402, the following words and phrases in this Article have the following meanings, unless the context otherwise requires:

1. “Annual account” means an accounting of water required to be filed pursuant to A.R.S. § 45-468.
2. “Annual report” means an annual report of water withdrawn, delivered, received, transported, recharged, stored, recovered, replenished or used as required by A.R.S. §§ 45-437, 45-467, 45-632, 45-875.01, 45-876.01, 45-877.01, 45-878.01 or 45-1004.
3. “Central Arizona project water” means Colorado River water delivered through the facilities of the central Arizona project, and surface water from any other source conserved and developed by dams and reservoirs in the central Arizona project and lawfully delivered by the United States or a multi-county conservation district.
4. “Decreed or appropriative surface water” means surface water which is delivered or used pursuant to a decreed or appropriative water right, except any such water which is included in central Arizona project water.
5. “Farm” means an area of irrigated land under the same ownership as defined in A.R.S. § 45-402, including the area of land described in a certificate of irrigation grandfathered right, as well as contiguous land that the owner is legally entitled to irrigate only with decreed or appropriative surface water.
6. “Maximum annual groundwater allotment” means the quantity of water in acre-feet obtained by multiplying the number of water duty acres for a farm by the current irrigation water duty for the farm unit.
7. “Normal flow” means water delivered or used pursuant to a right to appropriate an unstored, natural flow of surface water.
8. “Operating flexibility account” means an accounting of water use pursuant to an irrigation grandfathered right as provided in A.R.S. § 45-467.
9. “Responsible party” means a person required by law to file an annual account or annual report.
10. “Spillwater” means surface water, other than Colorado River water, released for beneficial use from storage, diversion, or distribution facilities to avoid spilling that would otherwise occur due to uncontrolled surface water inflows that exceed facility capacity and to which one of the following applies:
  - a. The water is released from the facility under written criteria for releasing water to avoid spilling that have been approved in writing by the Director.
  - b. The water is released from the facility because an unreasonable risk exists that the storage capacity of the facility will be exceeded within the next 30 days because the facility is near capacity and either the inflow to the facility or the forecast runoff into the facility is equal to or greater than the quantity of water ordered from the facility.
  - c. The water is released from the facility because an unreasonable risk exists that the storage capacity of the facility will be exceeded more than 30 days in the future because the forecast runoff into the facility exceeds current unused storage capacity and projected water demand during the forecast period, provided that the Director has made a written finding before the release that the forecast is reasonable.



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11. "Surface water right acre" means land to which the owner is legally entitled to apply decreed or appropriative surface water.
12. "Tailwater" means water which, after having been applied to a farm for irrigation purposes,
  - a. Is subsequently used for the irrigation of a different farm, without having entered the distribution system of a city, town, private water company or irrigation district, or
  - b. Is delivered to an irrigation district in accordance with R12-15-1010. Such water, once having entered the distribution system of the irrigation district, loses its characterization as tailwater.
13. "Water deliverer" means a city, town, private water company or irrigation district delivering a combination of groundwater and any other type of water for irrigation purposes.

**Historical Note**

Adopted effective December 27, 1982 (Supp. 82-6). Section R12-15-1001 renumbered to R12-15-1003, new Section R12-15-1001 adopted effective December 12, 1990 (Supp. 90-4). Amended to correct typographical error under A.A.C. R1-1-109 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1002. Form of Annual Account or Annual Report**

- A. A person filing an annual account or an annual report shall do so on a form prescribed by the Director, unless the person has requested and received the Director's prior written approval to use an alternative form.
- B. A person may file both an annual account and an annual report in one document. A person required to file an annual account shall designate in the annual account whether the annual account is being filed also as an annual report.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

**R12-15-1003. Accuracy of Annual Reports**

The quantity of water a responsible party reports in an annual report as having been withdrawn, delivered, received, transported, recharged, replenished, stored, recovered, or used during a year shall not deviate from the quantity of water actually withdrawn, delivered, received, transported, recharged, replenished, stored, recovered, or used by the responsible party during the year unless both of the following apply:

1. The deviation is 10 percent or less.
2. The deviation is not the result of an intentional act of misrepresentation by the responsible party.

**Historical Note**

Section R12-15-1003 renumbered from R12-15-1001 effective December 12, 1990 (Supp. 90-4). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1004. Annual Reports Filed on Behalf of a Responsible Party**

- A. A responsible party is liable for any fines, penalties, or other sanctions resulting from or attributable to the filing or content of an annual report filed on behalf of the responsible party by an irrigation district pursuant to A.R.S. § 45-632, or by another person in a form acceptable to the Director.
- B. If a responsible party has not filed an annual report for a calendar year, and the Department receives an annual report for that

calendar year purportedly filed on behalf of the responsible party by an irrigation district pursuant to A.R.S. § 45-632, or by another person in a form acceptable to the Director, there is a rebuttable presumption that the annual report was filed with the responsible party's knowledge, consent, and authorization.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).  
Amended to correct typographical error under A.A.C. R1-1-109 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1005. Management Plan Monitoring and Reporting Requirements**

A responsible party who is required by a provision of a management plan to comply with monitoring and reporting requirements shall comply with such requirements and shall include all such information in an annual account or annual report.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

**R12-15-1006. Reporting Requirements for Holders of Recovery Well Permits**

A responsible party recovering water during a year pursuant to a recovery well permit shall include in the annual report required by A.R.S. § 45-875.01 the names of any persons, other than non-irrigation customers of cities, towns, private water companies and irrigation districts, to whom the responsible party delivered the recovered water during the year, the quantity of recovered water delivered to each person named, and the uses to which the recovered water was applied. If the recovered water included commingled groundwater, decreed or appropriative surface water other than spillwater, central Arizona project water, effluent or spillwater, the responsible party shall include in the annual report an estimate of the quantity of each type of water delivered to each person named in the annual report or put to a specific use by the responsible party.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).  
Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1007. Reporting Requirements for Annual Account**

A person required to file an annual account pursuant to A.R.S. § 45-468 shall account for water provided to the following classes of users:

1. Cities and towns,
2. Private water companies,
3. Irrigation districts,
4. Dairies,
5. Metal mining facilities,
6. Cattle feed lots,
7. Turf-related facilities,
8. Sand and gravel facilities,
9. Electrical power generation facilities,
10. Other industrial users.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

**R12-15-1008. Information Required to Maintain an Operating Flexibility Account**

- A. A responsible party who withdraws, receives, or uses groundwater during a calendar year pursuant to an irrigation grandfathered right, including any in lieu water received pursuant to a groundwater savings facility permit issued pursuant to A.R.S. § 45-812.01, shall include the following information for the

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calendar year in an annual report filed pursuant to A.R.S. § 45-467 or 45-632:

1. The quantity of groundwater withdrawn from each well.
  2. The quantity of groundwater withdrawn and delivered to another person for irrigation purposes.
  3. The quantity of groundwater received from a city, town, private water company, or irrigation district, including any in lieu water received pursuant to a groundwater savings facility permit issued pursuant to A.R.S. § 45-812.01.
  4. The quantity of groundwater received from a person other than a city, town, private water company, or irrigation district, including any in lieu water received pursuant to a groundwater savings facility permit issued pursuant to A.R.S. § 45-812.01.
  5. The quantity of effluent received.
  6. The quantity of decreed or appropriative surface water received, other than normal flow and spillwater.
  7. The quantity of normal flow received.
  8. The quantity of spillwater received.
  9. The quantity of tailwater used.
  10. The quantity of tailwater delivered in accordance with the provisions of R12-15-1010(A), and the farm or irrigation district to which the tailwater was delivered.
  11. The quantity of central Arizona project water received.
  12. The quantity of any surface water received and not accounted for pursuant to subsections (6) through (11) of this subsection.
  13. The number of surface water right acres in the farm to which the irrigation grandfathered right is appurtenant.
  14. The quantity of water used for the legal irrigation of acres in the farm to which irrigation grandfathered rights are not appurtenant. If the responsible party omits this information, the Director shall presume that the total amount of water received or used for the irrigation of the farm was applied to acres to which irrigation grandfathered rights are appurtenant.
  15. Any other information the Director may reasonably require to accomplish the management goals of the applicable active management area.
- B.** A water deliverer shall include the following information for an accounting period in an annual account filed pursuant to A.R.S. § 45-468:
1. The quantity of groundwater delivered to each farm, including any in lieu water delivered pursuant to a groundwater savings facility permit issued pursuant to A.R.S. § 45-812.01.
  2. The quantity of normal flow delivered to each farm.
  3. The quantity of spillwater delivered to each farm.
  4. The quantity of decreed or appropriative surface water, other than normal flow and spillwater, delivered to each farm.
  5. The quantity of central Arizona project water delivered to each farm.
  6. The quantity of decreed or appropriative surface water, other than normal flow and spillwater, delivered for use within the service area of the water deliverer, including all farm and non-farm deliveries.
  7. The number of surface water right acres within the service area of the water deliverer.
  8. The quantity of effluent delivered to each farm.
  9. Any other information the Director may reasonably require to accomplish the purposes of A.R.S. § 45-468.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).  
Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1009. Credits to Operating Flexibility Account**

- A.** Except as provided in subsection (B) of this Section and in R12-15-1010, if the total amount of water from all sources other than spillwater used by a farm for irrigation purposes in a calendar year is less than the farm's maximum annual groundwater allotment for the year, the Director shall register the difference as a credit to the farm's operating flexibility account.
- B.** If a farm is within the service area of a water deliverer, the Director shall reduce the credit as calculated pursuant to subsection (A) of this Section by an amount equal to the difference between the farm's pro rata share of the total quantity of decreed or appropriative surface water, other than normal flow or spillwater, delivered by the water deliverer during the year for use within its service area, and the quantity of water actually received by the farm during the year. The Director shall determine the farm's pro rata share by dividing the number of surface water right acres in the farm that are within the service area of the water deliverer by the total number of surface water right acres within the service area of the water deliverer, and multiplying the quotient by the total quantity of decreed or appropriative surface water, other than normal flow or spillwater, delivered by the water deliverer during the year for use within its service area.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).  
Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1010. Operating Flexibility Account; Tailwater**

- A.** When calculating credits or debits to a farm's operating flexibility account for a year, the Director shall exclude from the total amount of water used on the farm during that year the amount of any tailwater that originated on the farm and that was delivered from the farm to another farm or to an irrigation district for irrigation purposes during the year if all of the following apply:
1. Prior to January 1 of the year in which the deliveries of tailwater take place, the Director approves a written plan to measure and record the tailwater deliveries. The plan shall include:
    - a. The installation and use of a totalizing water measuring device that will record tailwater deliveries with no greater than a 10 percent margin of error.
    - b. Procedures for keeping accurate records of the tailwater deliveries.
    - c. A description of how the tailwater will be delivered.
    - d. An identification of the farm or irrigation district to which the tailwater will be delivered.
  2. The person has measured, recorded, and delivered the tailwater in accordance with the plan approved under subsection (A)(1) of this Section.
  3. The tailwater was delivered directly from the farm on which it originated to:
    - a. A specified farm that used the tailwater for the legal irrigation of irrigation acres or surface water right acres on that farm, or
    - b. A specified irrigation district that delivered the tailwater for the legal irrigation of irrigation acres or surface water right acres within that district.

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- B. A person who delivers tailwater in accordance with subsection (A) of this Section, and a person who directly receives and uses the tailwater pursuant to subsection (A)(3)(a) of this Section, shall account for and report the tailwater as if it were comprised of a mixture of groundwater, decreed and appropriate surface water other than normal flow, central Arizona project water, spillwater, other surface water, and effluent, as applicable, in the same proportions as those types of water comprise the total amount of water other than normal flow received or withdrawn for irrigation use during the calendar year on the farm on which the tailwater originated.
- C. A person who uses tailwater that has not been delivered and accounted for as provided in subsections (A) and (B) of this Section may credit against the person's use of groundwater in a calendar year the amount of the tailwater used during the calendar year if the use of such tailwater would cause a debit to be incurred. The credit shall be applied only against the person's operating flexibility account debits that otherwise would have been incurred that year and shall not be used to discharge debits from prior years or accumulate credits for future years. For purposes of calculating credits to the person's operating flexibility account, the Director shall treat tailwater as groundwater, unless reported otherwise according to its source.
- D. An irrigation district that receives tailwater pursuant to subsection (A)(3)(b) shall account for the water in the same manner as other water in the district's distribution system.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1011. Statement of Operating Flexibility Account**

- A. The Director shall annually issue to each owner or user of an irrigation grandfathered right for which a current annual report has been filed a statement of the operating flexibility account setting forth the status of the operating flexibility account for the farm, based on the information submitted in the annual report filed for the right.
- B. Upon a motion or on the initiative of the Director, the Director may amend a statement of operating flexibility account at any time to correct clerical mistakes or to adjust the balance of the account based on information submitted in an amended or late annual report. The Director shall give written notice of any amendments made pursuant to this subsection to the person to whom the statement of operating flexibility account was issued.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1012. Rule of Construction**

Nothing in A.A.C. R12-15-1001 through R12-15-1011 shall be construed to determine the legality of any water use for which an accounting is required under these rules.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

**R12-15-1013. Retention of Records for Annual Accounts and Annual Reports**

The responsible party shall keep and maintain, for at least three calendar years following the filing of an annual account or an annual report, all records which may be necessary to verify the information and data contained therein.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

**R12-15-1014. Late Filing or Payment of Fees; Extension Penalties**

- A. An annual account, an annual report, or a request for extension pursuant to subsection (E) of this rule shall be deemed to be filed at the time a complete annual account, a complete annual report or a request for extension is hand-delivered to any Department office, or at the time the envelope in which it is mailed is postmarked.
- B. Except as provided in subsection (C) of this Section, groundwater withdrawal fees and long-term storage credit recovery fees are deemed paid at the time the fees are hand-delivered to any Department office, or at the time the envelope in which they are mailed is postmarked.
- C. If any groundwater withdrawal fees or long-term storage credit recovery fees are paid with a negotiable instrument that is not honored and paid upon the Department's initial demand, the fees are deemed paid at the time the Department actually receives the fees in cash or when the negotiable instrument is honored and paid to the Department.
- D. If an annual account or an annual report filed on or before the date required by the applicable statute is found by the Director to be incomplete, the Director shall notify the responsible party of the inadequacies and allow the responsible party 30 days from the date of the notice to provide the missing information in a form prescribed by the Director. If the responsible party does not provide the missing information within 30 days from the date of the notice, late penalties under A.R.S. §§ 45-437, 45-632, 45-875.01, 45-876.01, 45-877.01, 45-878.01 or 45-1004 shall begin to accrue on the 31st day following the date of the notice. The Director shall not recommend to a court, pursuant to A.R.S. §§ 45-634, 45-635, 45-881.01, 45-882.01, 45-1062 or 45-1063, that civil penalties be imposed through the first 30 days following the date of the notice. However, if the inadequacy included the failure to pay all groundwater withdrawal fees due or all long-term storage credit recovery fees due, late penalties under A.R.S. §§ 45-614 or 45-874.01 shall begin to accrue on April 1, except as provided in subsection (E) of this Section.
- E. A responsible party required to file an annual account or annual report for a year may request a 30-day extension of the first day of accrual of the late penalties under A.R.S. §§ 45-437, 45-614, 45-632, 45-874.01, 45-875.01, 45-876.01, 45-877.01, 45-878.01 or 45-1004 and of the civil penalties that the Director may recommend that a court impose pursuant to A.R.S. §§ 45-634, 45-635, 45-881.01, 45-882.01, 45-1062 or 45-1063. The request shall be filed no later than the date the annual account or annual report is required to be filed under the applicable statute. The Director shall grant a request for a 30-day extension if good cause is shown. If the Director grants the request, the late penalties and civil penalties shall begin to accrue on the first day after the 30-day extension period, except that if the Director finds that the person making the request presented false or misleading information to the Director and the Director relied on that information in granting the request, the late penalties and civil penalties shall begin to accrue as if the request was not granted. The Director shall not grant an extension to a responsible party who was granted an extension in the preceding calendar year and who subsequently failed to file a complete annual account or annual report and pay all groundwater withdrawal fees and all long-term storage credit recovery fees due within the 30-day extension period.

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**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).  
Amended by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1015. Reporting Requirements for Conveyances of Grandfathered Rights and Groundwater Withdrawal Permits**

- A. A person who is required by A.R.S. § 45-482 to notify the Director of a conveyance of a grandfathered right shall file a notice of conveyance, on a form prescribed by the Director, within 30 days of the conveyance. All parties to the conveyance may use a single form for the required notice. Except provided in subsection (B) of this rule, the notice of conveyance shall include an accounting of the amount of water withdrawn or received pursuant to that grandfathered right from January 1 to the date of conveyance for that calendar year.
- B. If the person to whom a grandfathered right is conveyed is unable, because of extraordinary circumstances and good cause shown, to perform the accounting otherwise required by subsection (A) of this rule, the Director may waive the requirement for that person.
- C. If a person, including a person who is granted a waiver pursuant to subsection (B) of this rule, fails to include the required accounting in a timely filed notice of conveyance pursuant to subsection (A) of this rule, the Director shall determine the amount of groundwater withdrawn or received pursuant to the grandfathered right from January 1 to the date of conveyance for that calendar year. Such a person shall bear the burden, in any subsequent administrative or judicial proceeding, of establishing by clear and convincing evidence that the Director's determination was incorrect.
- D. A person requesting the Director's approval of a proposed conveyance of a groundwater withdrawal permit pursuant to A.R.S. § 45-520(B) shall include with such request the quantity of groundwater withdrawn pursuant to the groundwater withdrawal permit for that calendar year and all other information required to be submitted pursuant to A.R.S. § 45-632.

**Historical Note**

Adopted effective December 12, 1990 (Supp. 90-4).

**R12-15-1016. Spillwater Reporting by Water Deliverers**

A water deliverer that delivers spillwater during a year shall include the following information in the annual account or annual report submitted by the water deliverer for that year:

1. The total quantity of spillwater delivered for non-irrigation uses during the year.
2. The total quantity of spillwater delivered for irrigation uses during the year.
3. Any other information the Director may reasonably require to determine whether the water qualifies as spillwater under R12-15-1001(10).

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**R12-15-1017. Maintenance and Filing of Annual Reports Required by A.R.S. § 45-343**

A community water system required to file an annual report under A.R.S. § 45-343 shall maintain the report on a calendar year basis and shall file the report with the Director no later than June 1 of each year for the preceding calendar year.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 5395, effective February 4, 2006 (Supp. 05-4).

**ARTICLE 11. INSPECTIONS AND AUDITS****R12-15-1101. Inspections**

- A. For the purpose of this rule, "inspection" means an entry by the Director at reasonable times onto private or public property for any of the following purposes:
  1. To obtain factual data or access to records required to be kept under A.R.S. §§ 45-632, 45-879.01, or 45-1004.
  2. To inspect a well or another facility for the withdrawal, transportation, use, measurement, or recharge of groundwater under A.R.S. § 45-633.
  3. To inspect a facility that is used for the purpose of water storage, stored water recovery, or stored water use under A.R.S. § 45-880.01(A).
  4. To inspect a body of water under A.R.S. § 45-135 or to ascertain compliance with A.R.S. Title 45, Chapter 1, Article 3.
  5. To inspect or to obtain factual data or access to records pursuant to any Section of A.R.S. Title 45 that requires the Director to adopt rules for conducting inspections, examining records, and obtaining warrants.
  6. To inspect facilities used for the withdrawal, diversion, or use of water pursuant to a water exchange under A.R.S. § 45-1061.
- B. Not less than seven days prior to an inspection, the Director shall mail notice of the inspection by first class letter to the owner, manager or occupant of the property. The notice shall include the statutory authorization and purpose for the inspection. The notice shall specify a date and time certain or a seven-day period within which the inspection may take place. If a request is made before the seven-day period, the Director shall schedule the inspection for a time certain within the seven-day period to allow an opportunity for a representative of the property to be present at the inspection. The notice shall include the name and telephone number of a Department employee who may be contacted to arrange such an appointment.
- C. Whenever practical, Department employees shall minimize disruptions to on-going operations caused by an inspection.
- D. If the property is controlled or secured against entry at the time specified in the notice of inspection but consent to the inspection was not denied, the Director shall give a second notice in the manner prescribed in subsection (B) before seeking a search warrant or its equivalent. The second notice shall request that a representative of the property be present at the inspection to accompany Department personnel.
- E. If the Director gives notice of an inspection and is not permitted to conduct an inspection, the Director may apply for and obtain a search warrant or its equivalent.
- F. Notice of inspection shall not be required under subsections (B) and (D) of this rule if the Director reasonably believes that notice would frustrate the enforcement of A.R.S. Title 45, or where entry is sought for the sole purpose of inspecting water measuring devices required pursuant to A.R.S. § 45-604.
- G. The Director shall mail a copy of the report of the inspection either to the person to whom the notice of inspection was directed, or to the owner, manager or occupant of the property if no notice of inspection was given. The report shall include the date of the inspection and a short summary of the findings. If no notice was given, the report shall include an explanation of the reason for determining that notice would not be given, unless providing the explanation would frustrate enforcement of A.R.S. Title 45. An aggrieved person may file with the Director written comments on the report within 30 days after the report is mailed.

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- H. The owner, manager or occupant of the property may waive the provisions for notice contained in this rule.
- I. The Director shall comply with the requirements of A.R.S. § 41-1009 when conducting inspections under this Section.

**Historical Note**

Adopted effective August 31, 1992 (Supp. 92-3).  
Amended effective July 22, 1994 (Supp. 94-3). Amended  
by final rulemaking at 11 A.A.R. 5395, effective  
February 4, 2006 (Supp. 05-4).

**R12-15-1102. Audits**

- A. For the purpose of this rule, “representative” means
  - 1. An officer or Director of a corporation subject to the audit,
  - 2. A general partner of a partnership subject to the audit, or
  - 3. A person who appears at an audit and produces a signed authorization to act on behalf of the person subject to the audit.
- B. This rule applies to audits conducted pursuant to A.R.S. §§ 45-633(C), 45-880.01, and any other Section of A.R.S. Title 45 that authorizes the Director to require a person to appear at the Director’s office and produce records and information and that also requires the Director to adopt rules for conducting inspections, examining records, and obtaining warrants.
- C. No less than 20 days prior to an audit, the Director shall mail notice of the audit by first class letter to the person that is the subject of the audit. The notice shall state the date, time and place of the audit. The notice shall specify the records or information which the person must produce. The notice shall also include the statutory authorization and purpose for the audit and the name and telephone number of a Department employee who may be contacted for further information. The audit shall be held at the Department’s offices, unless the Director grants a request to have the audit conducted at a different location.
- D. The person subject to the audit or a representative shall appear at the scheduled time and shall produce the records and information specified in the notice. The person subject to the audit or a representative may make one request to reschedule the audit, which the Department shall grant if practicable.
- E. The Director shall mail a copy of the report of the audit to the person subject to the audit. An aggrieved person may file with the Director written comments on the report within 30 days after the report is mailed.
- F. The person subject to the audit may waive the provisions for notice contained in this rule.

**Historical Note**

Adopted effective August 31, 1992 (Supp. 92-3).  
Amended effective July 22, 1994 (Supp. 94-3).

**ARTICLE 12. DAM SAFETY PROCEDURES****R12-15-1201. Applicability**

- A. This Article applies to any artificial barrier meeting the specifications of A.R.S. § 45-1201(1) as interpreted by R12-15-1204. This Article applies to an application for the construction of a dam and reservoir; an application to reconstruct, repair, alter, enlarge, breach, or remove an existing dam and reservoir, including a breached or damaged dam; operation and maintenance of an existing dam and reservoir; and enforcement. A structure identified in R12-15-1203 is exempt from this Article.
- B. This Article is applicable to any dam regardless of hazard potential classification, with the following exceptions:

- 1. R12-15-1208, R12-15-1209, R12-15-1213, R12-15-1221, R12-15-1225, and R12-15-1226 apply only to a dam classified as a high or significant hazard potential dam.
- 2. R12-15-1210 applies only to a dam classified as a low hazard potential dam. A low hazard potential dam is exempt from R12-15-1208, R12-15-1209, R12-15-1211, R12-15-1213, R12-15-1221, R12-15-1225, and R12-15-1226.
- 3. R12-15-1211 applies only to a dam classified as a very low hazard potential dam. A very low hazard potential dam is exempt from R12-15-1208, R12-15-1209, R12-15-1210, R12-15-1212, R12-15-1213, R12-15-1215, R12-15-1216, R12-15-1221, R12-15-1225, and R12-15-1226.
- 4. R12-15-1216(B) applies only to an embankment dam.

**Historical Note**

Adopted effective November 2, 1978 (Supp. 78-6). Former Section R12-15-01 renumbered without change as Section R12-15-1201 effective October 8, 1982 (Supp. 82-5). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1202. Definitions**

In addition to the definitions provided in A.R.S. § 45-1201, the following definitions are applicable to this Article:

- 1. “Alteration or repair of an existing dam or appurtenant structure” means to make different from the originally approved construction drawings and specifications or current condition without changing the height or storage capacity of the dam or reservoir, except for ordinary repairs and general maintenance as prescribed in R12-15-1217.
- 2. “Appurtenant structure” means any structure that is contiguous and essential to the safe operation of the dam including embankments, saddle dikes, outlet works and controls, diversion ditches, spillway and controls, access structures, bridges, and related housing at a dam.
- 3. “Classification of dams” means the placement of dams into categories based upon an evaluation of the size and hazard potential, regardless of the condition of the dam.
- 4. “Concrete dam” means any dam constructed of concrete, including arch, gravity, arch-gravity, slab and buttress, and multiple arch dams. A dam that only has a concrete facing is not a concrete dam.
- 5. “Construction” means any activity performed by the owner or someone employed by the owner that is related to the construction, reconstruction, repair, enlargement, removal, or alteration of any dam, unless the context indicates otherwise. Construction is performed after approval of an application and before issuance of a license.
- 6. “Dam failure inundation map” means a map depicting the maximum area downstream from a dam that would be flooded in the event of the worst condition failure of the dam.
- 7. “Department” means the Arizona Department of Water Resources.
- 8. “Director” means the Director of the Arizona Department of Water Resources or the Director’s designee.
- 9. “Embankment dam” means a dam that is constructed of earth or rock material.
- 10. “Emergency spillway” means a spillway designed to safely pass the inflow design flood routed through the reservoir. If the flow is controlled by gates, it is a con-

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- trolled spillway. If the flow is not controlled by gates, it is an uncontrolled spillway.
11. "Engineer" means a Professional Engineer registered and licensed in accordance with A.R.S. Title 32, Chapter 1, with proficiency in engineering and knowledge of dam technology.
  12. "Enlargement to an existing dam or appurtenant structure" means any alteration, modification, or repair that increases the vertical height of a dam or the storage capacity of the reservoir.
  13. "Flashboards" mean timber, concrete, or steel sections placed on the crest of a spillway to raise the retention water level that may be quickly removed at time of flood either by a tripping device or by designed failure of the flashboards or their supports.
  14. "Flood control dam" means a dam that uses all of its reservoir storage capacity for temporary impoundment of flood waters and collection of sediment or debris.
  15. "Hazard potential" means the probable incremental adverse consequences that result from the release of water or stored contents due to failure or improper operation of a dam or appurtenances.
  16. "Hazard potential classification" means a system that categorizes dams according to the degree of probable incremental adverse consequences of failure or improper operation of a dam or appurtenances. The hazard potential classification does not reflect the current condition of the dam with regard to safety, structural integrity, or flood routing capacity.
  17. "Height" means the vertical distance from the lowest elevation of the outside limit of the barrier at its intersection with the natural ground surface to the spillway crest elevation. For the purpose of determining jurisdictional status, the lowest elevation of the outside limit of the barrier may be the outlet pipe invert elevation if the outlet is constructed below natural ground.
  18. "Impound" means to cause water or a liquid to be confined within a reservoir and held with no discharge.
  19. "Incremental adverse consequences" means under the same loading conditions, the additional adverse consequences such as economic, intangible, lifeline, or human losses, that would occur due to the failure or improper operation of the dam over those that would have occurred without failure or improper operation of the dam.
  20. "Inflow design flood" or "IDF" means the reservoir flood inflow magnitude selected on the basis of size and hazard potential classification for emergency spillway design requirements of a dam.
  21. "Intangible losses" means incremental adverse consequences to property that are not economic in nature, including property related to social, cultural, unique, or resource-based values, including the loss of irreplaceable and unique historic and cultural features; long-lasting pollution of land or water; or long-lasting or permanent changes to the ecology, including fish and endangered species habitat identified and evaluated by a public natural resource management or protection agency.
  22. "Jurisdictional dam" means a barrier that meets the definition of a dam prescribed in A.R.S. § 45-1201 that is not exempted by R12-15-1203 over which the Department of Water Resources exercises jurisdiction.
  23. "Levee" means an embankment of earth, concrete, or other material used to prevent a watercourse from spreading laterally or overflowing its banks. A levee is not used to impound water.
  24. "License" means license of final approval issued by the Director upon completion or enlargement of a dam under A.R.S. § 45-1209.
  25. "Lifeline losses" mean disruption of essential services such as water, power, gas, telephone, or emergency medical services.
  26. "Liquid-borne material" means mine tailings or other milled ore products transported in a slurry to a storage impoundment.
  27. "Maximum credible earthquake" means the most severe earthquake that is believed to be possible at a point on the basis of geologic and seismological evidence.
  28. "Maximum water surface" means the maximum elevation of the reservoir water level attained during routing of the inflow design flood.
  29. "Natural ground surface" means the undisturbed ground surface before excavation or filling, or the undisturbed bed of the stream or river.
  30. "Outlet works" means a closed conduit under or through a dam or through an abutment for the controlled discharge of the contents normally impounded by a dam and reservoir. The outlet works include the inlet and outlet structures appurtenant to the conduit. Outlet works may be controlled or uncontrolled.
  31. "Probable" means likely to occur, reasonably expected, and realistic.
  32. "Probable maximum flood" or "PMF" means the flood runoff expected from the most severe combination of critical meteorologic and hydrologic conditions that are reasonably possible in the region, including rain and snow where applicable. 1/2 PMF is that flood represented by the flood hydrograph with ordinates equal to 1/2 the corresponding ordinates of the PMF hydrograph.
  33. "Probable maximum precipitation" means the greatest depth of precipitation for a given duration that is theoretically physically possible over a particular size storm area at a particular geographical location at a particular time of year.
  34. "Reservoir" means any basin that contains or is capable of containing water or other liquids impounded by a dam.
  35. "Residual freeboard" means the vertical distance between the highest water surface elevation during the inflow design flood and the lowest point at the top of the dam.
  36. "Restricted storage" means a condition placed on a license by the Director to reduce the storage level of a reservoir because of a safety deficiency.
  37. "Saddle dike or saddle dam" means any dam constructed in a topographically low area on the perimeter of a reservoir, required to contain the reservoir at the highest water surface elevation.
  38. "Safe" means that a dam has sufficient structural integrity and flood routing capacity to make failure of the dam unlikely.
  39. "Safe storage level" means the maximum reservoir water surface elevation at which the Director determines it is safe to impound water or other liquids in the reservoir.
  40. "Safety deficiency" means a condition at a dam that impairs or adversely affects the safe operation of the dam.
  41. "Safety inspection" means an investigation by an engineer or a person under the direction of an engineer to assess the safety of a dam and determine the safe storage level for a reservoir, which includes review of design

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reports, construction documents, and previous safety inspection reports of the dam, spillways, outlet facilities, seepage control and measurement systems, and permanent monument or monitoring installations.

42. "Spillway crest" means the highest elevation of the floor of the spillway along a centerline profile through the spillway.
43. "Storage capacity" means the maximum volume of water, sediment, or debris that can be impounded in the reservoir with no discharge of water, including the situation where an uncontrolled outlet becomes plugged. The storage capacity is reached when the water level is at the crest of the emergency spillway, or at the top of permanently mounted emergency spillway gates in the closed position. Storage capacity excludes dead storage below the natural ground surface.
44. "Surcharge storage" means the additional water storage volume between the emergency spillway crest or closed gates, and the top of the dam.
45. "Total freeboard" means the vertical distance between the emergency spillway crest and the top of the dam.
46. "Unsafe" means that safety deficiencies in a dam or spillway could result in failure of the dam with subsequent loss of human life or significant property damage.

**Historical Note**

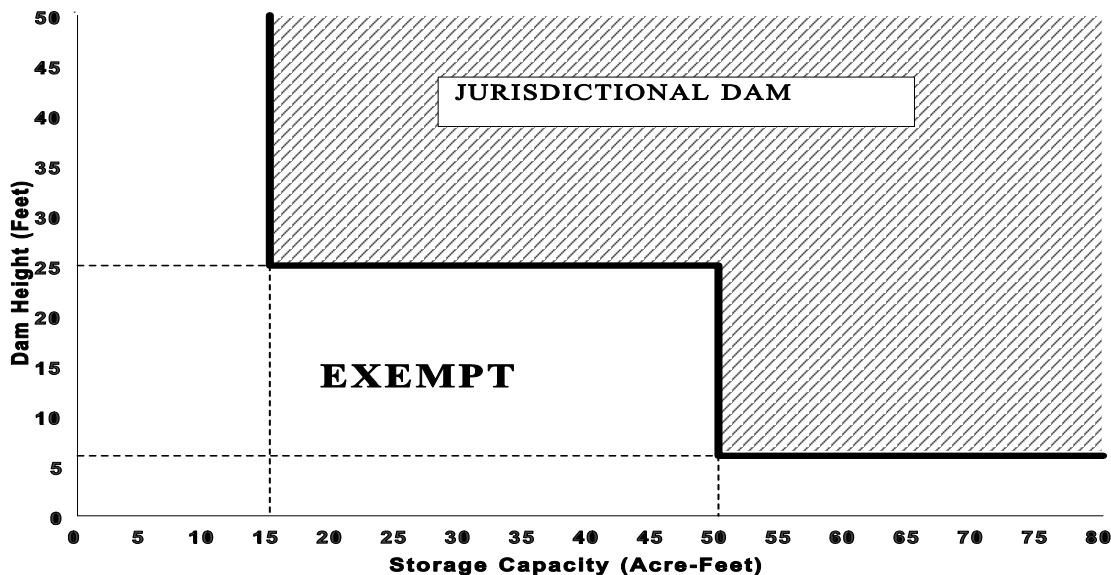
Adopted effective November 2, 1978 (Supp. 78-6). Former Section R12-15-02 renumbered without change as Section R12-15-1202 effective October 8, 1982 (Supp. 82-5). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2). Amended to correct typographical error under A.A.C. R1-1-109 (Supp. 01-2).

**R12-15-1203. Exempt Structures**

The following structures are exempt from regulation by the Department:

1. Any artificial barrier identified as exempt on Table 1 and defined as follows:

**Table 1. Exempt Structures**



**Historical Note**

- a. Less than 6 feet in height, regardless of storage capacity.
  - b. Between 6 and 25 feet in height with a storage capacity of less than 50 acre-feet.
  - c. Greater than 25 feet in height with 15 acre-feet or less of storage capacity.
2. A dam owned by the federal government. A dam designed by the federal government for any non-federal entity or person that will subsequently be owned or operated by a person or entity defined as an owner in A.R.S. § 45-1201 is subject to jurisdiction, beginning with design and construction of the dam.
  3. A dam owned or operated by an agency or instrumentality of the federal government, if a dam safety program at least as stringent as this Article is applicable to and enforced against the agency or instrumentality.
  4. A transportation structure such as a highway, road, or railroad fill that exists solely for transportation purposes. A transportation structure designed, constructed, or modified with the intention of impounding water on an intermittent or permanent basis and meeting the definition of dam in A.R.S. § 45-1201 is subject to jurisdiction.
  5. A levee constructed adjacent to or along a watercourse, primarily to control floodwater.
  6. A self-supporting concrete or steel water storage tank.
  7. An impoundment for the purpose of storing liquid-borne material.
  8. A release-contained barrier as defined by A.R.S. § 45-1201(5).

**Historical Note**

Adopted effective November 2, 1978 (Supp. 78-6). Former Section R12-15-03 renumbered without change as Section R12-15-1203 effective October 8, 1982 (Supp. 82-5). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

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New Table adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1204. Provision for Guidelines**

The Department may develop and adopt substantive policy statements that serve as dam safety guidelines to aid a dam owner or engineer in complying with this Article. The Department recommends that dam owners and engineers consult design guidelines published by agencies of the federal government, including the U.S. Bureau of Reclamation, the U.S. Army Corps of Engineers, the Natural Resources Conservation Service, and the Federal Energy Regulatory Commission, for the design of concrete, roller compacted concrete, stone masonry, timber, inflatable rubber, and mechanically-stabilized earth dams. The Director may require that other criteria be used or revise any of the specific criteria for the purpose of dam safety. An owner shall obtain advance approval by the Director of design criteria.

**Historical Note**

Adopted effective November 2, 1978 (Supp. 78-6). Former Section R12-15-04 renumbered without change as Section R12-15-1204 effective October 8, 1982 (Supp. 82-5). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1205. General Responsibilities**

- A. Each owner is responsible for the safe design, operation, and maintenance of a dam. The owner shall operate, maintain, and regularly inspect a dam so that it does not constitute a danger to human life or property. The owner of a high or significant hazard potential dam shall provide timely warning to the Department and all other persons listed in the emergency action plan of problems at the dam. The owner shall develop and maintain effective emergency action plans and coordinate those plans with local officials as prescribed in R12-15-1221.
- B. The owner shall conduct frequent observation of the dam, as prescribed in the emergency action plan and as follows:
  1. The owner shall increase the frequency of observation when the reservoir is full, during heavy rains or flooding, and following an earthquake.
  2. The owner shall report to the Director any condition that threatens the safety of the dam as prescribed in R12-15-1224(A). The owner shall make the report as soon as possible, but not later than 12 hours after discovery of the conditions.
  3. If dam failure appears imminent, the owner shall notify the county sheriff or other emergency official immediately.
  4. The owner is responsible for the safety of the dam and shall take action to lower the reservoir if it appears that the dam has weakened or is in danger of failing.
- C. The owner of a dam shall install, maintain, and monitor instrumentation to evaluate the performance of the dam. The Director shall require site-specific instrumentation that the Director deems necessary for monitoring the safety of the dam when failure may endanger human life and property. Conditions that may require monitoring include land subsidence, earth fissures, embankment cracking, phreatic surface, seepage, and embankment movements.
- D. The owner shall perform timely maintenance and ordinary repair of a dam. The owner shall implement an annual plan to inspect the dam and accomplish the maintenance and ordinary repairs necessary to protect human life and property.
- E. If a change of ownership of a dam occurs, the new owner shall notify the Department within 15 days after the date of the transaction and provide the mailing address and telephone

number where the new owner can be contacted. Within 90 days after the date of the transaction, the new owner shall provide the name and telephone number of the individual or individuals who are responsible for operating and maintaining the dam.

**Historical Note**

Adopted effective November 2, 1978 (Supp. 78-6). Former Section R12-15-05 renumbered without change as Section R12-15-1205 effective October 8, 1982 (Supp. 82-5). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1206. Classification of Dams**

- A. Size Classification. Dams are classified by size as small, intermediate, or large. Size is determined with reference to Table 2. An owner or engineer shall determine size by storage capacity or height, whichever results in the larger size.
- B. Hazard Potential Classification
  1. The Department shall base hazard potential classification on an evaluation of the probable present and future incremental adverse consequences that would result from the release of water or stored contents due to failure or improper operation of the dam or appurtenances, regardless of the condition of the dam. The evaluation shall include land use zoning and development projected for the affected area over the 10 year period following classification of the dam. The Department considers all of the following factors in hazard potential classification: probable loss of human life, economic and lifeline losses, and intangible losses identified and evaluated by a public resource management or protection agency.
    - a. The Department bases the probable incremental loss of human life determination primarily on the number of permanent structures for human habitation that would be impacted in the event of failure or improper operation of a dam. The Department considers loss of human life unlikely if:
      - i. Persons are only temporarily in the potential inundation area;
      - ii. There are no residences or overnight campsites; and
      - iii. The owner has control of access to the potential inundation area and provides an emergency action plan with a process for warning in the event of a dam failure or improper operation of a dam.
    - b. The Department bases the probable economic, lifeline, and intangible loss determinations on the property losses, interruptions of services, and intangible losses that would be likely to result from failure or improper operation of a dam.
  2. The 4 hazard potential classification levels are very low, low, significant, and high, listed in order of increasing probable adverse incremental consequences, as prescribed in Table 3. The Director shall classify intangible losses by considering the common or unique nature of features or habitats and temporary or permanent nature of changes.
    - a. Very Low Hazard Potential. Failure or improper operation of a dam would be unlikely to result in loss of human life and would produce no lifeline losses and very low economic and intangible losses.



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Losses would be limited to the 100 year floodplain or property owned or controlled by the dam owner under long-term lease. The Department considers loss of life unlikely because there are no residences or overnight camp sites.

- b. Low Hazard Potential. Failure or improper operation of a dam would be unlikely to result in loss of human life, but would produce low economic and intangible losses, and result in no disruption of lifeline services that require more than cosmetic repair. Property losses would be limited to rural or agricultural property, including equipment, and isolated buildings.
  - c. Significant Hazard Potential. Failure or improper operation of a dam would be unlikely to result in loss of human life but may cause significant or high economic loss, intangible damage requiring major mitigation, and disruption or impact on lifeline facilities. Property losses would occur in a predominantly rural or agricultural area with a transient population but significant infrastructure.
  - d. High Hazard Potential. Failure or improper operation of a dam would be likely to cause loss of human life because of residential, commercial, or industrial development. Intangible losses may be major and potentially impossible to mitigate, critical lifeline services may be significantly disrupted, and property losses may be extensive.
3. An applicant shall demonstrate the hazard potential classification of a dam before filing an application to construct. The Department shall review the applicant's demonstration early in the design process at pre-application meetings prescribed in R12-15-1207(D).
  4. The Department shall review the hazard potential classification of each dam during each subsequent dam safety inspection and revise the classification in accordance with current conditions.

**Historical Note**

Adopted effective November 2, 1978 (Supp. 78-6). Former Section R12-15-06 renumbered without change as Section R12-15-1206 effective October 8, 1982 (Supp. 82-5). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**Exhibit A. Repealed****Historical Note**

Exhibit repealed by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000; a Historical Note for Exhibit A did not exist before this date (Supp. 00-2).

**Table 2. Size Classification**

Category	Storage Capacity (acre-feet)	Height (feet)
Small	50 to 1,000	25 to 40
Intermediate	greater than 1,000 and not exceeding 50,000	higher than 40 and not exceeding 100
Large	greater than 50,000	higher than 100

**Historical Note**

New Table adopted by final rulemaking at 6 A.A.R. 2558,

effective June 12, 2000 (Supp. 00-2).

**Table 3. Downstream Hazard Potential Classification**

Hazard Potential Classification	Probable Loss of Human Life	Probable Economic, Lifeline, and Intangible Losses
Very Low	None expected	Economic and lifeline losses limited to owner's property or 100-year floodplain. Very low intangible losses identified.
Low	None expected	Low
Significant	None expected	Low to high
High	Probable - One or more expected	Low to high (not necessary for this classification)

**Historical Note**

New Table adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1207. Application Process**

- A. An applicant shall obtain written approval from the Director before constructing, reconstructing, repairing, enlarging, removing, altering, or breaching a dam. Application requirements differ according to the hazard potential of the dam.
  1. To construct, reconstruct, repair, enlarge, or alter a high or significant hazard potential dam, the applicant shall comply with R12-15-1208.
  2. To breach or remove a high or significant hazard potential dam, the applicant shall comply with R12-15-1209.
  3. To construct, reconstruct, repair, enlarge, alter, breach, or remove a low hazard potential dam, the applicant shall comply with R12-15-1210.
  4. To construct, reconstruct, repair, enlarge, alter, breach, or remove a very low hazard potential dam, the applicant shall comply with R12-15-1211.
- B. An application shall not be filed with the Director under the following circumstances:
  1. The dam is exempt under R12-15-1203;
  2. A dam owner starts repairs to an existing dam that are necessary to safeguard human life or property and the Director is notified without delay;
  3. The owner performs general maintenance or ordinary repairs as prescribed in R12-15-1217(A) or (B); or
  4. Breach, removal, or reduction of a very low hazard dam as prescribed in R12-15-1211(C).
- C. An applicant is not required to comply with a requirement in this Article if the Director finds that, considering the site characteristics and the proposed design, the requirement is unduly burdensome or expensive and is not necessary to protect human life or property. The Director shall consider the size, hazard potential classification, physical site conditions, and applicability of a requirement to a proposed dam. The Director shall state in writing the reason or reasons the applicant is not required to comply with a requirement.
- D. An applicant shall schedule pre-application conferences with the Department to discuss the requirements of this Article and to resolve issues essential to the design of a dam while the design is in preliminary stages. The Director shall view the dam site during the pre-application process. The following are examples of issues for pre-application conferences: the hazard potential classification, the approximate inflow design flood, the basic design concepts, and any requirements that may be found by the Director to be unduly burdensome or expensive and not necessary to protect human life or safety. In addition,

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the applicant may submit preliminary design calculations to the Department for review and comment. The Department shall comment as soon as practicable, depending on the size of the submittal and the current workload.

**E.** The Department shall review applications as follows:

1. Applications will be received by appointment. During this meeting the Department shall make a brief review of the application to determine that the application contains each of the items required by R12-15-1208, R12-15-1209, R12-15-1210, or R12-15-1211.
2. Following receipt of an application submitted under R12-15-1208, R12-15-1209, R12-15-1210, or R12-15-1211, the Director shall complete an administrative review as prescribed in R12-15-401(1) and notify the applicant in writing whether the application is administratively complete. If the application is not administratively complete, the notification shall include a list of additional information that is required to complete the application.
3. After finding the application submitted under R12-15-1208, R12-15-1209, R12-15-1210, or R12-15-1211 administratively complete, the Director shall complete a substantive review as prescribed in R12-15-401(3) and notify the applicant in writing of the Director's approval or disapproval. If during this review period, the Director determines that there are defects in the application that would impact human life and property, a written notice of the defects shall be sent to the applicant.
4. An applicant may request in writing that the Director expedite the review of an application by employing an expert consultant on a contract basis under A.R.S. § 45-104(D). The Director shall establish on-call contracts with expert consultants to facilitate the process of expediting review. The Director may retain a consultant to review all or a portion of the application as necessary to expedite the process in response to an owner's request or to comply with time-frame rules. Before conducting the review, the consultant shall provide the Director and the applicant with a proposed time schedule and cost estimate. If the applicant agrees to the consultant's proposal for an expedited review of an application and the Director employs the consultant, the applicant shall pay to the Department the cost of the consultant's services in addition to the application fees. The Director retains the authority to review and approve, disapprove, or modify the findings and recommendations of the consultant.
5. The Director shall not approve an application in less than 10 days from the date of receipt.
6. If the Director disapproves the application, the Director shall provide the applicant with a statement of the Director's objections.
7. If the Director approves an application, the applicant shall submit in triplicate revised drawings and specifications that incorporate any required changes.
  - a. The Director shall return to the applicant 1 set of final construction drawings and specifications with the Department's approval stamp to be retained onsite during construction;
  - b. The Director shall retain for permanent state record 1 set of final construction drawings and specifications with the Department's approval stamp; and
  - c. The Director shall retain for use by the Department during construction the 3rd set of final construction drawings and specifications with the Department's approval stamp.

8. The Director shall impose conditions and limitations that the Director deems necessary to safeguard human life and property. Examples of the conditions of approval include but are not limited to:
  - a. The applicant shall not cover the foundation or abutment with the material of the dam until the Department has been given notice and a reasonable time to inspect and approve them.
  - b. The applicant shall start construction within 1 year from the date of approval.
  - c. The applicant shall maintain a safe storage level for an existing dam being reconstructed, repaired, enlarged, altered, or breached.

**F.** An approval to construct a new dam or repair, enlarge, alter, breach, or remove an existing dam is valid for 1 year.

1. If construction does not begin within 1 year, the approval is void.
2. Upon written request and good cause shown by the owner, the time for commencing construction may be extended. An applicant shall not start construction before the Director reviews the application for changes and grants approval.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1208. Application to Construct, Reconstruct, Repair, Enlarge, or Alter a High or Significant Hazard Potential Dam**

- A.** An application package to construct, reconstruct, repair, enlarge, or alter a high or significant hazard potential dam shall include the following prepared by or under the supervision of an engineer as defined in R12-15-1202(11):
1. A completed application filed in duplicate on forms provided by the Director.
  2. A design information summary or checklist of items prepared in duplicate on forms provided by the Director.
  3. An initial application fee based on the total estimated project cost and computed in accordance with A.R.S. § 45-1204 and R12-15-104(A)(7).
  4. A detailed estimate of project costs. Project costs are all costs associated with construction of the dam and appurtenant works including preliminary investigations and surveys, engineering design, supervision of construction, and any other engineering costs.
  5. Two complete sets of construction drawings as prescribed in R12-15-1215(1).
  6. Two complete sets of construction specifications as prescribed in R12-15-1215(2).
  7. An engineering design report that includes information needed to evaluate all aspects of the design of the dam and appurtenances, including references with page numbers to support any assumptions used in the design, as prescribed in R12-15-1215(3). The engineering design report shall recommend a safe storage level for existing dams being reconstructed, repaired, enlarged, or altered.
  8. A construction quality assurance plan describing all aspects of construction supervision.
  9. A description of the use for the impounded or diverted water, proof of a right to appropriate, and a permit to store water as prescribed in A.R.S. §§ 45-152 and 45-161.
  10. A long-term budget plan and evidence of financing, prepared using customary accounting principles, that demonstrate that the applicant has the financial capability to construct, operate, and maintain the dam in a safe man-

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ner. If the applicant does not have evidence that can be verified by an independent audit of the financial capability to construct, operate, and maintain the dam in a safe manner, the Director may require a performance bond for the entire cost of the proposed construction work.

- B.** The following may be submitted with the application or during construction.
1. An emergency action plan as prescribed in R12-15-1221.
  2. An operation and maintenance plan to accomplish the annual maintenance.
  3. An instrumentation plan regarding instruments that evaluate the performance of the dam.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-1209. Application to Breach or Remove a High or Significant Hazard Potential Dam**

- A.** An applicant shall excavate the dam down to the level of the natural ground at the maximum section. Upon approval of the Director, additional breaches may be made. This provision shall not be construed to require more than total removal of the dam regardless of the flood magnitude. The breach or breaches shall be of sufficient width to pass the greater of:
1. The 100 year flood at a depth of less than 5 feet, or
  2. The 100 year flood at a normal flood depth of not more than 2 feet at a distance of 2,000 feet downstream of the dam.
- B.** The sides of each breach shall be excavated to a slope ratio that is stable and not steeper than 1 horizontal to 1 vertical.
- C.** Each breach shall be designed to prevent silt that has previously been deposited on the reservoir bottom and the excavated material from the breach from washing downstream.
- D.** Before breaching the dam, the reservoir shall be emptied in a controlled manner that will not endanger lives or damage downstream property. The applicant shall obtain approval from the Director for the method of breaching or removal.
- E.** An application package to breach or remove a high or significant hazard potential dam shall include the following prepared by or under the supervision of an engineer as defined in R12-15-1202(11).
1. The construction drawing or drawings for the breach or removal of a dam, including the location, dimensions, and lowest elevation of each breach.
  2. A long-term budget plan and evidence of financing, prepared using customary accounting principles, that demonstrate that the applicant has the financial capability to breach or remove the dam in a safe manner. If the applicant does not have evidence that can be verified by an independent audit of the financial capability to breach or remove the dam in a safe manner, the Director may require a performance bond for the entire cost of the proposed construction work.
  3. A construction quality assurance plan describing all aspects of construction supervision.
- F.** Reduction of a high or significant downstream hazard potential dam to nonjurisdictional size may be approved by letter under the following circumstances:

1. The owner shall submit a completed application form and construction drawings for the reduction and the appropriate specifications, prepared by or under the supervision of an engineer as defined in R12-15-1202(11).
2. The construction drawings and specifications shall contain sufficient detail to enable a contractor to bid on and complete the project.
3. The plans shall comply with all requirements of this Section except that the breach is not required to be to natural ground.
4. Upon completion of an alteration to nonjurisdictional size, the engineer shall file as constructed drawings and specifications with the Department.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1210. Application to Construct, Reconstruct, Repair, Enlarge, Alter, Breach, or Remove a Low Hazard Potential Dam**

- A.** An application package to construct, reconstruct, repair, enlarge, or alter a low hazard potential dam shall include the following prepared by or under the supervision of an engineer as defined in R12-15-1202(11):
1. A completed application filed in duplicate on forms provided by the Director.
  2. An initial application fee based on the total estimated project cost, computed in accordance with A.R.S. § 45-1204 and R12-15-104(A)(7).
  3. A detailed estimate of project costs. Project costs are all costs associated with construction of the dam and appurtenant works, including preliminary investigations and surveys, engineering design, supervision of construction, and any other engineering costs.
  4. The seal and signature of the responsible engineer in accordance with A.A.C. R4-30-304.
  5. A statement by the responsible engineer that classifies the dam as low hazard in accordance with R12-15-1206(B). The responsible engineer shall submit a map of the area that would be inundated by failure or improper operation of the dam. The responsible engineer shall demonstrate that failure or improper operation of the dam would be unlikely to result in:
    - a. Loss of human life. The demonstration may be based on an emergency action plan for persons who may be in the area of inundation;
    - b. Significant incremental adverse consequences; or
    - c. Significant intangible losses, as defined in R12-15-1202(21) and identified and evaluated by a public natural resource management or protection agency.
  6. Two complete sets of construction drawings as prescribed by R12-15-1215(1).
  7. Two complete sets of construction specifications as prescribed by R12-15-1215(2).
  8. An engineering design report that includes information needed to evaluate all aspects of the design of the dam and appurtenances, including references with page numbers to support any assumptions used in the design, as prescribed in R12-15-1215(3).
  9. A description of the use for the impounded or diverted water, proof of a right to appropriate, and a permit to store water as prescribed in A.R.S. §§ 45-152 and 45-161.
  10. A construction quality assurance plan clearly describing all aspects of construction supervision.

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11. A long-term budget plan and evidence of financing, prepared using customary accounting principles, that demonstrate that the applicant has the financial capability to construct, operate, and maintain the dam in a safe manner. If the applicant does not have evidence that can be verified by an independent audit of the financial capability to construct, operate, and maintain the dam in a safe manner, the Director may require a performance bond for the entire cost of the proposed construction work.
- B.** An application package for the breach or removal of a low hazard potential dam shall include the following:
  1. A completed application filed in duplicate on forms provided by the Director that contains the following information:
    - a. The name and address of the owner of the dam or the agent of the owner.
    - b. A description of the proposed removal.
    - c. The proposed time for beginning and completing the removal.
  2. An initial application fee based on the total estimated project cost and computed in accordance with A.R.S. § 45-1204 and R12-15-104(A)(7).
  3. A statement by the responsible engineer demonstrating both of the following:
    - a. That the dam will be excavated to the level of natural ground at the maximum section; and
    - b. That the breach or breaches will be of sufficient width to pass the greater of:
      - i. The 100 year flood at a depth of less than 5 feet, or
      - ii. The 100 year flood at a normal flood depth of not more than 2 feet at a distance of 2,000 feet downstream of the dam,
      - iii. Subsection (B)(3)(b) shall not be construed to require more than a total removal of the dam regardless of flood magnitude.
    - c. That the sides of the breach will be excavated to a slope ratio that is stable and not steeper than 1 horizontal to 1 vertical.
  4. A detailed estimate of project costs. Project costs are all costs associated with the removal of the dam and appurtenant works, including preliminary investigations and surveys, engineering design, supervision of removal, and any other engineering costs.
- C.** An applicant intending to reduce a low hazard potential dam to nonjurisdictional size shall submit a written notice to the Director at least no less than 60 days before the date that construction begins.
- D.** Within 45 days after receipt of a complete application package as prescribed by subsection (A) or (B), the Director shall either:
  1. Determine that the dam falls within the low hazard potential classification, or
  2. Issue a written notice that the dam does not fall within the low hazard potential classification.
- E.** The Director's determination that the proposed dam does not fall within the low hazard classification is an appealable agency action and subject to administrative and judicial review under A.R.S. Title 41, Chapter 6, Article 10.
- F.** Upon completion of construction, the owner shall notify the Department in writing. The owner shall not use the dam or reservoir before issuance of a license unless the Director issues written approval.
- G.** Within 90 days after completing construction, reconstruction, repair, enlargement, or alteration of a low hazard potential dam, the owner shall file the following:
  1. An affidavit showing the actual cost of construction, reconstruction, repair, enlargement, or alteration of the dam. The owner shall submit a detailed accounting of the costs, including all engineering costs.
  2. An additional fee or refund request computed in accordance with A.R.S. § 45-1209 and R12-15-104(A)(7), based on the actual cost of construction, reconstruction, repair, enlargement, or alteration.
  3. A brief completion report summarizing the salient features of the project, including a description of the causes for any changes or deviations from the approved application package prepared by the engineer who supervised the construction, in accordance with A.R.S. Title 32, Chapter 1. The engineer shall indicate:
    - a. That the dam has been designed and constructed in compliance with basic principles of dam construction currently being practiced in the industry;
    - b. That the dam as constructed has structural integrity and flood routing capacity consistent with its hazard potential classification; and
    - c. That the as constructed drawings and the report accurately represent the construction of the dam.
  4. As constructed drawings prepared and sealed by the engineer who supervised the construction. The owner and the engineer shall maintain a record of the drawings.
- H.** Upon receiving the Director's written approval, the owner may operate the dam and appurtenant works. Within 30 days after receipt of the information in subsection (G), the Director shall issue to the owner either a license or a notice that the dam and appurtenant works shall not be operated because the dam and appurtenant works do not qualify as low hazard or were not built according to the submitted design. The license shall include conditions of operation, including:
  1. The safe storage level of the reservoir,
  2. A requirement that the dam be operated and maintained so that it does not constitute a danger to human life and property,
  3. A requirement that the conditions resulting in the low hazard classification be maintained throughout the life of the dam, and
  4. A requirement that the owner demonstrate in writing the low hazard classification in the manner prescribed by subsection (A)(5) every five years.
- I.** Within 90 days after completing removal of a low hazard potential dam, the owner shall file the following. The Director shall remove the dam from jurisdiction upon approval of the submittal.
  1. An affidavit showing the actual cost of removal of the dam. The owner shall submit a detailed accounting of the costs, including all engineering costs.
  2. An additional fee or refund request computed in accordance with A.R.S. § 45-1204 and R12-15-104(A)(7), based on the actual cost of removal.
  3. A brief completion report, including a description of the causes for any changes or deviations from the approved application package prepared by the engineer who supervised the construction, in accordance with A.R.S. Title 32, Chapter 1. The engineer shall certify that the as removed drawings and the report accurately represent the actual removal of the dam.

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4. As-removed drawings prepared and sealed by the engineer who supervised the removal. The owner and the engineer shall maintain a record of the drawings.
- J. An owner shall immediately commence repairs necessary to safeguard human life and property and prevent failure and improper operation of a low hazard potential dam. The owner shall notify the Department as soon as reasonably possible and in all cases within 10 days of commencing the required repairs.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2). Amended by final rulemaking at 13 A.A.R. 3022, effective October 6, 2007 (Supp. 07-3). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-1211. Application to Construct, Reconstruct, Repair, Enlarge, Alter, Breach, or Remove a Very Low Hazard Potential Dam**

- A. An application package to construct, reconstruct, repair, enlarge, or alter a very low hazard potential dam shall include the following prepared by an engineer or a person under the supervision of an engineer as defined in R12-15-1202(11):
  1. A completed application filed in duplicate on forms provided by the Director that contains the following information:
    - a. The name and address of the owner of the dam or the agent of the owner.
    - b. The location, type, size, and height of the proposed dam and appurtenant works.
    - c. The storage capacity of the reservoir associated with the proposed dam.
    - d. The proposed time for beginning and completing construction.
    - e. A description of the use for the impounded or diverted water and proof of a right to impound that water.
  2. The means, plans, and specifications by which the stream or body of water is to be dammed, by-passed, or controlled during construction.
  3. Maps, drawings, and specifications of the proposed dam.
  4. An initial application fee based on the total estimated project cost and computed in accordance with A.R.S. § 45-1204 and R12-15-104(A)(7).
  5. A detailed estimate of project costs. Project costs are all costs associated with construction of the dam and appurtenant works, including preliminary investigations and surveys, engineering design, supervision of construction, and any other engineering costs.
  6. A statement by the responsible engineer that classifies the dam as very low hazard in accordance with R12-15-1206(B). The responsible engineer shall submit a map of the area that would be inundated by failure or improper operation of the dam. The responsible engineer shall demonstrate that failure or improper operation would be unlikely to result in:
    - a. Loss of human life. The demonstration may be based on an emergency action plan for persons who may be in the area of inundation;
    - b. Significant incremental adverse consequences; or
    - c. Significant intangible losses, as defined in R12-15-1202(21) and identified and evaluated by a public natural resource management protection agency, because the dam has a size classification of either small or intermediate under R12-15-1206(A) and any release would be limited to the 100 year floodplain or property owned or controlled by the dam owner under long-term lease.
7. The seal and signature of the responsible engineer in accordance with A.R.S. Title 32, Chapter 1.
8. The drawings required by subsection (A)(3) shall include a plan view and maximum section of the dam; the outlet works; and the spillway plan, profile, and cross section.
9. The specifications required by subsection (A)(3) shall include the construction materials, testing criteria, and installation techniques.
- B. The Director may make other requirements for drawings and specifications for the proposed repair or alteration of a very low hazard potential dam. In determining other requirements, the Director shall consider the size and extent of the repair or alteration, the portions of the dam that will be repaired or altered, and whether the requirements elicit a description of the proposed construction work that is adequate to allow the Director to evaluate the repair or alteration.
- C. An owner intending to breach, remove, or reduce a very low hazard potential dam to nonjurisdictional size shall submit written notice to the Director at least 60 days before the date that construction begins.
- D. After receipt of a complete application package as prescribed by subsection (A), the Director shall either:
  1. Determine that the dam falls within the very low hazard classification and approve the application in writing; or
  2. Issue a written notice that the dam does not fall within the very low hazard classification.
- E. The Director's determination that the proposed dam does not fall within the very low hazard classification is an appealable agency action and subject to administrative and judicial review under A.R.S. Title 41, Chapter 6, Article 10.
- F. Upon completion of construction, the owner shall notify the Department in writing. The owner shall not use the dam and reservoir before receipt of a license unless the Director issues written approval.
- G. Within 90 days after completion of the construction, reconstruction, repair, enlargement, or alteration of a very low hazard potential dam, the owner shall file the following:
  1. An affidavit showing the actual cost of construction, reconstruction, repair, enlargement, or alteration of the dam. The owner shall submit a detailed accounting of the costs, including all engineering costs.
  2. An additional fee or refund request computed in accordance with A.R.S. § 45-1209 and R12-15-104(A)(7), based on the actual cost of construction, reconstruction, repair, enlargement, or alteration.
  3. A brief completion report summarizing the salient features of the project, including a description of the causes for any changes or deviations from the approved application package prepared by the engineer who supervised the construction in accordance with A.R.S. Title 32, Chapter 1. The report shall include:
    - a. That the dam has been designed and constructed in compliance with basic principles of dam construction currently being practiced in the industry;

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- b. That the dam as constructed has structural integrity and flood routing capacity consistent with its hazard potential classification; and
  - c. That the as constructed drawings and the report accurately represent the construction of the dam.
- 4. As constructed drawings prepared by the engineer who supervised the construction. The owner and the engineer shall maintain a record of the drawings.
- H. Within 30 days after receipt of the information in subsection (G), the Director shall issue to the owner either a license or a notice that the dam and appurtenant works shall not be operated because the dam and appurtenant works do not qualify as very low hazard or were not built according to the submitted design. Upon receiving the Director's written approval, the owner may operate the dam and appurtenant works. The license shall include conditions of operation, including:
  - 1. The safe storage level of the reservoir,
  - 2. A requirement that the conditions resulting in the very low hazard classification be maintained throughout the life of the dam, and
  - 3. A requirement that the owner demonstrate in writing the very low hazard classification in the manner prescribed by subsection (A)(6) every five years.
- I. An owner shall immediately commence repairs necessary to safeguard human life and property and prevent failure or improper operation of a very low hazard potential dam. The owner shall notify the Department as soon as reasonably possible and in all cases within 10 days of commencing the required repairs.
- J. The Department may periodically inspect construction to confirm that it is proceeding according to the approved design and that proper construction quality assurance is being exercised by the owner's engineer. The owner, or the owner's engineer under the direction of the owner, shall remedy any unsatisfactory condition using the contractor.
- K. The owner shall provide the Department access to the dam site for purposes of inspecting all phases of construction, including the foundation, embankment and concrete placement, inspection and test records, and mechanical installations.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-1212. Construction of a High, Significant, or Low Hazard Potential Dam**

- A. Before commencement of construction activities, the owner shall invite to a pre-construction conference all involved regulatory agencies, the prime contractor, and all subcontractors. At this meeting the Department shall identify, to the extent possible, the key construction stages at which an inspection will be made. At least 48 hours before each key construction stage identified for inspection, the owner or the owner's engineer shall provide notice to the Department.
- B. The owner and the owner's engineer shall oversee construction of a new dam or reconstruction, repair, enlargement, alteration, breach, or removal of an existing dam. Failure to perform the work in accordance with the construction drawings and specifications approved by the Director renders the

approval revocable. The owner's engineer shall exercise professional judgment independent of the contractor.

- C. A professional engineer with proficiency in engineering and knowledge of dam technology shall supervise or direct the supervision of construction in accordance with the construction quality assurance plan.
- D. The owner's engineer shall submit summary reports of construction activities and test results according to a schedule approved by the Department.
- E. The owner shall immediately report to the Department any condition encountered during construction that requires a deviation from the approved plans and specifications.
- F. The owner shall promptly submit a written request for approval of any necessary change and sufficient information to justify the proposed change. The owner shall not commence construction without the written approval of the Director unless the change is a minor change. A minor change is a change that complies with the requirements of this Article and provides equal or better safety performance.
- G. Upon completion of construction, the owner shall notify the Department in writing. The Department shall make a final inspection. The owner shall correct any deficiencies noted during the inspection.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1213. Completion Documents for a Significant or High Hazard Potential Dam**

Within 90 days after completion of the construction or removal work for a significant or high hazard potential dam and final inspection by the Department, the owner shall file the following:

- 1. An affidavit showing the actual cost of the construction. The owner shall submit a detailed accounting of the costs, including all engineering costs.
- 2. An additional fee or refund request based on the actual cost of the construction, computed in accordance with A.R.S. § 45-1209 and R12-15-104(A)(7).
- 3. One set of full sized as constructed drawings prepared and sealed by the engineer who supervised the construction. If changes were made during construction, the owner shall file supplemental drawings showing the dam and appurtenances as actually constructed.
- 4. Construction records, including grouting, materials testing, and locations and baseline readings for permanent bench marks and instrumentation, initial surveys, and readings.
- 5. Photographs of construction from exposure of the foundation to completion of construction.
- 6. A brief completion report summarizing the salient features of the project, including a description of the causes for any changes or deviations from the approved drawings and specifications that were made during the construction phase.
- 7. A schedule for filling the reservoir, specifying fill rates, water level elevations to be held for observation, and a schedule for inspecting and monitoring the dam. The owner shall monitor the dam monthly during the first filling.
- 8. An operating manual for the dam and its appurtenant structures. The operating manual shall include a process for safety inspections prescribed in R12-15-1219. The operating manual shall include schedules for surveillance

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activities and baseline information for any installed instrumentation as follows:

- a. The frequency of monitoring,
- b. The data recording format,
- c. A graphical presentation of data, and
- d. The person who will perform the work.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-1214. Licensing**

- A. Upon review and approval of the documents filed under R12-15-1213 and finding that the construction at the dam has been completed in accordance with the approved plans and specifications and finding that the dam is safe, the Director shall issue a license. The license shall specify the safe storage level for the reservoir and shall specify conditions for the safe operation of the dam. The dam and reservoir shall not be used before issuance of a license unless the Director issues written approval. Procedures for issuance of a license for low and very low hazard potential dams are prescribed in R12-15-1210(H) and R12-15-1211(H), respectively.
- B. A new license shall be issued in the following instances:
  1. Upon change of ownership of a dam.
  2. Upon change of the safe storage level.
  3. Upon expiration of time to appeal a notice issued under R12-15-1223(B).
  4. Upon expiration of time to appeal an order issued by the Director under R12-15-1223(D).
  5. Upon expiration of time to appeal an order of a court.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1215. Construction Drawings, Construction Specifications, and Engineering Design Report for a High, Significant, or Low Hazard Potential Dam**

The owner and engineer are responsible for complete and adequate design of a dam and for including in the application all aspects of the design pertaining to the safety of the dam.

1. Construction Drawing Requirements. The construction drawings required by R12-15-1208(5), R12-15-1209(E)(1), and R12-15-1210(A)(6) shall include the following:
  - a. The seal and signature of the responsible engineer in accordance with A.A.C. R4-30-304.
  - b. One or more topographic maps of the dam, spillway, outlet works, and reservoir on a scale large enough to accurately locate the dam and appurtenances, indicate cut and fill lines, and show the property lines and ownership status of the land. Contour intervals shall be compatible with the height and size of the dam and its appurtenances and shall show design and construction details.
  - c. A reservoir area and capacity curve that reflect area in acres and capacity in acre-feet in relation to depth of water and elevation in the reservoir. The construction drawings shall show the spillway invert and top of dam elevations. The construction drawings shall

also show the reservoir volume and space functional allocations. The construction drawings may include alternate scales as required for the owner's use.

- d. Spillway and outlet works rating curves and tables at a scale or scales that allow determination of discharge rate in cubic feet per second at both low and high flows as measured by depth of water passing over the spillway control section.
- e. A location map showing the dam footprint and all exploration drill holes, test pits, trenches, adits, borrow areas, and bench marks with elevations, reference points, and permanent ties. This map shall use the same vertical and horizontal control as the topographic map.
- f. Geologic information including 1 or more geologic maps, profile along the centerline, and other pertinent cross sections of the dam site, spillway or spillways, and appurtenant structures, aggregate and material sources, and reservoir area at 1 or more scales compatible with the site and geologic complexity, showing logs of exploration drill holes, test pits, trenches, and adits.
- g. One or more plans of the dam to delineate design and construction details.
- h. Foundation profile along the dam centerline at a true scale where the vertical scale is equal to the horizontal scale, showing the existing ground and proposed finished grade at cut and fill elevations, including anticipated geologic formations. The foundation profile shall include any proposed grout and drain holes.
- i. Profile and a sufficient number of cross sections of the dam to delineate design and construction details. The drawings shall illustrate and show dimensions of camber, details of the top, core zone, interior filters and drains, and other zone details. The profile of the dam may be drawn to different horizontal and vertical scales if required for detail. A maximum section of the dam shall be drawn to a true scale, where the vertical scale is equal to the horizontal scale. The outlet conduit may be shown on the maximum section if this is typical of the proposed construction.
- j. One or more dam foundation plans showing excavation grades and cut slopes with any proposed foundation preparation, grout and drain holes, and foundation dewatering requirements.
- k. Plan, profile, and details of the outlet works, including the intake structure, the gate system, conduit, trashrack, conduit filter diaphragm, conduit concrete encasement, and the downstream outlet structure. The drawings shall include all connection and structural design details.
- l. Plan, profile, control section, and cross sections of the spillway, including details of any foundation preparation, grouting, or concrete work that is planned. A complex control structure, a concrete chute, or an energy dissipating device for a terminal structure shall include both hydraulic and structural design details.
- m. Hydrologic data, drainage area and flood routing, and diversion criteria.

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2. Construction Specification Requirements. The construction specifications required by R12-15-1208(6) and R12-15-1210(A)(7) shall include the following:
  - a. The seal and signature of the responsible engineer in accordance with A.A.C. R4-30-304.
  - b. The statement that the construction drawings and specifications shall not be materially changed without the prior written approval of the Director.
  - c. A detailed description of the work to be performed and a statement of the requirements for the various types of materials and installation techniques that will enter into the permanent construction.
  - d. The statement that construction shall not be considered complete until the Director has approved the construction in writing.
  - e. The statement that the owner's engineer shall control the quality of construction.
  - f. The following construction information:
    - i. All earth and rock material descriptions, placement criteria, and construction requirements for all elements of the dam and related structures.
    - ii. All concrete, grout, and shotcrete material and mix descriptions, placement and consolidation criteria, temperature controls, and construction requirements for all elements of the dam and related structures.
    - iii. Material criteria and material testing, cleaning, and treatment. If foundation or curtain grouting is required, the specifications shall describe the type of grout, grouting method, special equipment necessary, recording during grouting, and foundation monitoring to avoid disturbance from grouting.
    - iv. All materials testing that will be performed by the contractor for pre-qualification of materials, including special performance testing, such as water pressure tests in conduits. The Director shall accept materials that are pre-tested successfully and constructed in-place in accordance with specifications.
    - v. A plan for control or diversion of surface water during construction. The design engineer may determine frequency of storm runoff to be controlled during construction, commensurate with the risk of economic loss during construction.
    - vi. Criteria for blast monitoring and acceptable blast vibration levels, including particle velocities for the dam and other critical appurtenances. Monitoring equipment and monitoring locations shall be specified.
    - vii. Instrumentation material descriptions, placement criteria, and construction requirements and a statement that instrumentation shall be installed by experienced speciality subcontractors.
3. Engineering Design Report Requirements. The engineering design report required by R12-15-1208(7) and R12-15-1210(A)(8) shall include the following:
  - a. The seal and signature of the responsible engineer in accordance with A.A.C. R4-30-304.
  - b. The classification under R12-15-1206 of the proposed dam, or for the proposed enlargement of an existing dam or reservoir.
  - c. Hydrologic considerations, including calculations and a summary table of data used in determining the required emergency spillway capacity and freeboard, and design of any diversion or detention structures. The design report shall include input and output listings on both hard copy and computer diskette.
  - d. Hydraulic characteristics, engineering data, and calculations used in determining the capacities of the outlet works and emergency spillway. The design report shall include input and output listings on both hard copy and computer diskette.
  - e. Geotechnical investigation and testing of the dam site and reservoir basin. Results and analysis of subsurface investigations, including logs of test borings and geologic cross sections.
  - f. Guidelines and criteria for blasting to be used by the contractor in preparing the blasting plan.
  - g. Details of the plan for control or diversion of surface water during construction.
  - h. Details of the dewatering plan for subsurface water during construction.
  - i. Testing results of earth and rock materials, including the location of test pits and the logs of these pits.
  - j. Discussion and design of the foundation blanket grouting, grout curtain, and grout cap based on foundation stability and seepage considerations.
  - k. Calculations and basic assumptions on loads and limiting stresses for reinforced concrete design. The design report shall include input and output listings on both hard copy and computer diskette.
  - l. A discussion and stability analysis of the dam including appropriate seismic loading, safety factors, and embankment zone strength characteristics. Analyses shall include both short-term and long-term loading on upstream and downstream slopes. The design report shall include input and output listings on both hard copy and computer diskette.
  - m. A discussion of seismicity of the project area and activity of faults in the vicinity. The design report shall use both deterministic and statistical methods and identify the appropriate seismic coefficient for use in analyses.
  - n. Discussion and design of the cutoff trench based on seepage and other considerations.
  - o. Permeability characteristics of foundation and dam embankment materials, including calculations for seepage quantities through the dam, the foundation, and anticipated in the internal drain system. The design report shall include input and output listings on both hard copy and computer diskette. The design report shall include copies of any flow nets used.
  - p. Discussion and design of internal drainage based on seepage quantity calculations. The design report shall include instrumentation necessary to monitor the drainage system and filter design calculations for protection against piping of foundation and embankment.
  - q. Erosion protection against waves and rainfall runoff for both the upstream and downstream slopes, as appropriate.
  - r. Discussion and design of foundation treatment to compensate for geological weakness in the dam



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foundation and abutment areas and in the spillway foundation area.

- s. Post-construction vertical and horizontal movement systems.
- t. Discussion of foundation conditions including the potential for subsidence, fissures, dispersive soils, collapsible soils, and sink holes.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1216. Design of a High, Significant, or Low Hazard Potential Dam****A. General Requirements.**

1. Emergency Spillway Requirements. An applicant shall:
  - a. Construct each spillway in a manner that avoids flooding in excess of the flooding that would have occurred in the same location under the same conditions before construction. The owner of a dam shall demonstrate that a spillway discharge would not result in incremental adverse consequences. In determining whether a spillway discharge of a dam would result in incremental adverse consequences, the Director shall evaluate whether the owner has taken any or all of the following actions: issuing public notice to downstream property owners, complying with flood insurance requirements, adopting emergency action plans, conducting mock flood drills, acquiring flow easements or other acquisitions of real property, or other actions appropriate to safeguard the dam site and flood channel.
  - b. Include a control structure to avoid head cutting and lowering of the spillway crest for spillways excavated in soils or soft rock. In the alternative, the design may provide evidence acceptable to the Director that erosion during the inflow design flood will not result in a sudden release of the reservoir.
  - c. Provide each spillway and channel with a minimum width of 10 feet and suitable armor to prevent erosion during the discharge resulting from the inflow design flood.
  - d. Ensure that downstream spillway channel flows do not encroach on the dam unless suitable erosion protection is constructed.
  - e. Ensure that each spillway, in combination with outlets, is able to safely pass the peak discharge flow rate, as calculated on the basis of the inflow design flood.
  - f. Not construct bridges or fences across a spillway unless the construction is approved in writing by the Director. The Director's approval may include conditions regarding the design and operation of the spillway and fencing, based on safety concerns.
  - g. Not use a pipe or culvert as an emergency spillway unless the Director approves the use following review of the dam design and site characteristics.
2. Inflow Design Flood Requirements
  - a. Unless directed otherwise in writing by the Director, the inflow design flood requirements for determining the spillway minimum capacity are stated in Table 4.
  - b. As an alternative to the requirements prescribed in Table 4, the Director may accept an inflow design flood determined by an incremental damage assess-

ment study, based on the relative safety of the alternatives.

- c. The Director may accept site-specific probable maximum precipitation studies in determination of the inflow design flood.
- d. An applicant shall ensure that the total freeboard is the largest of the following:
  - i. The sum of the inflow design flood maximum water depth above the spillway crest plus wave run up.
  - ii. The sum of the inflow design flood maximum water depth above the spillway crest plus 3 feet.
  - iii. A minimum of 5 feet.
- 3. Outlet Works Requirements. An applicant shall ensure that a dam has a low level outlet works that:
  - a. Is capable of draining the reservoir to the sediment pool level. A low level outlet works for a high or significant hazard potential dam shall be a minimum of 36 inches in diameter. A low level outlet works for a low hazard potential dam shall be a minimum of 18 inches in diameter.
  - b. For a high or significant hazard potential dam, has the capacity to evacuate 90% of the storage capacity of the reservoir within 30 days, excluding reservoir inflows.
  - c. Has a filter diaphragm or other current practice measures to reduce the potential for piping along the conduit.
  - d. Has accessible outlet controls when the spillway is in use.
  - e. Has an emergency manual override system or can be operated manually.
  - f. Is constructed of materials appropriate for loading condition, seismic forces, thermal expansion, cavitation, corrosion, and potential abrasion. The applicant shall not use corrugated metal pipes or other thin-walled pipes except as a form for a cast-in-place concrete conduit. The applicant shall construct outlet conduits of cast-in-place reinforced concrete. The applicant shall design each outlet to maintain water tightness. The applicant shall construct each outlet to prevent the occurrence of piping adjacent to the outlet.
  - g. Has an operating or guard gate on the upstream end of any gated outlet.
  - h. Has an outlet conduit near the base of 1 of the abutments on native bedrock or other competent material. The applicant shall support the entire length of the conduit on foundation materials of uniform density and consistency to prevent adverse differential settlement.
  - i. Has an upstream valve or gate capable of controlling the discharge through all ranges of flow on any gated outlet conduit.
  - j. Has a trashrack designed for a minimum of 25% of the reservoir head to which it would be subjected if completely clogged at the upstream end of the outlet.
  - k. Has an air vent pipe just downstream of the control gate. The applicant shall include a blow-off valve at or near the downstream toe of the dam for an outlet conduit that is connected directly to a distribution system.

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1. Has an outlet conduit designed for internal pressure equal to the full reservoir head and for superimposed embankment loads, acting separately.
  4. Dam Site And Reservoir Area Requirements
    - a. An applicant shall demonstrate that reservoir storage during the inflow design flood will not result in incremental adverse consequences and that the design will not result in the inundation or wave damage of properties within the reservoir, except marina-type structures, during the inflow design flood. In determining whether a discharge will result in incremental adverse consequences, the Director shall evaluate whether the owner has taken any or all of the following actions: issuing public notice to upstream affected property owners, complying with flood insurance requirements, adopting emergency action plans, conducting mock flood drills, acquiring flood easements or other acquisitions of real property, or other actions appropriate to safeguard the dam site and reservoir. Permanent habitations are not allowed within the reservoir below the spillway elevation.
    - b. The applicant shall clear the reservoir storage area of logs and debris.
    - c. The applicant shall place borrow areas a safe distance from the upstream toe and the downstream toe of the dam to prevent a piping failure of the dam.
    - d. The applicant shall keep the top of the dam and appurtenant structures accessible by equipment and vehicles for emergency operations and maintenance.
  5. Geotechnical Requirements
    - a. The applicant shall provide an evaluation of the static stability of the foundation, dam, and slopes of the reservoir rim and demonstrate that sufficient material is available to construct the dam as designed.
    - b. The applicant shall not construct a dam on active faults, collapsible soils, dispersive soils, sink holes, or fissures, unless the applicant demonstrates that the dam can safely withstand the anticipated offset or other unsafe effects on the dam.
  6. Seismic Requirements
    - a. The applicant shall submit a review of the seismic or earthquake history of the area around the dam within a radius of 100 miles to establish the relationship of the site to known faults and epicenters. The review shall include any known earthquakes and the epicenter locations and magnitudes of the earthquakes.
    - b. The applicant shall identify the location of active or potentially active faults that have experienced Holocene or Late Pleistocene displacement within a radius of 100 miles of the site.
    - c. For a high or significant hazard potential dam, the applicant shall design the dam to withstand the maximum credible earthquake.
    - d. For a low hazard potential dam, the applicant shall use probabilistic or deterministic methods to determine the design earthquake. The magnitude of the design earthquake shall vary with the size of the dam, site condition, and specific location.
- B. Embankment Dam Requirements.**
1. Geotechnical Requirements. Table 5 states minimum factors of safety for embankment stability under various loading conditions. For an embankment dam an applicant shall provide a written analysis of minimum factors of safety for stability.
    - a. The analysis of minimum factors of safety shall include the effects of anisotropy on the phreatic surface position by using a ratio of horizontal permeability to vertical permeability of at least 10. The Director may require ratios of up to 100 if the material types and construction techniques will cause excessive stratification.
    - b. The applicant shall use tests modeling the conditions being analyzed to determine the strengths used in the stability analysis. The stability analysis shall include total and effective stress strengths appropriate for the different material zones and conditions analyzed. The stability analysis shall use undrained strengths or strength parameters for all saturated materials.
    - c. The applicant shall perform an analysis of the upstream slope stability for a partial pool with steady seepage considering the reservoir level that provides the lowest factor of safety.
    - d. A stability analysis is not required for low hazard potential dams if the owner or the owner's engineer demonstrates that conservative slopes and competent materials are included in the design.
  2. Seismic Requirements
    - a. The applicant shall determine the seismic characteristics of the site as prescribed in subsection (A)(6).
    - b. The applicant shall determine the liquefaction susceptibility of the embankment, foundation, and abutments. The applicant shall use standard penetration testing, cone penetration testing, shear wave velocity measurements, or a combination of these methods to make this determination. The applicant shall compute the minimum factor of safety against liquefaction at specific points and make a determination of whether the overall site is subject to liquefaction.
    - c. The applicant shall determine the safety of the dam under seismic loading using a pseudo static stability analysis, computing the minimum factor of safety if the embankment, foundation or abutment is not subject to liquefaction and has a maximum peak acceleration of 0.2g or less, or a maximum peak acceleration of 0.35g or less, and consists of clay on a clay or bedrock foundation. The applicant shall use in the pseudo static stability analysis a pseudo static coefficient that is at least 60% of the maximum peak bedrock acceleration at the site.
    - d. The applicant shall compute a minimum factor of safety against overtopping due to deformation and settlement in each of the following cases. The minimum factor of safety against overtopping can be no less than 2.5, determined by dividing the total pre-earthquake freeboard by the estimated vertical settlement in feet. The applicant shall determine the total vertical settlement by adding the settlement values of the upstream and downstream slopes.
      - i. The minimum factor of safety in a pseudo static analysis is less than 1.0;
      - ii. An embankment, foundation, or abutment is not subject to liquefaction, has a maximum peak acceleration of more than 0.2g or a maximum peak acceleration of more than 0.35g and consists of clay on a clay or bedrock foundation; or

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- iii. The embankment, foundation or abutment is subject to liquefaction.
  - e. The applicant shall perform a liquefaction analysis to establish approximate boundaries of liquefiable zones and physical characteristics of the soil following liquefaction for an embankment, foundation, or abutment subject to liquefaction. The applicant shall perform an analysis of the potential for flow liquefaction.
  - f. Other, more sophisticated analytical procedures may be required by the Director for sites with high seismicity or low strength embankment or foundation soils.
3. Miscellaneous Design Requirements
- a. The design of any significant or high hazard potential dam shall provide seepage collection and prevent internal erosion or piping due to embankment cracking or other causes.
  - b. The Director shall review the filter and permeability design for a chimney drain, drain blanket, toe drain, or outlet conduit filter diaphragms on the basis of unique site characteristics.
    - i. The minimum thickness of an internal drain is 3 feet.
    - ii. The minimum width of a chimney drain is 6 feet.
    - iii. The applicant shall filter match an internal drain to its adjacent material.
    - iv. The applicant shall design internal drains with sufficient capacity for the expected drainage without the use of drainpipes using only natural granular materials.
  - c. The use of a geosynthetic is not permitted in a design if it serves as the sole defense against dam failure. The use of geotextiles and geonets as a filter or drain material or a geomembrane liner is permitted only in a location that is easily accessible for repair or if its excavation cannot create an unsafe condition at the dam. A geosynthetic liner is allowed under special conditions and in specific situations if it is subject to monitoring and redundant safety controls. The Director may impose conditions, including monitoring appropriate to the hazard classification, inspection, and necessary repairs, each performed every 5 years.
  - d. The applicant shall use armoring on any upstream slope of an embankment dam that impounds water for more than 30 days at a time. If the applicant uses rock riprap, it shall be well-graded, durable, sized to withstand wave action, and placed on a well-graded pervious sand and gravel bedding or geotextile with filtering capacity appropriate for the site.
  - e. The applicant shall protect the downstream slopes and groins of an embankment dam from erosion.
  - f. The minimum width of the top of an embankment dam is equal to the structural height of the dam divided by 5 plus an additional 5 feet. The required minimum width for any embankment dam is 12 feet. The maximum width for any embankment dam is 25 feet.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R.

- 8. Patching or caulking spalled or cracked concrete to pre-

2558, effective June 12, 2000 (Supp. 00-2).

**Table 4. Inflow Design Flood**

Dam Hazard Class	Dam Size Classification	IDF Magnitude
Very Low	All Sizes	100-year
Low	All Sizes	0.25 PMF
Significant	Small Intermediate Large	0.25 PMF 0.5 PMF 0.5 PMF
High*	All Sizes	*

\* For a high hazard potential dam, the applicant shall design the dam to withstand an inflow design flood that varies from .5 PMF to the full PMF, with size increasing based on persons at risk and potential for downstream damage. The applicant shall consider foreseeable future conditions.

**Historical Note**

New Table adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**Table 5. Minimum Factors of Safety for Stability<sup>1</sup>**

Embankment Loading Condition	Minimum Factor of Safety
End of construction case – upstream and downstream slopes	1.3
End of construction case for embankments greater than 50 feet in height on weak foundations	1.4
Steady state seepage - upstream (critical partial pool) and downstream slope (full pool)	1.5
Instantaneous drawdown - upstream slope	1.2

<sup>1</sup> Not applicable to an embankment on a clay shale foundation.

**Historical Note**

New Table adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1217. Maintenance and Repair; Emergency Actions**

- A. An owner shall perform general maintenance and ordinary repairs that do not impair the safety of the dam. General maintenance and ordinary repair activities listed under this subsection do not require prior approval of the Director. These repair activities include:
  - 1. Removing brush or tall weeds.
  - 2. Cutting trees and removing slash from the embankment or spillway. Small stumps may be removed provided no excavation into the embankment occurs.
  - 3. Exterminating rodents by trapping or other methods. Rodent damage may be repaired provided it does not involve excavation that extends more than 2 feet into the embankment and replacement materials are compacted as they are placed.
  - 4. Repairing erosion gullies less than 2 feet deep on the embankment or in the spillway.
  - 5. Grading the surface on the top of the dam embankment or spillway to eliminate potholes and provide proper drainage, provided the freeboard is not reduced.
  - 6. Placing additional riprap and bedding on the upstream slope, or in the spillway in areas that have sustained minor damage and restoring the original riprap protection where the damage has not yet resulted in erosion and weakening of the dam.
  - 7. Painting, caulking, or lubricating metal structures. vent deterioration.

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9. Removing debris, rock, or earth from outlet conduits or spillway channels and basins.
  10. Patching to prevent deterioration within outlet works.
  11. Replacing worn or damaged parts on outlet valves or controls to restore them to original condition or its equivalent.
  12. Repairing or replacing fences intended to keep traffic or livestock off the dam or spillway.
- B.** General maintenance and ordinary repair that may impair or adversely effect safety, such as excavation into or near the toe of the dam, construction of new appurtenant structures for the dam, and repair of damage that has already significantly weakened the dam shall be performed in accordance with this Article. The Director may approve maintenance performed according to a standard detail or method of repair on file with the Department upon submittal of a letter. The Director shall determine whether general maintenance and ordinary repair activities not listed in subsection (A) will impair safety.
- C.** Emergency actions not impairing the safety of the dam may be taken before guidance can be provided by an engineer and do not require prior approval of the Director. Emergency actions do not excuse an owner's responsibility to promptly undertake a permanent solution. Emergency actions include:
1. Stockpiling materials such as riprap, earth fill, sand, sandbags, and plastic sheeting.
  2. Lowering the reservoir level by making releases through the outlet or a gated spillway, by pumping, or by siphoning.
  3. Armoring eroded areas by placing sandbags, riprap, plastic sheeting, or other available material.
  4. Plugging leakage entrances on the upstream slope.
  5. Increasing freeboard by placing sandbags or temporary earth fill on the dam.
  6. Diverting flood waters to prevent them from entering the reservoir basin.
  7. Constructing training berms to control flood waters.
  8. Placing sandbag ring dikes or reverse filter materials around boils at the downstream toe to provide back pressure.
  9. Removing obstructions from outlet or spillway flow areas.
- D.** Emergency actions impairing the safety of the dam require prior approval of the Director. An owner shall not lower the water level by excavating the spillway or embankment unless failure is imminent.
- E.** For all high and significant hazard potential dams, the emergency action plan shall be implemented with any emergency actions taken at the dam.
- F.** The owner shall notify the Director immediately of any emergency condition that exists and any emergency action taken.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1218. Safe Storage Level**

The Director has the authority to determine the safe storage level for the reservoir behind each dam, including the storage level of an existing dam while it is being repaired, enlarged, altered, breached, or removed. The elevation of the safe storage level is stated on the license. The owner shall not store water in excess of the level determined by the Director to be safe. The owner shall not place flashboards or other devices in the emergency spillway without approval of an alteration of the dam in accordance with this Article.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1219. Safety Inspections; Fees**

- A.** Except as provided in subsection (E), the Director shall conduct a dam safety inspection annually or more frequently for each high hazard potential dam, triennially for each significant hazard potential dam, and once every five years for each low and very low hazard potential dam. An owner of a dam shall pay the inspection fee required by R12-15-105 for each inspection of the dam pursuant to this subsection.
- B.** An engineer is considered qualified to provide information to the Director regarding the safe storage level of a reservoir if the engineer:
1. Meets the criteria in R12-15-1202(11),
  2. Has three years of experience in the field of dam safety, and
  3. Has actual experience in conducting dam safety inspections.
- C.** A dam safety inspection includes:
1. Review of previous inspections, reports, and drawings;
  2. Inspection of the dam, spillways, outlet facilities, seepage control, and measurement systems;
  3. Inspection of any permanent monument or monitoring installations;
  4. Assessment of all parts of the dam that are related to the dam's safety; and
  5. A recommendation regarding the safe storage level of the reservoir.
- D.** The engineer shall submit a safety inspection report that describes the findings and lists actions that will improve the safety of the dam. The report shall include the engineer's recommendation of the safe storage level. The engineer shall use a report form approved by the Director.
- E.** Inspections by the Owner
1. An owner may provide to the Director, at the owner's expense, a safety inspection report that complies with the requirements of subsections (B), (C), and (D) in place of an inspection by the Department. The owner's engineer shall notify the Director and submit a written summary of the engineer's qualifications at least 14 days before the scheduled safety inspection.
  2. The Director may refuse to accept an inspection that does not conform to this Article.
  3. A safety inspection report submitted pursuant to this subsection shall include the fee required by R12-15-105(D).
- F.** Inspections by the Department
1. The Director may enter at reasonable times upon private or public property and the owner shall permit such entry, where a dam is located, including a dam under construction, reconstruction, repair, enlargement, alteration, breach, or removal, for any of the following purposes:
    - a. To enforce the conditions of approval of the construction drawings and specifications related to an application for construction, reconstruction, repair, enlargement, alteration, breach, or removal.
    - b. To inspect a dam that is subject to this Article.
    - c. To investigate or assemble data to aid review and study of the design and construction of dams, reservoirs, and appurtenances or make watershed investigations to facilitate decisions on public safety to fulfill the duties of A.R.S. § 45-1214.
    - d. To ascertain compliance with this Article and A.R.S. Title 45, Chapter 6.

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2. Upon receipt of a complaint that a dam is endangering people or property:
  - a. The Director shall inspect the dam unless there is substantial cause to believe the complaint is without merit.
  - b. If the complainant files a complaint in writing and deposits with the Director sufficient funds to cover the costs of the inspection, the Director shall make an inspection.
  - c. The Director shall provide a written report of the inspection to the complainant and the dam owner.
  - d. If an unsafe condition is found, the Director shall cause it to be corrected and return the deposit to the complainant. If the complaint was without merit the deposit shall be paid into the general fund.
3. The Director may employ qualified on-call consultants to conduct inspections.
4. Inspections under subsection (A) shall comply with the requirements of A.R.S. § 41-1009.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2). Amended by exempt rulemaking at 16 A.A.R. 1205, effective June 15, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1950, effective September 10, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 659, effective June 4, 2011 (Supp. 11-2).

**R12-15-1220. Existing Dams**

- A. The requirements of this Article apply to existing dams, except as provided in subsections (B) and (C).
- B. If the Director has determined that an existing dam is in a safe condition, the owner is not required to comply with R12-15-1216 unless the Director determines that it is cost effective to upgrade the dam to comply with the requirements of R12-15-1216 at the time a major alteration or major repair is planned. In determining whether it is cost effective to upgrade a dam, the Director shall consider:
  1. The hazard potential classification of the dam;
  2. Whether the cost of the upgrade would exceed 25% of the total cost of the major alteration or major repair; and
  3. Whether there is a more cost effective alternative that would provide an equivalent increase in safety.
- C. If the Director has determined that a dam is in an unsafe condition, the owner shall comply with the requirements in R12-15-1216. The owner is not required to comply with a requirement in this Article if the Director finds that, considering the site characteristics and the proposed design, the requirement is unduly burdensome or expensive and is not necessary to protect human life or property. The Director shall consider the size, hazard potential classification, physical site conditions, and applicability of a requirement to the dam. The Director shall state in writing the reason or reasons the owner is not required to comply with a requirement.
- D. The owner shall ensure that installation of utilities beneath or through an existing dam is accomplished by open cuts or jacking and boring methods.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1221. Emergency Action Plans**

- A. Each owner of a high or significant hazard potential dam shall prepare, maintain, and exercise a written emergency action

plan for immediate defensive action to prevent failure of the dam and minimize any threat to downstream development. The emergency action plan shall contain a:

1. Notification chart showing the priority for notification in an emergency situation. The owner shall notify local emergency response agencies, affected downstream populations, county emergency management agencies, and affected flood control districts;
  2. Description of the demand reservoir and scope of the emergency action plan;
  3. Delineation of potentially unsafe conditions, evaluation procedures, and triggering events that require the initiation of partial or full emergency notification procedures, based on the urgency of the situation;
  4. Delineation of areas of responsibility of the owner and other parties. The emergency action plan shall clearly identify individuals responsible for notifications and declaring an emergency;
  5. Specific notification procedure for each emergency situation anticipated;
  6. Description of emergency supplies and resources, equipment access to the site, and alternative means of communication. The emergency action plan shall also identify specific preparedness activities required, such as annual full or partial mock exercises and updates of the emergency action plan; and
  7. Map showing the area that would be subject to flooding due to spillway flows and dam failures.
- B. The owner shall use the Director's model emergency action plan, which is available at no cost, or an equivalent model, for guidance in preparing the emergency action plan.
  - C. The owner shall submit a copy of the proposed emergency action plan for review by the Arizona Division of Emergency Management and all local emergency coordinators involved in the plan. The owner shall incorporate appropriate recommendations generated by the reviews and submit the revised emergency action plan to the Department.
  - D. The owner shall review and update the emergency action plan annually or more frequently to incorporate changes such as new personnel, changing roles of emergency agencies, emergency response resources, conditions of the dam, and information learned from mock exercises. The owner shall send updated portions of the plan to persons and agencies holding copies of the plan within 15 days after preparation of an update.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1222. Right of Review**

- A. An applicant or owner aggrieved by a decision of the Director regarding the determination of hazard classification, jurisdictional status, or the Director's application of this Article may seek review of an appealable agency action under A.R.S. Title 41, Chapter 6, Article 10.
- B. An applicant or owner aggrieved by a decision of the Director that requires the exercise of professional engineering judgment or discretion or the assessment of risk to human life or property, such as the adequacy of an applicant's project documentation, dam design, safe storage level, requirements for existing dams, or maintenance, may seek review by a board of review under A.R.S. §§ 45-1210 and 45-1211.
- C. The following actions are not subject to review:

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1. Emergency measures taken under A.R.S. §§ 45-1212 or 45-1221.
2. Agency decisions made under A.R.S. §§ 41-1009(E) or (F).
3. Agency actions made exempt from review by law.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1223. Enforcement Authority**

- A. The Department may exercise its discretion to take action necessary to prevent danger to human life or property. The Director may take any legal action that is proper and necessary for the enforcement of this Chapter.
- B. If the Director has cause to believe that a dam is unsafe or a person is violating or has violated a provision of this Article or A.R.S. Title 45, Chapter 6, Article 1, the Director may issue a notice directing the owner to remedy the safety deficiency or correct the violation. The owner may appeal a notice issued under this subsection as an appealable agency action in accordance with A.R.S. Title 41, Chapter 6, Article 10. If the owner does not appeal within 30 days after the date on the notice, the notice becomes final and may be incorporated as a condition of any license based on the duration of the requirement.
- C. If the Director has cause to believe that a dam is unsafe or a person is violating or has violated a provision of this Article or A.R.S. Title 45, Chapter 6, Article 1, the Director may proceed under A.R.S. § 45-1221 to initiate a contested case under A.R.S. Title 41, Chapter 6, Article 10 by requesting an administrative hearing.
- D. Following a written decision by an administrative law judge, the Director shall issue a decision and order accepting, rejecting, or modifying the administrative law judge's decision. Upon expiration of time to appeal, the decision and order becomes final and may be incorporated as a condition of any license based on the duration of the requirement.
- E. If the Director has cause to believe that a dam is unsafe or a person is violating or has violated a provision of this Article or A.R.S. Title 45, Chapter 6, Article 1 the Director may commence an action in a court of appropriate jurisdiction if:
  1. The violation is an emergency requiring appropriate steps to be taken without delay; or
  2. The Director has cause to believe that use of the administrative procedure would be ineffective or that delay would ensue and a deterioration in the safety of the dam would occur.
- F. If the Director commences an action it shall be brought in a court of appropriate jurisdiction in which:
  1. The cause or some part of the cause arose; or
  2. The owner or person complained of has his or her place of business; or
  3. The owner or person complained of resides.
- G. A person determined to be in violation of this Article; A.R.S. Title 45, Chapter 6; a license; or order may be assessed a civil penalty not exceeding \$1,000 per day of violation. The Director may offer evidence relating to the amount of the penalty in accordance with A.R.S. § 45-1222.
- H. A violation of A.R.S. Title 45, Chapter 6, Article 1 regarding Supervision of Dams, Reservoirs, and Projects is a class 2 misdemeanor, in accordance with A.R.S. § 45-1216.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R.

2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1224. Emergency Procedures**

- A. The owner of a dam shall immediately notify the Department and responsible authorities in adjacent and downstream communities, including emergency management authorities, of a condition that may threaten the safety of the dam. The owner shall take necessary actions to protect human life and property, including action required under an emergency action plan or order issued under this Article.
  1. A condition that may threaten the safety of a dam includes:
    - a. Sliding of upstream or downstream slopes or abutments contiguous to the dam;
    - b. Sudden subsidence of the top of the dam;
    - c. Longitudinal or transverse cracking of the top of the dam;
    - d. Unusual release of water from the downstream slope or face of the dam;
    - e. Other unusual conditions at the downstream slope of the dam;
    - f. Significant landslides in the reservoir area;
    - g. Increasing volume of seepage;
    - h. Cloudy seepage or recent deposits of soil at seepage exit points;
    - i. Sudden cracking or displacement of concrete in a concrete or masonry dam spillway or outlet works;
    - j. Loss of freeboard or dam cross section due to storm wave erosion;
    - k. Flood waters overtopping an embankment dam; or
    - l. Spillway backcutting that threatens evacuation of the reservoir.
  2. In case of an emergency, the owner shall telephone the Arizona Department of Public Safety.
- B. The Director shall issue an emergency approval to repair, alter, or remove an existing dam if the Director finds that immediate remedial action is necessary to alleviate an imminent threat to human life or property.
  1. The emergency approval shall be provided in writing on a form developed for this purpose.
  2. The emergency approval may contain conditions the Director determines are appropriate to protect human life or property.
  3. The emergency approval is effective immediately for 30 days after notice is issued unless extended in writing by the Director. The Director shall also send notice to the county flood control district of the county in which the dam is located, all municipalities within five miles downstream of the dam, and any additional persons identified in the emergency action plan.
  4. The Director may institute legal or administrative proceedings that the Director deems appropriate for violations of the emergency approval or conditions of the emergency approval.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2). Amended by final expedited rulemaking at 28 A.A.R. 266 (January 28, 2022), with an immediate effective date of January 5, 2022 (Supp. 22-1).

**R12-15-1225. Emergency Repairs**

- A. The Director shall use monies from the dam repair fund, established under A.R.S. § 45-1212.01 to employ any remedial measure necessary to protect human life and property resulting

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from a condition that threatens the safety of a dam if the dam owner is unable or unwilling to take action and there is not sufficient time to issue and enforce an order.

- B. The Deputy Director may authorize an expenditure not to exceed \$10,000 from the dam repair fund for remedial measures under A.R.S. § 45-1212. The expenditure of any additional funds shall be approved by the Director.
- C. The Director shall hold a lien against all property of the owner in accordance with A.R.S. § 45-1212.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**R12-15-1226. Non-Emergency Repairs; Loans and Grants**

- A. If the Director determines that a dam represents a threat to human life and property but is not in an emergency condition, the Director may use the dam repair fund, established under A.R.S. § 45-1212.01, as prescribed in this Article to defray the costs of repair.
- B. Monies from the dam repair fund may be used for loans and grants to owners as provided in A.R.S. §§ 45-1218 and 45-1219.
- C. To qualify for a loan or grant from the dam repair fund, a dam shall be classified as unsafe by the Director.
- D. The Director may authorize grant funds for all or part of the cost of engineering studies or construction needed to mitigate the threat to human life and property created by a dam.
  - 1. The Director and the grantee shall execute a financial assistance agreement that includes terms of financial assistance, the work progress, and payment schedule.
  - 2. The Director shall disburse grant funds in accordance with the financial assistance agreement.
  - 3. The Director shall establish a priority ranking for grants based on factors including the potential for failure of a dam, the number of lives at risk, and the capability of the owner to pay a portion of the costs.
- E. The Director may loan funds for engineering studies or for all or part of construction as prescribed in A.R.S. § 45-1218.
  - 1. The Director and the dam owner shall execute a loan repayment agreement. The loan repayment agreement shall be delivered to and held by the Department.
  - 2. The Director shall establish a priority ranking for loans based on factors including the potential for failure of a dam, the number of human lives at risk, and the capability of the owner to pay a portion of the costs.

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 2558, effective June 12, 2000 (Supp. 00-2).

**ARTICLE 13. WELL SPACING REQUIREMENTS; REPLACEMENT WELLS IN APPROXIMATELY THE SAME LOCATION****R12-15-1301. Definitions**

In addition to the definitions in A.R.S. §§ 45-101, 45-402, and 45-591, the following words and phrases in this Article shall have the following meanings, unless the context otherwise requires:

- 1. "Abandoned well" means a well for which a well abandonment completion report has been filed pursuant to R12-15-816(E) or for which a notification of abandonment has been filed pursuant to R12-15-816(K).
- 2. "Additional drawdown" means a lowering in the water levels surrounding a well that is the result of the operation of the well and that is not attributable to existing regional rates of decline or existing impacts from other wells.

- 3. "Applicant" means any of the following:
  - a. A person who has filed an application for a permit to construct a new well or a replacement well in a new location under A.R.S. § 45-599;
  - b. A person who has filed an application for a recovery well permit under A.R.S. § 45-834.01 for a new well as defined in A.R.S. § 45-591 or, except as provided in A.R.S. § 45-834.01(B)(2) or (3), an existing well as defined in A.R.S. § 45-591;
  - c. A person who has filed an application for approval to use a well to withdraw groundwater for transportation to an active management area under A.R.S. § 45-559; or
  - d. A person, other than a city, town, private water company, or irrigation district, who has filed an application for a water exchange permit under A.R.S. § 45-1041.
- 4. "ADEQ" means the Arizona Department of Environmental Quality.
- 5. "Contaminated groundwater" means groundwater that has been contaminated by a release of a hazardous substance, as defined in A.R.S. § 49-201, or a pollutant, as defined in A.R.S. § 49-201.
- 6. "DOD" means the United States Department of Defense.
- 7. "EPA" means the United States Environmental Protection Agency.
- 8. "LCR plateau groundwater transporter" means a person transporting groundwater from the Little Colorado River plateau groundwater basin to another groundwater basin pursuant to A.R.S. § 45-544(B)(1).
- 9. "Notice of water exchange participant" means a person, other than a city, town, private water company, or irrigation district, named as a participant in a water exchange in a notice of water exchange filed under A.R.S. § 45-1051.
- 10. "Original well" means the well replaced by a replacement well in approximately the same location, except that if the replacement well is the latest in a succession of two or more wells drilled as replacement wells in approximately the same location under R12-15-1308 or temporary rule R12-15-840 adopted by the Director on March 11, 1983, "original well" means the well replaced by the first replacement well in approximately the same location.
- 11. "Remedial action site" means any of the following:
  - a. The site of a remedial action undertaken pursuant to the comprehensive environmental response, compensation, and liability act ("CERCLA") of 1980, as amended, 42 U.S.C. 9601, et seq., commonly known as a "superfund" site;
  - b. The site of a corrective action undertaken pursuant to A.R.S. Title 49, Chapter 6, commonly known as a leaking underground storage tank ("LUST") site;
  - c. The site of a voluntary remediation action undertaken pursuant to A.R.S. Title 49, Chapter 1, Article 5;
  - d. The site of a remedial action undertaken pursuant to A.R.S. Title 49, Chapter 2, Article 5, commonly known as a water quality assurance revolving fund ("WQARF") site;
  - e. The site of a remedial action undertaken pursuant to the Resource Conservation and Recovery Act ("RCRA"), 42 U.S.C. 6901, et seq.; or
  - f. The site of remedial action undertaken pursuant to the Department of Defense Environmental Resto-

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ration Program, 10 U.S.C. 2701, et seq., commonly known as a "Department of Defense site" or a "DOD site."

12. "Replacement well" means a well drilled for the purpose of replacing another well.
13. "Replacement well in a new location" means a replacement well that does not qualify as a replacement well in approximately the same location under R12-15-1308.
14. "Replacement well in approximately the same location" means a replacement well that qualifies as a replacement well in approximately the same location under R12-15-1308.
15. "Well" has the meaning prescribed in A.R.S. § 45-402. An abandoned well is not a well.
16. "Well of record" means, with respect to an applicant, an LCR plateau groundwater transporter, or a notice of water exchange participant, any well or proposed well not owned by the applicant, LCR plateau groundwater transporter, or notice of water exchange participant, or proposed to be drilled by the applicant, LCR plateau groundwater transporter, or notice of water exchange participant, to which any of the following apply:
  - a. The well is an existing well as defined in A.R.S. § 45-591 and the owner or operator has registered the well with the Department, unless the current well information on file with the Department identifies the sole purpose or purposes of the well as one or more of the following:
    - i. Cathodic protection;
    - ii. Use as a sump pump or heat pump;
    - iii. Air sparging;
    - iv. Injection of liquids or gasses into the aquifer or vadose zone, including injection wells that are part of an underground storage facility permitted under A.R.S. Title 45, Chapter 3.1;
    - v. Monitoring water levels or water quality, including a piezometer well;
    - vi. Obtaining geophysical, mineralogical, or geotechnical data;
    - vii. Grounding;
    - viii. Soil vapor extraction;
    - ix. Electrical energy generation pursuant to a temporary permit for electrical energy generation issued under A.R.S. § 45-517;
    - x. Dewatering pursuant to a dewatering permit issued under A.R.S. § 45-513 or a temporary dewatering permit issued under A.R.S. § 45-518;
    - xi. Drainage pursuant to a drainage water withdrawal permit issued under A.R.S. § 45-519; or
    - xii. Hydrologic testing pursuant to a hydrologic testing permit issued under A.R.S. § 45-519.01.
  - b. The well is a new well as defined in A.R.S. § 45-591 for which a notice of intention to drill was not filed pursuant to A.R.S. § 45-596 and for which a permit was not issued pursuant to A.R.S. §§ 45-599 or 45-834.01, and the owner or operator has registered the well with the Department, unless the current well information on file with the Department identifies the sole purpose or purposes of the well as one or more of the purposes in subsection (16)(a)(i) through (xii) of this Section;
    - c. A filing has been made for the well pursuant to A.R.S. § 45-596(A) or (B), unless any of the following apply:
      - i. The filing has expired pursuant to A.R.S. § 45-596(E);
      - ii. The filing identifies the sole purpose or purposes of the well as one or more of the purposes in subsection (16)(a)(i) through (xii) of this Section; or
      - iii. The well is an exempt well and the Director is prohibited by A.R.S. § 45-454(D)(4) from considering impacts on the well when determining whether to approve or reject a permit application filed under A.R.S. § 45-599.
    - d. An application for a permit to drill the well has been received by the Department pursuant to A.R.S. § 45-599, unless the application has been rejected after exhaustion of all administrative and judicial appeals or the permit issued pursuant to the application has been revoked or has expired according to its terms or for failure to complete the well in a timely manner pursuant to A.R.S. § 45-599(G);
    - e. An application for a permit pursuant to A.R.S. §§ 45-514 or 45-516 has been received by the Department pursuant to A.R.S. § 45-521, unless the application has been rejected after exhaustion of all administrative and judicial appeals or the permit issued pursuant to the application has been revoked or has expired according to its terms or for failure to complete the well before expiration of the drilling authority; or
    - f. An application for a permit to drill a recovery well has been received by the Department pursuant to A.R.S. § 45-834.01, unless the application has been rejected after exhaustion of all administrative and judicial appeals or the permit issued pursuant to the application has been revoked or has expired according to its terms or for failure to complete the well in a timely manner pursuant to A.R.S. § 45-834.01(F).

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2193, effective August 7, 2006 (Supp. 06-2).

**R12-15-1302. Well Spacing Requirements - Applications to Construct New Wells or Replacement Wells in New Locations Under A.R.S. § 45-599**

- A. The Director shall not approve an application for a permit to construct a new well or a replacement well in a new location under A.R.S. § 45-599 if the Director determines that the withdrawals from the proposed well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B) of this Section.
- B. The Director shall determine that the withdrawals from the proposed well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells if any of the following apply:
  1. Except as provided in subsection (D) of this Section, the Director determines that the probable impact of the withdrawals from the proposed well or wells on any well of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of operation of the proposed well or wells. To assist the Director in making a determination under



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this subsection, the applicant may submit a hydrological study delineating those areas surrounding the proposed well or wells in which the projected impacts on water levels will exceed 10 feet of additional drawdown after the first five years of operation of the proposed well or wells. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection;

2. The Director determines that the proposed well or wells will be located in an area of known land subsidence and the withdrawals from the proposed well or wells will likely cause unreasonably increasing damage from additional regional land subsidence. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study, which may include a geophysical evaluation, demonstrating the impact of the withdrawals from the proposed well or wells on regional land subsidence. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection; or
  3. Except as provided in subsection (E) of this Section, the Director determines, after consulting with ADEQ, that withdrawals from the proposed well or wells will likely cause the migration of contaminated groundwater from a remedial action site to a well of record in existence as of the date of the receipt of the application, resulting in a degradation of the quality of the water withdrawn from the well of record so that the water will no longer be usable for the purpose for which it is currently being used without additional treatment, and that the damage to the owner of the well of record will not be prevented or adequately mitigated through the implementation of a program regulated under Title 49 of the Arizona Revised Statutes, or a program regulated by EPA or DOD. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study demonstrating whether the withdrawals from the proposed well or wells will have the effect described in this subsection. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection.
- C. In making a determination under subsection (B)(1), (B)(2), or (B)(3) of this Section, if the proposed well is a replacement well in a new location, the Director shall take into account the collective effects of reducing or terminating withdrawals from the well being replaced combined with the proposed withdrawals from the replacement well if the applicant submits a hydrological study demonstrating those collective effects to the satisfaction of the Director.
- D. If the Director determines under subsection (B)(1) of this Section that the probable impact of the withdrawals from the proposed well or wells on one or more wells of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of operation of the proposed well or wells, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the withdrawals from the proposed well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under sub-

section (B)(1) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:

1. A signed and notarized consent form from the owner of the well of record consenting to the withdrawals from the proposed well or wells. The applicant shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- E. If the Director determines that withdrawals from the proposed well or wells will have the effect described in subsection (B)(3) of this Section on one or more wells of record in existence as of the date of receipt of the application, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the withdrawals from the proposed well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(3) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:
1. A signed and notarized consent form from the owner of the well of record consenting to the withdrawals from the proposed well or wells. The applicant shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- F. At any time before a final determination under this Section, the applicant may:
1. Amend the application to change the location of the proposed well or wells or the amount of groundwater to be withdrawn from the proposed well or wells to lessen the degree of impact on wells of record or regional land subsidence; or
  2. Agree to construct or operate the proposed well or wells in a manner that lessens the degree of impact on wells of record or regional land subsidence. The Director shall indicate in the well permit that compliance with the agreement is a condition of the well permit.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R.  
2193, effective August 7, 2006 (Supp. 06-2).

**R12-15-1303. Well Spacing Requirements - Applications for Recovery Well Permits Under A.R.S. § 45-834.01**

- A. The Director shall not approve an application for a recovery well permit under A.R.S. § 45-834.01 that is filed for a new well as defined in A.R.S. § 45-591 or, except as provided in A.R.S. § 45-834.01(B)(2) or (3), for an existing well as defined in A.R.S. § 45-591, if the Director determines that the recovery of stored water from the proposed well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B) of this Section.

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- B.** The Director shall determine that the recovery of stored water from the proposed well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells if any of the following apply:
1. Except as provided in subsection (D) of this Section, the Director determines that the probable impact of the recovery of stored water from the proposed well or wells on any well of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of the recovery of stored water from the proposed well or wells. To assist the Director in making a determination under this subsection, the applicant shall submit with the application a hydrological study delineating those areas surrounding the proposed well or wells in which the projected impacts on water levels will exceed 10 feet of additional drawdown after the first five years of the recovery of stored water from the proposed well or wells;
  2. The Director determines that the proposed recovery well or wells will be located in an area of known land subsidence and the recovery of stored water from the proposed well or wells will likely cause unreasonably increasing damage from additional regional land subsidence. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study, which may include a geophysical evaluation, demonstrating the impact of the recovery of stored water from the proposed recovery well or wells on regional land subsidence. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection; or
  3. Except as provided in subsection (E) of this Section, the Director determines, after consulting with ADEQ, that the recovery of stored water from the proposed well or wells will likely cause the migration of contaminated groundwater from a remedial action site to a well of record in existence as of the date of receipt of the application, resulting in a degradation of the quality of the water withdrawn from the well of record so that the water will no longer be usable for the purpose for which it is currently being used without additional treatment, and that the damage to the owner of the well of record will not be prevented or adequately mitigated through the implementation of a program regulated under Title 49 of the Arizona Revised Statutes, or a program regulated by EPA or DOD. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study demonstrating whether the recovery of stored water from the proposed well or wells will have the effect described in this subsection. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection.
- C.** In making a determination under subsection (B)(1), (B)(2), or (B)(3) of this Section:
1. If the proposed recovery well is a replacement well in a new location, the Director shall take into account the collective effects of reducing or terminating withdrawals from the well being replaced combined with the proposed recovery of stored water from the replacement well if the applicant submits a hydrological study demonstrating those collective effects to the satisfaction of the Director.
  2. If the proposed recovery well will be located within the area of impact, as defined in A.R.S. § 45-802.01, of an underground storage facility and the applicant will account for all of the water recovered from the well as water stored at the facility, the Director shall take into account the effects of water storage at the facility on the proposed recovery of stored water from the recovery well if the applicant submits a hydrological study demonstrating those effects to the satisfaction of the Director.
- D.** If the Director determines under subsection (B)(1) of this Section that the probable impact of the recovery of stored water from the proposed recovery well or wells on any well of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of operation of the proposed well or wells, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the recovery of stored water from the proposed recovery well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(1) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:
1. A signed and notarized consent form from the owner of the well of record consenting to the recovery of stored water from the proposed recovery well or wells. The applicant shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- E.** If the Director determines that the recovery of stored water from the proposed recovery well or wells will have the effect described in subsection (B)(3) of this Section on one or more wells of record in existence as of the date of receipt of the application, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the recovery of stored water from the proposed recovery well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(3) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:
1. A signed and notarized consent form from the owner of the well of record consenting to the recovery of stored water from the proposed recovery well or wells. The applicant shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- F.** At any time before a final determination under this Section, the applicant may:
1. Amend the application to change the location of the proposed recovery well or wells or the amount of stored

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water to be recovered from the proposed recovery well or wells to lessen the degree of impact on wells of record or regional land subsidence; or

2. Agree to construct or operate the proposed recovery well or wells in a manner that lessens the degree of impact on wells of record or regional land subsidence. The Director shall indicate in the recovery well permit that compliance with the agreement is a condition of the recovery well permit.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2193, effective August 7, 2006 (Supp. 06-2).

**R12-15-1304. Well Spacing Requirements - Wells Withdrawing Groundwater From the Little Colorado River Plateau Groundwater Basin for Transportation to Another Groundwater Basin Under A.R.S. § 45-544(B)(1)**

- A. An LCR plateau groundwater transporter may not withdraw groundwater from a well or wells drilled in the Little Colorado river plateau groundwater basin after January 1, 1991, except a replacement well in approximately the same location or a well drilled after that date pursuant to a notice of intention to drill filed on or before that date, for transportation away from the basin pursuant to A.R.S. § 45-544(B)(1) if the Director determines that the withdrawals for that purpose will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B) of this Section.
- B. The Director shall determine that the withdrawals of groundwater from the well or wells will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells if any of the following apply:
  1. Except as provided in subsection (D) of this Section, the Director determines that the probable impact of the withdrawals of groundwater from the well or wells on any well of record in existence when the withdrawals commenced or are proposed to commence will exceed 10 feet of additional drawdown after the first five years of the withdrawals. To assist the Director in making a determination under this subsection, the LCR plateau groundwater transporter may submit to the Director a hydrological study delineating those areas surrounding the LCR plateau groundwater transporter's well or wells in which the projected impacts on water levels will exceed 10 feet of additional drawdown after the first five years of the withdrawals. The Director may require the LCR plateau groundwater transporter to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection;
  2. The Director determines that the well or wells from which the groundwater is withdrawn are located in an area of known land subsidence and the withdrawals of groundwater will likely cause unreasonably increasing damage from additional regional land subsidence. To assist the Director in making a determination under this subsection, the LCR plateau groundwater transporter may submit to the Director a hydrological study, which may include a geophysical evaluation, demonstrating the impact of the withdrawals on regional land subsidence. The Director may require the LCR plateau groundwater transporter to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection; or
  3. Except as provided in subsection (E) of this Section, the Director determines, after consulting with ADEQ, that the withdrawals of groundwater from the well or wells will likely cause the migration of contaminated groundwater from a remedial action site to a well of record in existence when the groundwater withdrawals commenced or are proposed to commence, resulting in a degradation of the quality of the water withdrawn from the well of record so that the water will no longer be usable for the purpose for which it is currently being used without additional treatment, and that the damage to the owner of the well of record will not be prevented or adequately mitigated through the implementation of a program regulated under Title 49 of the Arizona Revised Statutes, or a program regulated by EPA or DOD. To assist the Director in making a determination under this subsection, the LCR plateau groundwater transporter may submit to the Director a hydrological study demonstrating whether the withdrawals of groundwater will have the effect described in this subsection. The Director may require the LCR plateau groundwater transporter to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection.
- C. In making a determination under subsection (B)(1), (B)(2), or (B)(3) of this Section, if a well from which the groundwater is withdrawn is a replacement well in a new location, the Director shall take into account the collective effects of reducing or terminating withdrawals from the well being replaced combined with the withdrawals from the replacement well if the LCR plateau groundwater transporter submits a hydrological study demonstrating those collective effects to the satisfaction of the Director.
- D. If the Director determines under subsection (B)(1) of this Section that the probable impact of the withdrawals of groundwater from the well or wells on any well of record in existence when the withdrawals commenced or are proposed to commence will exceed 10 feet of additional drawdown after the first five years of the withdrawals, the Director shall notify the LCR plateau groundwater transporter in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the withdrawals will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(1) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the LCR plateau groundwater transporter submits one of the following for each well of record identified in the notice:
  1. A signed and notarized consent form from the owner of the well of record consenting to the withdrawals. The LCR plateau groundwater transporter shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the LCR plateau groundwater transporter made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- E. If the Director determines that the withdrawals of groundwater from the well or wells will have the effect described in subsection (B)(3) of this Section on one or more wells of record in existence when the groundwater withdrawals commenced or are proposed to commence, the Director shall notify the LCR

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plateau groundwater transporter in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the withdrawals will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(3) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the LCR plateau groundwater transporter submits one of the following for each well of record identified in the notice:

1. A signed and notarized consent form from the owner of the well of record consenting to the withdrawals. The LCR plateau groundwater transporter shall use the consent form furnished by the Director; or
2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the LCR plateau groundwater transporter made a reasonable attempt to locate the current owner of the well of record but was unable to do so.

- F. At any time before a final determination under this Section, the LCR plateau groundwater transporter may agree to construct or operate the well or wells in a manner that lessens the degree of impact on wells of record or regional land subsidence. Compliance with the agreement is a condition for the use of the well or wells to withdraw groundwater for transportation away from the basin pursuant to A.R.S. § 45-544(B)(1).

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2193, effective August 7, 2006 (Supp. 06-2).

**R12-15-1305. Well Spacing Requirements - Applications to Use a Well to Withdraw Groundwater for Transportation to an Active Management Area Under A.R.S. § 45-559**

- A. The Director shall not approve an application to use a well or wells constructed after September 21, 1991, to withdraw groundwater for transportation to an active management area under A.R.S. § 45-559 if the Director determines that the withdrawals for that purpose will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B) of this Section.
- B. The Director shall determine that the withdrawals of groundwater will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells if any of the following apply:
1. Except as provided in subsection (C) of this Section, the Director determines that the probable impact of the groundwater withdrawals on any well of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of the withdrawals. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study delineating those areas surrounding the proposed well or wells in which the projected impacts of the groundwater withdrawals on water levels will exceed 10 feet of additional drawdown after the first five years of the withdrawals. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection;
  2. The Director determines that the proposed well or wells will be located in an area of known land subsidence and the groundwater withdrawals will likely cause unreasonably increasing damage from additional regional land

subsidence. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study, which may include a geophysical evaluation, demonstrating the impact of the groundwater withdrawals on regional land subsidence. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection; or

3. Except as provided in subsection (D) of this Section, the Director determines, after consulting with ADEQ, that the groundwater withdrawals will likely cause the migration of contaminated groundwater from a remedial action site to a well of record in existence as of the date of receipt of the application, resulting in a degradation of the quality of the water withdrawn from the well of record so that the water will no longer be usable for the purpose for which it is currently being used without additional treatment, and that the damage to the owner of the well of record will not be prevented or adequately mitigated through the implementation of a program regulated under Title 49 of the Arizona Revised Statutes, or a program regulated by EPA or DOD. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study demonstrating whether the groundwater withdrawals will have the effect described in this subsection. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection.
- C. If the Director determines under subsection (B)(1) of this Section that the probable impact of the groundwater withdrawals on any well of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of the withdrawals, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the groundwater withdrawals will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(1) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:
1. A signed and notarized consent form from the owner of the well of record consenting to the withdrawals. The applicant shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- D. If the Director determines that the groundwater withdrawals will have the effect described in subsection (B)(3) of this Section on one or more wells of record in existence as of the date of receipt of the application, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the groundwater withdrawals will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(3)

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of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:

1. A signed and notarized consent form from the owner of the well of record consenting to the withdrawals. The applicant shall use the consent form furnished by the Director; or
2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.

E. At any time before a final determination under this Section, the applicant may:

1. Amend the application to change the location of the proposed well or wells or the amount of groundwater to be withdrawn from the proposed well or wells to lessen the degree of impact on wells of record or regional land subsidence; or
2. Agree to construct or operate the proposed well or wells in a manner that lessens the degree of impact on wells of record or regional land subsidence. The Director shall indicate in the permit that compliance with the agreement is a condition of the permit to use the well or wells to withdraw groundwater for transportation to an active management area under A.R.S. § 45-559.

#### Historical Note

New Section made by final rulemaking at 12 A.A.R. 2193, effective August 7, 2006 (Supp. 06-2).

#### R12-15-1306. Well Spacing Requirements - Applications for Water Exchange Permits Under A.R.S. § 45-1041

A. The Director shall not approve an application for a water exchange permit filed under A.R.S. § 45-1041 by a person other than a city, town, private water company or irrigation district if the Director determines that any new or increased pumping by the applicant from a well or wells within an active management area pursuant to the water exchange will cause unreasonably increasing damage to surrounding land or other water users under subsection (B) of this Section.

B. The Director shall determine that new or increased pumping by the applicant from a well or wells within an active management area will cause unreasonably increasing damage to surrounding land or other water users if any of the following apply:

1. Except as provided in subsection (C) of this Section, the Director determines that the probable impact of the new or increased pumping on any well of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of the pumping. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study delineating those areas surrounding the proposed well or wells in which the projected impacts of the new or increased pumping on water levels will exceed 10 feet of additional drawdown after the first five years of the pumping. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection;
2. The Director determines that the new or increased pumping will occur in an area of known land subsidence and the pumping will likely cause unreasonably increasing

damage from additional regional land subsidence. To assist the Director in making a determination under this subsection, the applicant may submit a hydrological study, which may include a geophysical evaluation, demonstrating the impact of the new or increased pumping on regional land subsidence. The Director may require the applicant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection; or

3. Except as provided in subsection (D) of this Section, the Director determines, after consulting with ADEQ, that the new or increased pumping will likely cause the migration of contaminated groundwater from a remedial action site to a well of record in existence as of the date of receipt of the application, resulting in a degradation of the quality of the water withdrawn from the well of record so that the water will no longer be usable for the purpose for which it is currently being used without additional treatment, and that the damage to the owner of the well of record will not be prevented or adequately mitigated through the implementation of a program regulated under Title 49 of the Arizona Revised Statutes, or a program regulated by EPA or DOD. To assist the Director in making a determination under this subsection, the applicant may submit with the application a hydrological study demonstrating whether the new or increased pumping will have the effect described in this subsection. If the applicant does not submit such a hydrological study with the application, the Director may require the applicant to submit the study if the Director determines that the study will assist the Director in making a determination under this subsection.

C. If the Director determines under subsection (B)(1) of this Section that the probable impact of the new or increased pumping on any well of record in existence as of the date of receipt of the application will exceed 10 feet of additional drawdown after the first five years of the pumping, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the new or increased pumping will cause unreasonably increasing damage to surrounding land or other water users under subsection (B)(1) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:

1. A signed and notarized consent form from the owner of the well of record consenting to the new or increased pumping. The applicant shall use the consent form furnished by the Director; or
2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.

D. If the Director determines that the new or increased pumping will have the effect described in subsection (B)(3) of this Section on one or more wells of record in existence as of the date of receipt of the application, the Director shall notify the applicant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the new or increased pumping will cause unreason-

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ably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(3) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the applicant submits one of the following for each well of record identified in the notice:

1. A signed and notarized consent form from the owner of the well of record consenting to the new or increased pumping. The applicant shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the applicant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- E. At any time before a final determination under this Section, the applicant may:
1. Amend the application to change the location of the proposed well or wells or the amount of the new or increase pumping to lessen the degree of impact on wells of record or regional land subsidence; or
  2. Agree to construct or operate the proposed well or wells in a manner that lessens the degree of impact on wells of record or regional land subsidence. The Director shall indicate in the water exchange permit that compliance with the agreement is a condition of the water exchange permit.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2193, effective August 7, 2006 (Supp. 06-2).

**R12-15-1307. Well Spacing Requirements - Notices of Water Exchange Under A.R.S. § 45-1051**

- A. A notice of water exchange participant may not participate in a water exchange for which a notice is filed under A.R.S. § 45-1051 if the Director determines that any new or increased pumping by the person from a well or wells within an active management area pursuant to the water exchange will cause unreasonably increasing damage to surrounding land or other water users under subsection (B) of this Section.
- B. The Director shall determine that new or increased pumping from the well or wells in an active management area will cause unreasonably increasing damage to surrounding land or other water users if any of the following apply:
1. Except as provided in subsection (C) of this Section, the Director determines that the probable impact of the new or increased pumping on any well of record in existence when the pumping commenced or is proposed to commence will exceed 10 feet of additional drawdown after the first five years of the pumping. To assist the Director in making a determination under this subsection, the notice of water exchange participant may submit to the Director a hydrological study delineating those areas surrounding the notice of water exchange participant's well or wells in which the projected impacts of the new or increased pumping on water levels will exceed 10 feet of additional drawdown after the first five years of the pumping. The Director may require the notice of water exchange participant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection;
  2. The Director determines that the new or increased pumping is in an area of known land subsidence and the pumping will likely cause unreasonably increasing damage

from additional regional land subsidence. To assist the Director in making a determination under this subsection, the notice of water exchange participant may submit to the Director a hydrological study, which may include a geophysical evaluation, demonstrating the impact of the pumping on regional land subsidence. The Director may require the notice of water exchange participant to submit such a hydrological study if the Director determines that the study will assist the Director in making a determination under this subsection; or

3. Except as provided in subsection (D) of this Section, the Director determines, after consulting with ADEQ, that the new or increased pumping will likely cause the migration of contaminated groundwater from a remedial action site to a well of record in existence when the pumping commenced or is proposed to commence, resulting in a degradation of the quality of the water withdrawn from the well of record so that the water will no longer be usable for the purpose for which it is currently being used without additional treatment, and that the damage to the owner of the well of record will not be prevented or adequately mitigated through the implementation of a program regulated under Title 49 of the Arizona Revised Statutes, or a program regulated by EPA or DOD. To assist the Director in making a determination under this subsection, the notice of water exchange participant may submit to the Director a hydrological study demonstrating whether the new or increased pumping will have the effect described in this subsection. The Director may require the notice of water exchange participant to submit such a study if the Director determines that the study will assist the Director in making a determination under this subsection.
- C. If the Director determines under subsection (B)(1) of this Section that the probable impact of the new or increased pumping on any well of record in existence when the pumping commenced or is proposed to commence will exceed 10 feet of additional drawdown after the first five years of the pumping, the Director shall notify the notice of water exchange participant in writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the new or increased pumping will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(1) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the notice of water exchange participant submits one of the following for each well of record identified in the notice:
1. A signed and notarized consent form from the owner of the well of record consenting to the new or increased pumping. The notice of water exchange participant shall use the consent form furnished by the Director; or
  2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the notice of water exchange participant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.
- D. If the Director determines that the new or increased pumping will have the effect described in subsection (B)(3) of this Section on one or more wells of record in existence when the pumping commenced or is proposed to commence, the Director shall notify the notice of water exchange participant in

## TITLE 12. NATURAL RESOURCES

## CHAPTER 15. DEPARTMENT OF WATER RESOURCES

writing of the location of the wells of record and the names and addresses of the owners of the wells as shown in the Department's well registry. The Director shall not determine that the new or increased pumping will cause unreasonably increasing damage to surrounding land or other water users from the concentration of wells under subsection (B)(3) of this Section if within 60 days after the date on the notice, or a longer time period approved by the Director, the notice of water exchange participant submits one of the following for each well of record identified in the notice:

1. A signed and notarized consent form from the owner of the well of record consenting to the new or increased pumping. The notice of water exchange participant shall use the consent form furnished by the Director; or
2. Evidence satisfactory to the Director that the address of the owner of the well of record as shown in the Department's well registry records is inaccurate and that the notice of water exchange participant made a reasonable attempt to locate the current owner of the well of record but was unable to do so.

- E. At any time before a final determination under this Section, the notice of water exchange participant may agree to construct or operate the well or wells in a manner that lessens the degree of impact on wells of record or regional land subsidence. Compliance with the agreement is a condition for the use of the well to pump water for the water exchange.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2193, effective August 7, 2006 (Supp. 06-2).

**R12-15-1308. Replacement Wells in Approximately the Same Location**

- A. For purposes of A.R.S. §§ 45-544, 45-596, and 45-597, a replacement well in approximately the same location is a proposed well to which all of the following apply:

1. The proposed well will be located no greater than 660 feet from the original well, and the location of the original well can be determined at the time the notice of intention to drill the proposed well is filed;
2. Except as provided in subsections (A)(3) and (A)(4) of this Section, the proposed well will not annually withdraw an amount of water in excess of the maximum annual capacity of the original well. The Director shall determine the maximum annual capacity of the original well by multiplying the maximum pump capacity of the original well in gallons per minute by 525,600, and then converting the result into acre-feet by dividing the result by 325,851 gallons. The Director shall presume that the maximum pump capacity of the original well is the maximum pump capacity of the well in gallons per minute as shown in the Department's well registry records, except that:

- a. If the Director has reason to believe that the maximum pump capacity as shown in the Department's well registry records is inaccurate, or if the applicant submits evidence demonstrating that the maximum pump capacity as shown in the Department's well registry records is inaccurate, the Director shall determine the maximum pump capacity by considering all available evidence, including the depth and

diameter of the well and any evidence submitted by the applicant; or

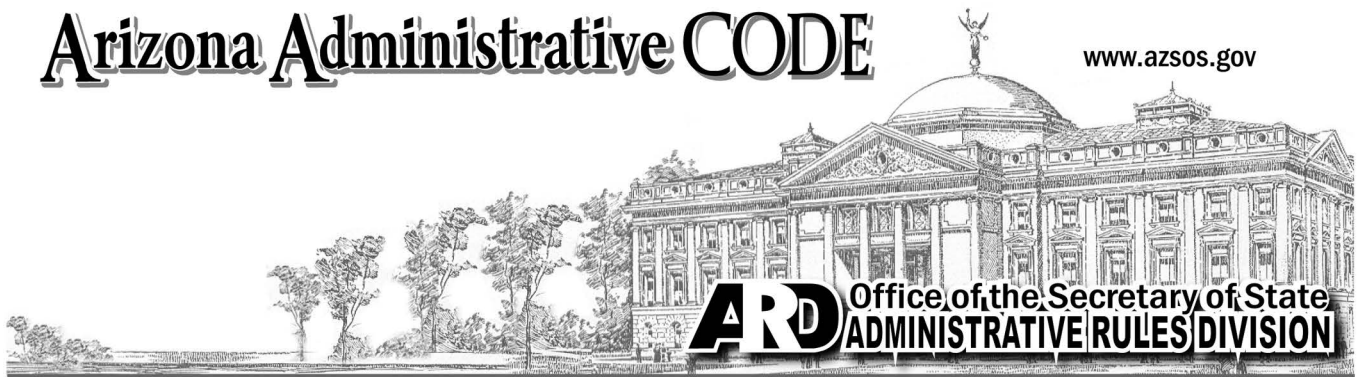
- b. If the Department's well registry records do not show the maximum pump capacity of the original well, the Director shall not approve the proposed well as a replacement well in approximately the same location unless the applicant demonstrates to the Director's satisfaction the maximum pump capacity of the original well;
3. If a well permit was issued for the original well under A.R.S. § 45-599, the proposed well will not annually withdraw an amount of groundwater in excess of the maximum annual volume set forth in the well permit;
4. If a recovery well permit was issued for the well to be replaced pursuant to A.R.S. § 45-834.01(B) and the permit sets forth a maximum annual volume of stored water that may be recovered from the well, the proposed well will not annually recover an amount of stored water in excess of the maximum annual volume set forth in the recovery well permit;
5. If the well to be replaced has been physically abandoned in accordance with R12-15-816, a notice of intention to drill the proposed well is filed no later than 90 days after the well to be replaced was physically abandoned; and
6. If the proposed well will be used to withdraw groundwater from the Little Colorado river plateau groundwater basin for transportation away from the basin pursuant to A.R.S. § 45-544(B)(1), one of the following applies:
  - a. The original well was drilled on or before January 1, 1991, or was drilled after that date pursuant to a notice of intention to drill that was on file with the Department on that date; or
  - b. The Director previously determined that the withdrawal of groundwater from the original well for transportation away from the Little Colorado river plateau groundwater basin complies with R12-15-1304.
- B. After a replacement well in approximately the same location is drilled, the replacement well may be operated in conjunction with the original well and any other wells that replaced the original well if the total annual withdrawals from all wells do not exceed the maximum amount allowed under subsection (A)(2), (A)(3), or (A)(4) of this Section, whichever applies.
- C. A proposed well may be drilled as a replacement well in approximately the same location for more than one original well if the criteria in subsections (A)(1), (A)(5), and (A)(6) of this Section are met with respect to each original well and if the total annual withdrawals from the proposed well will not exceed the combined maximum annual amounts allowed for each original well under subsections (A)(2), (A)(3), or (A)(4) of this Section, whichever apply.
- D. The Director may include conditions in the approval of the notice of intention to drill the replacement well to ensure that the drilling and operation of the replacement well meets the requirements of this Section.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2193, effective August 7, 2006 (Supp. 06-2).

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17 A.A.C. 7

Supp. 24-4

## TITLE 17. TRANSPORTATION

### CHAPTER 7. DEPARTMENT OF TRANSPORTATION - THIRD-PARTY PROGRAMS

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This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

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**The release of this Chapter in Supp. 24-4 replaces Supp. 19-2, 1-10 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

The Office began to authenticate Chapters of the *Code* in Supp. 18-1 to comply with A.R.S. §§ 41-1012(B) and A.R.S. § 41-5505.

A certification verifies the authenticity of each *Code* Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the *Code* includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

### PERSONAL USE/COMMERCIAL USE

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 17. TRANSPORTATION

## CHAPTER 7. DEPARTMENT OF TRANSPORTATION - THIRD-PARTY PROGRAMS

Authority: A.R.S. § 28-366

## Supp. 24-4

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## TITLE 17. TRANSPORTATION

## CHAPTER 7. DEPARTMENT OF TRANSPORTATION - THIRD-PARTY PROGRAMS

**ARTICLE 1. DEFINITIONS**

*Article 1, consisting of Section R17-7-101, made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2).*

**R17-7-101. Definitions**

The following definitions apply to this Chapter unless otherwise specified:

“Accountable inventory” means an item that is reproduced by the Department in a consecutively numbered series for:

Recording the number of a completed, issued, or voided item in a log; and

Reporting the number of a completed, issued, or voided item to the Department.

“Activity” means a function or service that is provided by an authorized third party pursuant to A.R.S. Title 28, Chapter 13 and that is performed by a certified individual as defined in this Article.

“Agency head” or “political subdivision head” means the chief officer of an agency or political subdivision or another individual with authority to act for the agency head or political subdivision head.

“Application date” means the date an application is received by the Department.

“Authorized third party” means an entity that:

Has written permission from the Department to operate a business under A.R.S. Title 28, Chapter 13; and

Employs or contracts with at least one certified individual to provide a third-party activity.

“Branch” means an authorized third party’s business location that is an additional established place of business.

“Certified individual” means an individual who is certified by the Department under A.R.S. Title 28, Chapter 13 to perform specified activities for an authorized third party as an employee or contractor. The Department may certify an individual as:

A commercial driver license examiner,

A dealer license processor,

A driver license processor,

A driver license trainer,

An office personnel member,

A tax report processor,

A title and registration processor,

A vehicle inspector, or

A vehicle permit processor.

“Commercial driver license examiner” means an individual certified by the Department to administer class A, B, or C driver license skills tests.

“Concentration Banking System” means a depository eligible to be a servicing bank for the State of Arizona.

“Contact individual” means a principal or designated individual of an authorized third party who communicates with the Department on behalf of the authorized third party.

“Convenience fee” means the amount exceeding the statutorily prescribed fees and taxes that an authorized third party collects for its services.

“Department” means the Arizona Department of Transportation.

“Dealer license processor” means an individual certified by the Department to:

Review applications for vehicle dealer licenses;

Enter information related to the applications in the Department’s database; and

Issue vehicle dealer licenses under A.R.S. Title 28, Chapter 10.

“Driver license processor” means an individual certified by the Department to perform any one or a combination of driver license, including commercial driver license, processing functions under A.R.S. Title 28 as specified in the authorization agreement between the Department and an authorized third party who has engaged the individual to perform those functions.

“Driver license trainer” means an individual certified by the Department to:

Educate and train persons, either practically or theoretically, or both, to operate or drive motor vehicles;

Prepare applicants for an examination given by the Department or an authorized third party driver license provider for a driver license or instruction permit; and

Charge a consideration or tuition for these services.

“Established place of business” means an authorized third party’s business location that is:

Approved by the Department,

Located in Arizona,

Not used as a residence, and

Where the authorized third party performs authorized activities.

“Floor plan” means a Department-approved diagram of a building’s interior, as seen from above, that shows the interior dimensions and the location of doors, windows, and equipment.

“Good standing” means an authorized third party applicant or an applicant seeking certification:

Has not had a similar business license or certification issued suspended, revoked, canceled, or denied within the previous five years of the application date;

Does not owe delinquent fees, taxes, or unpaid balances to the Department;

Has not had any substantiated derogatory information relevant to the requested authorization or certification reported to the Department about the applicant from any state agency or from any consumer protection agency contacted by the Department; or

If the applicant is a former Department employee, a former authorized third party, or a former employee of an authorized third party, has not been dismissed or resigned from a position for cause, including:

## TITLE 17. TRANSPORTATION

## CHAPTER 7. DEPARTMENT OF TRANSPORTATION - THIRD-PARTY PROGRAMS

Committing a serious violation, as defined in A.R.S. § 28-5108;

Misconduct; or

Resignation from position:

In lieu of dismissal, or

By mutual agreement following allegations of misconduct or committing a serious violation.

“Log” means a complete, chronological record of accountable inventories or activities or both performed and kept by the authorized third party as prescribed by the Department.

“Motor vehicle inspection” means vehicle verification as prescribed in A.R.S. § 28-2011.

“Office personnel member” means an individual who does not perform any other of the activities requiring certification under this Chapter and who is certified by the Department as an employee who performs functions that:

Have exposure to protected personal information, or

Has complete oversight and responsibility for all day-to-day operations necessary to ensure full compliance with all applicable program requirements.

“Principal” means any of the following:

If a sole proprietorship, the sole proprietor;

If a partnership, limited partnership, limited liability partnership, limited liability company, or corporation, the:

Partner;

Manager;

Member;

Officer;

Director;

Agent; or

If a limited liability company or corporation, each stockholder owning 20 percent or more of the limited liability company or corporation; or

If a political subdivision or government agency, the political subdivision or agency head.

“Principal place of business” means an authorized third party’s administrative headquarters, which shall not be used as a residence.

“SAAM” means the State of Arizona Accounting Manual.

“Skills test” means a set of tests, authorized and approved by the Department and administered by the Department or by an authorized third party commercial driver license examiner or driver license processor to determine whether the applicant possesses the required skills for the type of license for which the applicant applies.

“Skills test route” means a public road or highway driving course, identified by an authorized third party and approved by the Department, for administering skills tests to driver license applicants.

“Tax report processor” means an individual certified by the Department to:

Process fuel tax reports and interstate user fuel tax reports from fuel suppliers, fuel vendors, and motor carriers; and

File the reports with the Department.

“Test site” means a location, identified by an authorized third party, for administering skills tests to driver license applicants that is:

Approved by the Department,

Permanently marked, and

Off the public road or highway.

“Title and registration processor” means an individual certified by the Department to:

Review applications for vehicle certificates of title or registrations under A.R.S. Title 28, Chapter 7;

Enter information related to applications for vehicle certificates of title or registrations into the Department’s database; and

Issue or deny vehicle certificates of title or registrations.

“Vehicle inspector” means an individual certified by the Department to perform motor vehicle inspections.

“Vehicle permit processor” means an individual certified by the Department to:

Review applications for permits or registrations under A.R.S. Title 28, Chapter 3, Articles 18 and 19, and Chapter 7;

Enter information related to the applications in the Department’s database; and

Issue or deny permits or registrations.

“Vicinity” means the area adjacent to, or in the immediate proximity of, any authorized third party’s places of business.

### Historical Note

New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

## ARTICLE 2. AUTHORIZATION

*Article 2, consisting of Sections R17-7-201 through R17-7-204, made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2).*

### R17-7-201. Authorization Application Requirements

- A. An applicant, who must be at least 18 years of age, for third-party authorization shall provide to the Department on request:
1. The applicant’s identifying information;
  2. The applicant’s bond status as exempt or nonexempt under A.R.S. Title 28, Chapter 13, if exempt, the applicant must complete a bond exemption form, which must be submitted annually unless an exemption has been granted by the Department, and if nonexempt, the applicant must provide proof of a surety bond pursuant to A.R.S. Title 28, Chapter 13;
  3. The name of the person who is the applicant’s principal;

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4. The identifying information of the applicant's contact individual;
  5. The activities for which the applicant seeks third-party authorization;
  6. The address of the applicant's principal place of business and each established place of business;
  7. A statement that the applicant is in good standing;
  8. The signature of all applicable principles;
  9. The following documents relating to the applicant's business if the applicant is a:
    - a. Corporation:
      - i. A copy of the articles of incorporation, including any amendments filed with the Arizona Corporation Commission; and
      - ii. Any other official documents, including copies of board meeting minutes and annual reports, that reflect the most recent change to the corporate name, structure, or officers;
    - b. Limited liability company:
      - i. A copy of the articles of organization, including any amendments filed with the Arizona Corporation Commission; or
      - ii. A copy of the application for registration as a foreign limited liability company filed with the Arizona Corporation Commission and a copy of the certificate of registration issued by the Arizona Corporation Commission to a foreign limited liability company;
    - c. Limited partnership, or a limited liability partnership:
      - i. A copy of a valid certificate of existence issued by the Arizona Secretary of State;
      - ii. A copy, stamped "Filed" by the Arizona Secretary of State, of a Certificate of Limited Partnership, Certificate of Foreign Limited Partnership, Limited Liability Partnership form, Foreign Limited Liability Partnership form, or Statement of Qualification for Conversion of Limited Partnership or Limited Liability Partnership; or
      - iii. A copy of a valid trade name certificate issued by the Arizona Secretary of State; or
    - d. Sole Proprietor:
      - i. A copy of a valid certificate of existence issued by the Arizona Secretary of State; or
      - ii. A copy of a valid trade name certificate issued by the Arizona Secretary of State;
  10. A floor plan for each place of business that includes:
    - a. A computer-generated graphic,
    - b. A blueprint or other photographic reproduction of an architectural plan or technical drawing, or
    - c. A nontechnical drawing made by hand using a straightedge;
  11. A map or drawing, and a narrative description of each skills test route and a photograph or drawing of each test site; and
  12. Unless exempt, a full set of fingerprints from a criminal records check in accordance with A.R.S. § 28-5105 of each principal.
- B.** Unless exempt pursuant to A.R.S. § 28-5105, an applicant for a third-party authorization shall submit, for each principal, a properly signed personal history and authorization to release information form provided by the Department which includes identifying information and notification of any history of fraud, felony, or a business license withdrawal action as indicated on the form.
- C.** The authorization application, as provided under subsections (A) and (B), is received within 30 days of application date.
- Historical Note**
- New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).
- R17-7-202. Notification of Authorization Approval or Denial and Hearing**
- A.** Notification. The Department shall send a written and dated notification of approval or denial of third-party authorization application, in accordance with A.R.S. § 28-5107.
- B.** Administrative Hearing. An applicant whose application for third-party authorization is denied by the Department may request a hearing from the Department on the denial pursuant to A.R.S. § 28-5107 and 17 A.A.C. 1, Article 5.
- Historical Note**
- New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).
- R17-7-203. Authorization Agreement**
- A.** An applicant whose third-party authorization application has been approved must sign an authorization agreement with the Department which specifies the terms and conditions of the third-party authorization before performing any third party program activities.
- B.** The third-party authorization agreement may include exhibits identifying specific requirements unique to each third party program activity.
- Historical Note**
- New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).
- R17-7-204. Authorized Third-party Requirements**
- A.** An authorized third party shall maintain compliance with all state and federal laws, Department rules, and authorization agreement provisions.
- B.** While holding a third-party authorization, any principal or certified individual of an authorized third party shall:
1. Not have a suspension, cancellation, revocation, or denial of another similar business license or agreement issued by the Department;
  2. Not have delinquent fees, taxes, or unpaid balance owed to the Department; and
  3. Remain in good standing with the Department.

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- C.** Until returned to the Department, an authorized third party shall retain the following records at an established place of business or at the principal place of business:
1. All logs and copies of completed, issued, or voided accountable inventory;
  2. All unused accountable inventory; and
  3. All other paper and electronic records, including all supporting documents, relating to the activities provided by the authorized third party.
- D.** On the request of the Department, an authorized third party shall produce and deliver to the Department the records listed in subsection (C).
- E.** An authorized third party shall maintain a copy of the certificate issued by the Department relating to each type of authorized activity that a certified individual performs at the principal place of business.
- F.** An authorized third party shall retain a certified individual's personnel file for a minimum of one year after the certified individual's last day of work. The personnel file of the certified individual shall include the following:
1. Dates of employment,
  2. All computer access forms (if applicable),
  3. Computer access termination form (if applicable), and
  4. All relevant Department correspondence.
- G.** An authorized third party shall comply with the audit and inspection requirements of A.R.S. § 28-5102 and R17-7-401.
- H.** An authorized third party shall provide a safe work area adequate in size and otherwise suitable to accommodate all authorized activities.
- I.** An authorized third party shall:
1. Have facilities, including the vicinity and equipment, pre-approved or prescribed by the Department;
  2. Have one or more established places of business as approved by the Department; and
  3. Conduct all authorized activities only at the approved established places of business.
- J.** An authorized third party shall obtain the Department's written approval before:
1. Changing the location or floor plan of each established place of business,
  2. Changing a skills test route or test site,
  3. Performing any additional authorized activity,
  4. Conducting any other businesses at an established place of business, or
  5. Using or adopting a name different from the name specified on its authorization agreement.
- K.** An authorized third party shall provide written notice to the Department, within two business days, of any changes, including full name and address, to the list of certified individuals or the contact individual.
- L.** An authorized third party that is open to the public shall post at each place of business the sign required by A.R.S. § 28-5101(J), and a sign provided by the Department that states the business:
1. Is a Department-authorized third-party provider, and
  2. May charge the customer a convenience fee when applicable.
- M.** An authorized third party shall comply with the application requirements of R17-7-201 and provide the required information 60 days before making any ownership changes.
- N.** An authorized third party shall attend all ongoing Department-approved training within the time-frames established by the Department in its authorization agreement.
- O.** An authorized third party shall not employ, contract with, or otherwise engage a current Department employee.
- P.** An authorized third party shall:
1. Submit all documents and corrections, according to state laws, rules, and the terms and conditions of its authorization agreement;
  2. Immediately notify the Department of any unlawful actions relating to motor vehicle transactions that become known to the authorized third party;
  3. Require that a customer submit all supporting documentation prescribed by the Department relating to a transaction before updating the Department databases;
  4. Provide notice on the form provided by the Department within 24 hours if a certified individual's:
    - a. Driver license is suspended, revoked, canceled, or disqualified by the Department, including a commercial driver license medical suspension under A.A.C. R17-4-508;
    - b. Vehicle certificate of title is canceled by the Department; or
    - c. Vehicle registration is suspended or canceled by the Department;
  5. Conduct skills tests, if applicable, only on test routes approved by the Department; and
  6. Maintain all minimum required surety bond and insurance coverage as prescribed in the authorization agreement.
- Q.** An authorized third party shall not solicit an individual or another business on Department property or any other business authorized under this Chapter unless approved by the Department.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-205. Financial Requirements**

If an authorized third party collects monies required to be remitted to the Department under A.R.S. § 28-5101, the authorized third party shall deposit those monies by the next business day following the transaction date in the designated:

1. Concentration Banking System account, or
2. Account through an electronic method preapproved by the Department.

**Historical Note**

New Section R17-7-205 renumbered from R17-7-705 and amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**R17-7-206. Expired****Historical Note**

New Section R17-7-206 renumbered from R17-7-706 and amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 1736, effective December 4, 2018 (Supp. 19-2).

**R17-7-207. Expired**



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**Historical Note**

New Section R17-7-207 renumbered from R17-7-609 and amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 1736, effective December 4, 2018 (Supp. 19-2).

**ARTICLE 3. CERTIFICATION**

*Article 3, consisting of Sections R17-7-301 and R17-7-302, made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2).*

**R17-7-301. Certification Application Requirements**

- A.** A certification applicant shall provide to the Department the following:
1. The applicant's identifying information and contact information;
  2. The activities for which the applicant seeks certification;
  3. Information related to any previous employment with the Department;
  4. Information related to any previous certification of the applicant by the Department;
  5. The applicant's signature;
  6. A statement that the applicant is in good standing;
  7. A full set of fingerprints from a criminal records check in accordance with A.R.S. § 28-5105;
  8. The applicant's driving record for the past 39 months before the application date or commercial driver license record, which has the same meaning as a CDLIS motor vehicle record as defined in 49 CFR 384.105, if the applicant holds a commercial driver license, which must be dated within seven days of the application date; and
  9. The official name of the authorized third party at which the applicant will be employed.
- B.** An applicant for a certification shall submit to the Department a properly signed personal history and authorization to release information form as required under R17-7-201(B).
- C.** An applicant may be eligible for certification if the applicant:
1. Is at least 18 years of age on the application date or 21 years of age, if the applicant requests certification as a commercial driver license examiner, driver license trainer, or a driver license processor who will be performing driver license skills tests;
  2. Is employed by or under contract for an employer applying for authorization or is authorized as an authorized third party;
  3. Is in good standing;
  4. Does not have any driver license suspensions, revocations, or cancellations within 39 months of the application date, including convictions related to:
    - a. Driving under the influence of intoxicating liquor or drugs,
    - b. Reckless driving,
    - c. Racing upon the highway, or
    - d. Leaving the scene of an accident;
  5. Successfully completes all training courses required by the Department; and
  6. Submits the certification application as provided in subsections (A) through (C) to the Department within 30 days of the application date.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006

(Supp. 06-2). Amended by exempt rulemaking at 20

A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-302. Notification of Certification Approval or Denial and Hearing**

- A.** Notification. The Department shall send a written and dated notification of certification approval or denial to an address provided on the application and in accordance with A.R.S. § 28-5107.
- B.** Administrative Hearing. An applicant whose application to become a certified individual is denied by the Department may request a hearing from the Department on the denial pursuant to A.R.S. § 28-5107 and 17 A.A.C. 1, Article 5.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-303. General Requirements of a Certified Individual**

- A.** A certified individual shall:
1. Submit all documents and corrections, according to all state laws and rules and the authorization agreement between the Department and the authorized third party;
  2. Immediately notify the authorized third party of unlawful actions relating to motor vehicle transactions;
  3. Require that a customer submit all supporting documentation relating to a transaction before updating the Department databases;
  4. Provide notification within 24 hours to the authorized third party if the certified individual's:
    - a. Driver license is suspended, revoked, canceled, or disqualified by the Department;
    - b. Vehicle certificate of title is canceled by the Department; or
    - c. Vehicle registration is suspended or canceled by the Department;
  5. Provide notification within five business days to the authorized third party of any changes to the certified individual's name or address; and
  6. Attend ongoing Department-approved training, including, if applicable, a commercial driver license refresher training course, before each renewal of the authorization agreement.
- B.** A certified individual shall not:
1. Witness or notarize signatures on documents relating to a transaction unless the customer submits appropriate identification; or
  2. Solicit an individual or another business on Department property or any other business authorized under this Chapter unless approved by the Department.

**Historical Note**

New Section R17-7-303 renumbered from R17-7-704 and amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22,

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2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-304. Expired****Historical Note**

New Section R17-7-304 made by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 1736, effective December 4, 2018 (Supp. 19-2).

**R17-7-305. Expired****Historical Note**

New Section R17-7-305 made by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 1736, effective December 4, 2018 (Supp. 19-2).

**ARTICLE 4. AUDITS AND INSPECTION**

*Article 4, consisting of Section R17-7-401, made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2).*

**R17-7-401. Audits and Inspection**

- A.** During an onsite audit or inspection, employees or agents of the Department, any law enforcement agency, or the Federal Motor Carrier Safety Administration may:
1. Request, review, audit, inspect, copy, or seize all paper, photographic, audio, and electronic records generated in the performance of any activities under this Chapter, whether in the possession of a current or former authorized third party or a certified individual;
  2. Examine the site of any places of business or other location where any of the materials in subsection (A)(1) are kept or may be found, or where any activities under this Chapter are or have been conducted during current or previous periods of authorization or certification; and
  3. Interview all or any of the authorized third party's:
    - a. Current or former employees or contractors,
    - b. Current or former certified individuals, and
    - c. Customers during current or previous periods of authorization or certification.
- B.** If Department personnel or the Department's representative conducts an onsite audit outside Arizona under A.R.S. § 28-5102(B)(3), the Department shall charge, and the authorized third party shall timely pay, for the costs of the audit, as well as any fees authorized under A.R.S. § 28-5102. The audit charge and payment shall include the Arizona Department of Administration reimbursement amounts for out-of-state travel authorized by A.R.S. Title 38, Chapter 4, Article 2 and stated in SAAM 5055, Travel Claims, prepared by the Arizona Department of Administration, which is available on the Arizona General Accounting Office website at [www.gao.az.gov](http://www.gao.az.gov).

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1630, effective July 5, 2003 (Supp. 03-2). Amended by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**ARTICLE 5. EXPIRED****R17-7-501. Expired****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 1736, effective December 4, 2018 (Supp. 19-2).

**R17-7-502. Expired****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Section expired under A.R.S. § 41-1056(J) at 25 A.A.R. 1736, effective December 4, 2018 (Supp. 19-2).

**ARTICLE 6. COMMERCIAL DRIVER LICENSE EXAMINATION PROGRAM****R17-7-601. Definitions**

The following definitions apply to this Article, unless otherwise specified:

"CDL" means commercial driver license.

"CDLE" means commercial driver license examination.

"CDLE coach or transit bus" means the program activity for administering examinations for a Passenger (P) endorsement on a CDL.

"CDLE school bus" means the program activity for administering examinations for a School Bus (S) endorsement on a CDL.

"CDLE truck" means the program activity for administering examinations for a Class A, B, or C license.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-602. Activities**

The authorized and certified activities for the CDLE Program are:

1. CDLE coach or transit bus,
2. CDLE school bus, or
3. CDLE truck.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**R17-7-603. Additional Authorization Application Requirements for CDLE Program**

In addition to satisfying the requirements of R17-7-201, an applicant for third-party authorization as a CDLE provider shall:

1. Submit the following:
  - a. Photographs and a floor plan of the principal place of business that shows the location of the accountable inventory storage,
  - b. Photographs and a floor plan of each established place of business,

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- c. A test route that complies with the specifications provided by the Department, and
- d. Photographs and a diagram with the dimensions of any proposed CDL test site. The physical dimensions of the site shall comply with the specifications provided by the Department. The test site shall provide sufficient room to perform all skill maneuvers, be obstacle free and be off the roadway.
- 2. Provide to the Department a copy of the current lease or other written agreement for the use of the land if the applicant does not own the land on which the place of business or test site is located.
- 3. Ensure that each place of business and test site:
  - a. Meets all local zoning requirements, and
  - b. Is not used as a residence.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-604. Additional Certification Application Requirements for Commercial Driver License Examiners**

- A. In addition to satisfying the requirements of R17-7-301, an applicant for certification as a commercial driver license examiner shall:
  - 1. Possess a valid Arizona driver license of the class and endorsement representative of the examinations to be administered by the commercial driver license examiner; and
  - 2. Not have a driver license suspension, cancellation, revocation, or disqualification within 39 months of the application date, including a CDL medical suspension under A.A.C. R17-4-508, or a conviction or finding of responsibility for any violation under A.R.S. § 28-3312 within five years of the application date.
- B. An authorized third party that has entered into an authorization agreement may withdraw a certification application if the examiner applicant has failed to meet certification requirements.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-605. Additional Authorized CDLE Program Requirements**

In addition to satisfying the requirements of R17-7-204, the authorized third party shall:

- 1. Ensure all vehicles used for examination:
  - a. Are representative of the class and type for which the individual is seeking a commercial driver license;
  - b. Are maintained in a safe operating condition;
  - c. Comply with registration and insurance requirements set forth in A.R.S. Title 28, Chapters 7, 9, 15, and 16; and

- d. Comply with applicable Federal Motor Carrier Safety Regulations;
- 2. Maintain compliance with applicable federal rules and the federal rules as adopted by the Department under 17 A.A.C. 5, Article 2;
- 3. Allow employees or agents of the Department, any law enforcement agency, or the Federal Motor Carrier Safety Administration without prior notice to do any of the following:
  - a. Take the tests administered by the authorized third party as if the employee or agent is a test applicant,
  - b. Co-score along with the commercial driver license examiner during skills tests to compare pass or fail results,
  - c. Retest a sample of drivers who were examined by the authorized third party, or
  - d. Provide access to a vehicle for use under this subsection;
- 4. Maintain the following records at the authorized third party's principal place of business:
  - a. A copy of its current authorization agreement with the Department,
  - b. A copy of the current commercial driver license examiner's certificate for each examiner,
  - c. A copy of each completed skills test score sheet for the current calendar year and the past two calendar years,
  - d. A copy of the authorized third party's approved skills test routes and test sites, and
  - e. A copy of each commercial driver license examiner's training record;
- 5. Submit to the Department by the fifth day of each month, a list of all voided score sheets or an indication if none of the score sheets have been voided; and
- 6. Verify each CDL applicant:
  - a. Possesses a valid Arizona driver license with a photograph and a valid Department-issued commercial instruction permit for the class and endorsement of the vehicle to be used in the skills test,
  - b. Has successfully completed the CDL written tests, and
  - c. Has successfully completed the entry-level driver training from a certified organization on the national registry of entry-level driver training providers as prescribed in 49 CFR 380, Subpart F.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-606. Certified Commercial Driver License Examiner Requirements**

- A. In addition to satisfying the requirements of R17-7-303, a certified commercial driver license examiner shall:
  - 1. Comply with all state and federal laws, rules, and the terms and conditions of the authorization agreement requirements between the Department and the authorized third party;
  - 2. Maintain compliance with all certification requirements as prescribed in R17-7-301;

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3. Not administer any examination unless the CDL applicant meets the requirements of all statutes, rules and policies relating to driver licensing;
  4. Conduct skills tests only on Department-approved test routes; and
  5. Complete, in the presence of the CDL applicant, the score sheet at the time of the skills test. The score sheet is valid for one year from the day the CDL applicant completes the skills test.
- B.** If the commercial driver license examiner's CDL is suspended, revoked, canceled, or disqualified, the certified commercial driver license examiner shall not administer any CDLE.
- C.** A commercial driver license examiner shall not accompany an applicant into any office or testing location rented, leased, or owned by the Department.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-607. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Repealed by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**R17-7-608. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Repealed by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**R17-7-609. Renumbered****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section R17-7-609 renumbered to R17-7-207 by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**ARTICLE 7. DRIVER LICENSE TRAINING PROVIDER PROGRAM****R17-7-701. Definitions**

The following definitions apply to this Article unless otherwise specified:

"Driver license training provider" means a business enterprise conducted by an individual, association, partnership, or corporation that educates and trains persons, either practically or theoretically, or both, to operate or drive motor vehicles; that prepares applicants for an examination given by the state for a driver license or instruction permit; and that charges a consideration or tuition for these services.

"Minimum professional training standards" means the Department's approved basic content of material to be presented to and understood by the student through evaluation.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Amended by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**R17-7-702. Additional Authorization Application Requirements for Driver License Training Providers**

In addition to satisfying the requirements of R17-7-201, an applicant for third-party authorization as a driver license training provider shall:

1. Submit the following:
  - a. The specified course of instruction which will be offered, and
  - b. Sample copies of the contracts that will be offered to prospective students or given to enrolled students.
2. Provide a certified statement that the applicant will meet the minimum professional training standards as set forth by the Department. The minimum professional training standards will be provided to the applicant and included in the authorization agreement.
3. Provide a copy of any current leases or agreements for the use of the land or buildings on which the applicant's places of business and training sites are located.
4. Ensure that all places of business and training sites:
  - a. Meet all local zoning requirements, and
  - b. Are not used as a residence.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-703. Additional Certification Application Requirements for Driver License Trainers**

In addition to satisfying the requirements of R17-7-301, an applicant for certification as a driver license trainer shall satisfy all of the following:

1. Pass an examination given by the Department consisting of an actual demonstration or a written test, or both, covering:
  - a. Traffic laws;
  - b. Safe driving practices;
  - c. Operation of motor vehicles;
  - d. Knowledge of teaching methods, techniques, and practices; and
  - e. Authorized third-party statutes and rules, business ethics, office procedures, and elementary record-keeping;
2. Have at least a high school diploma or its equivalent;
3. Hold a valid driver license;
4. Be physically and mentally able to safely operate a motor vehicle and to train others in the operation of motor vehicles, to substantiate this requirement, the Department may require a properly signed and completed certificate of medical examination conducted by a person qualified and licensed to practice medicine in this state; and
5. Provide other information the Department deems pertinent for determining the applicant's good moral character.

## TITLE 17. TRANSPORTATION

## CHAPTER 7. DEPARTMENT OF TRANSPORTATION - THIRD-PARTY PROGRAMS

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-704. Additional Authorized Driver License Training Provider Program Requirements**

In addition to satisfying the requirements of R17-7-204, the authorized third party shall comply with the following:

1. The authorized third party driver license training provider shall comply with the Department's approved curriculum.
2. The established place of business of each authorized third party driver license training provider must be used only for activities authorized by the Department.
3. Each established place of business shall meet all requirements of state law, local ordinances, and the accessibility requirements of the Americans with Disability Act of 1990 (42 U.S.C. 12101 et seq.). The Department may require proof of compliance with local zoning ordinances.
4. An authorized third party driver license training provider must post its office hours in a conspicuous place clearly visible to the public within that location and be open to the public during the posted hours. The person left in charge of the office during the posted office hours must be fully trained to give pertinent information to the public as well as give information to any representative of the Department or to any law enforcement agency.
5. The authorized third party driver license training provider shall provide adequate facilities for any student being given instruction in other than behind-the-wheel driver training.
6. An authorized third party driver license training provider shall maintain the following records at an established place of business or at the principal place of business and make them available for audit and inspection during normal business hours:
  - a. All records setting forth the name, address, contract number, and terms of payment with respect to every person receiving training of any kind, or any other service relating to the operation of a motor vehicle. These records must also contain the date, type, and duration of all training, including the name of the certified individual giving the lessons and the license plate number, make, and model of the vehicle used to conduct the training.
  - b. A record of all receipts and disbursements.
  - c. A record of all training vehicle maintenance and repairs.
7. If an authorized third party driver license training provider enters into a written contract with any person or group of persons receiving training relating to the operation of a motor vehicle, the training provider shall give the original contract to the student or the student's agent who executes the contract and shall retain a copy of the contract in its records.
8. An authorized third party driver license training provider shall equip each motor vehicle used for driver training with at least the following that enables an accompanying driver license trainer to bring the motor vehicle under control in case of emergency:
  - a. A dual braking device if the motor vehicle is equipped with an automatic transmission, or
  - b. A dual clutch and braking device if the motor vehicle is equipped with a standard transmission.

9. An authorized third party driver license training provider must maintain all motor vehicles in safe operating condition at all times.
10. An authorized third party driver license training provider shall conduct training only on test routes approved by the Department.
11. An authorized third party driver license training provider shall not:
  - a. Indicate or represent in any advertisement that the training provider can issue or guarantee issuance of a driver license in any jurisdiction,
  - b. Imply or represent that the training provider can in any way influence the Department or an authorized third party in the issuance of a driver license, or
  - c. Imply or represent that preferential or advantageous treatment from the Department or an authorized third party can be obtained.
12. An authorized third party driver license training provider or a certified trainer shall not accompany any student into any examining office or testing location rented, leased, or owned by the Department or an authorized third party for the purpose of taking a driver license examination.
13. In case of loss or mutilation, a duplicate authorization certificate may be issued by the Department on submission of a properly signed and completed application accompanied by an affidavit setting forth the circumstances. The affidavit must show the date the previously-issued authorization certificate was lost, mutilated, or destroyed, and the circumstances involving its loss, mutilation, or destruction.
14. An authorization for a driver training provider is non-transferable.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section R17-7-704 renumbered to R17-7-303; new Section R17-7-704 made by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-705. Certified Driver License Trainer Requirements**

- A. In addition to satisfying the requirements of R17-7-303, a certified driver license trainer shall maintain compliance with all certification requirements as prescribed in R17-7-301.
- B. In case of loss or mutilation, a duplicate certification may be issued by the Department on submission of a properly signed and completed application accompanied by an affidavit setting forth the circumstances. The affidavit must show the date the previously-issued certification was lost, mutilated, or destroyed, and the circumstances involving its loss, mutilation, or destruction.
- C. If a certified driver license trainer is not employed by an authorized driver license training provider for a period of at least one year, the trainer must reapply and satisfy all the driver license training requirements.

**Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section

## TITLE 17. TRANSPORTATION

## CHAPTER 7. DEPARTMENT OF TRANSPORTATION - THIRD-PARTY PROGRAMS

R17-7-705 renumbered to R17-7-205; new Section R17-7-705 made by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2). Amended by final expedited rulemaking at 30 A.A.R. 3524 (November 22, 2024), with an immediate effective date of November 6, 2024 (Supp. 24-4).

**R17-7-706. Renumbered****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section R17-7-706 renumbered to R17-7-206 by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**R17-7-707. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section

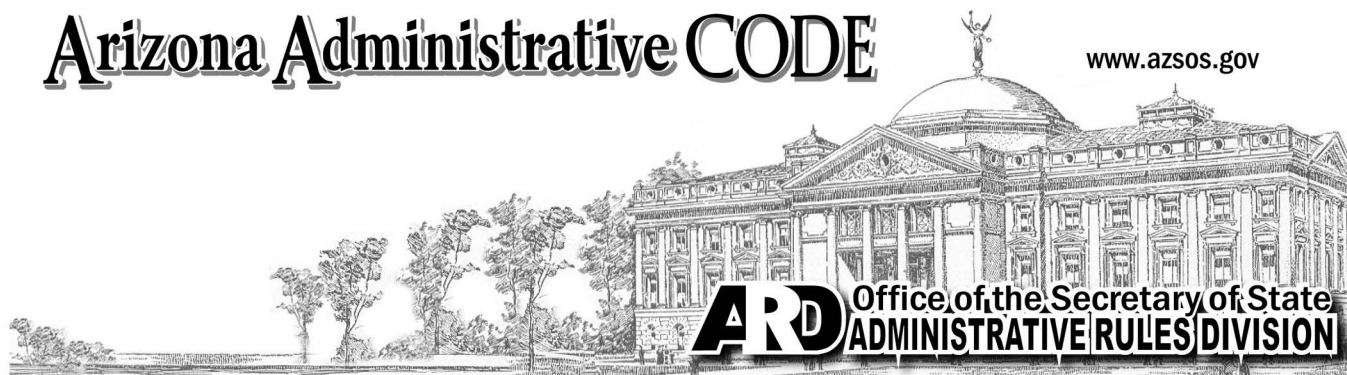
R17-7-707 repealed by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**ARTICLE 8. REPEALED****R17-7-801. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section R17-7-801 repealed by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).

**R17-7-802. Repealed****Historical Note**

New Section made by final rulemaking at 12 A.A.R. 2418, effective August 5, 2006 (Supp. 06-2). Section R17-7-801 repealed by exempt rulemaking at 20 A.A.R. 1138, effective May 1, 2014 (Supp. 14-2).



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## TITLE 18. ENVIRONMENTAL QUALITY

### CHAPTER 13. DEPARTMENT OF ENVIRONMENTAL QUALITY - SOLID WASTE MANAGEMENT

The table of contents on page one contains links to the referenced page numbers in this Chapter.

Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

*Sections amended in this Chapter are too numerous to list on the cover page. Refer to the historical notes for Sections made and amended in Supp. 24-4.*

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**The release of this Chapter in Supp. 24-4 replaces Supp. 21-4, 1-42 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

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### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 18. ENVIRONMENTAL QUALITY

## CHAPTER 13. DEPARTMENT OF ENVIRONMENTAL QUALITY - SOLID WASTE MANAGEMENT

Authority: A.R.S. §§ 41-1003 and 49-104

## Supp. 24-4

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*Editor's Note: This Chapter contains rules which were adopted under an exemption from the provisions of the Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to A.R.S. § 49-701.01(C)(1) and (2). Exemption from A.R.S. Title 41, Chapter 6 means that the Department did not submit these rules to the Governor's Regulatory Review Council for review; the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the Department was not required to hold public hearings on these rules.*

## ARTICLE 1. RESERVED

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*Article 2, consisting of Section R18-13-201, adopted effective July 27, 1998, under an exemption from the provisions of A.R.S. Title 41, Chapter 6 (Supp. 98-3).*

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*Article 15, consisting of Sections R18-13-1501 through R18-13-1514 and Appendix A, recodified to 18 A.A.C. 9, Article 9 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2).*

*Article 15, consisting of Sections R18-13-1501 through R18-13-1514 and Appendix A, adopted effective April 23, 1996 (Supp. 96-2).*

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*Article 16, consisting of Sections R18-13-1601 through R18-13-1614, recodified from 18 A.A.C. 8, Article 16 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).*

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*Article 22, consisting of Sections R18-13-2201 and R18-13-2202, made by final rulemaking at 30 A.A.R. 3900 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).*

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*Article 25, consisting of Section R18-13-2501, expired at 23 A.A.R. 3429, effective October 10, 2017 (Supp. 17-4).*

*Article 25, consisting of Section R18-13-2501, adopted by final rulemaking at 5 A.A.R. 4654, effective November 15, 1999 (Supp. 99-4).*

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*Article 26, consisting of Sections R18-13-2601 through R18-13-2604, expired at 16 A.A.R. 705, effective April 6, 2010 (Supp. 10-2).*

*Article 26, consisting of Sections R18-13-2601 through R18-13-2604, made by exempt rulemaking at 14 A.A.R. 4258, effective October 20, 2008 (Supp. 08-4).*

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*Article 27 consisting of Sections R18-13-2701 through R18-13-2703, expired under A.R.S. § 41-1056(J) at 22 A.A.R. 2984, effective September 15, 2016 (Supp. 16-3).*

*Article 27 consisting of Sections R18-13-2701 through R18-13-2703, made by exempt rulemaking at 16 A.A.R. 848, effective July 1, 2010 (Supp. 10-2).*

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## TITLE 18. ENVIRONMENTAL QUALITY

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**ARTICLE 1. RESERVED**

*Editor's Note: Article 2, consisting of Section R18-13-201, was adopted under an exemption from the provisions of A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 49-701.01(C)(1) and (2). Exemption from A.R.S. Title 41, Chapter 6 means the Department did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the Department did not submit the rules to the Governor's Regulatory Review Council for review; and the Department was not required to hold public hearings on this Section (Supp. 98-3).*

**ARTICLE 2. SOLID WASTE DEFINITIONS; EXEMPTIONS**

*Editor's Note: The following Section was adopted under an exemption from the provisions of the Administrative Procedure Act which means that these rules were not reviewed by the Governor's Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and the agency was not required to hold public hearings on these rules (Supp. 98-3).*

**R18-13-201. Land Application of Biosolids Exemption**

- A. This Section applies only to biosolids as defined in R18-9-1001. The land application of biosolids, when placed on or applied to the land in full conformity with 18 A.A.C. 9, Article 10 and A.R.S. § 49-761(F), and if the site of land application has ceased to receive application of biosolids and all applicable site restrictions set by A.A.C. Title 18 Environmental Quality have been satisfied, is exempt statewide from the definition of solid waste found at A.R.S. § 49-701.01(A). This exemption applies only when the biosolids and the soil to which it has been applied remain at the site of the application.
- B. This exemption does not alter or set any new standard for the soil remediation standards found at 18 A.A.C. 7, Article 2.

**Historical Note**

Adopted under and exemption from A.R.S. Title 41, Chapter 6, pursuant to A.R.S. § 49-701.01(C)(1) and (2), effective July 27, 1998 (Supp. 98-3). Amended by exempt rulemaking at 5 A.A.R. 4004, effective September 17, 1999 (Supp. 99-3). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-202. Coal Slurry Discharges from Pipeline Leaks Exemption**

This Section applies only to coal slurry discharges onto the ground from pipeline leaks. Coal slurry discharges onto the ground from pipeline leaks are exempt statewide from the definition of solid waste prescribed in A.R.S. § 49-701.01(A) if both of the following conditions are met:

1. The discharge was the result of an accidental pipeline leak.
2. The thickness of the layer of coal slurry on the ground that resulted from the discharge is 3 inches or less.

**Historical Note**

New Section adopted by exempt rulemaking at 5 A.A.R. 4004, effective September 17, 1999 (Supp. 99-3).

**ARTICLE 3. REFUSE AND OTHER OBJECTIONABLE WASTES****R18-13-301. Reserved****R18-13-302. Definitions**

- A. "Approved" means acceptable to the Department.
- B. "Ashes" means residue from the burning of any combustible material.

- C. "Department" means the Department of Environmental Quality or a local health department designated by the Department of Environmental Quality.
- D. "Garbage" means all animal and vegetable wastes resulting from the processing, handling, preparation, cooking, and serving of food or food materials.
- E. "Manure" means animal excreta, including cleanings from barns, stables, corrals, pens, or conveyances used for stabling, transporting, or penning of animals or fowls.
- F. "Person" means the state, a municipality, district or other political subdivision, a cooperative, institution, corporation, company, firm, partnership or individual.
- G. "Refuse" means all putrescible and nonputrescible solid and semisolid wastes, except human excreta, but including garbage, rubbish, ashes, manure, street cleanings, dead animals, abandoned automobiles, and industrial wastes.
- H. "Rubbish" means nonputrescible solid wastes, excluding ashes, consisting of both combustible and noncombustible wastes, such as paper, cardboard, waste metal, tin cans, yard clippings, wood, glass, bedding, crockery and similar materials.

**Historical Note**

Section recodified from A.A.C. R18-8-502, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-303. Responsibility**

- A. The owner, agent, or the occupant of any premises, business establishment, or industry shall be responsible for the sanitary condition of said premises, business establishment, or industry. No person shall place, deposit, or allow to be placed or deposited on his premises or on any public street, road, or alley any refuse or other objectionable waste, except in a manner described in these rules.
- B. The owner, agent, or the occupant of any premises, business establishment, or industry shall be responsible for the storage and disposal of all refuse accumulated, by a method or methods described in these rules.
- C. The collection and disposal of all refuse not acceptable for collection by a collection agency is the responsibility of each occupant, business establishment, or industry where such refuse accumulates, and all such refuse shall be stored, collected, and disposed of in a manner approved by the Department.
- D. All dangerous materials and substances shall, where necessary, be rendered harmless prior to collection and disposal.

**Historical Note**

Section recodified from A.A.C. R18-8-503, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-304. Inspection**

Representatives of the Department shall make such inspections of any premises, container, process, equipment, or vehicle used for collection, storage, transportation, disposal, or reclamation or refuse as are necessary to ensure compliance with these rules.

**Historical Note**

Section recodified from A.A.C. R18-8-504, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-305. Collection Required**

- A. Where refuse collection service is available, the following refuse shall be required to be collected: Garbage, ashes, rub-

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bish, and small dead animals which do not exceed 75 pounds in weight.

- B.** The following refuse is not considered acceptable for collection but may be collected at the discretion of the collection agency where special facilities or equipment required for the collection and disposal of such wastes are provided:
1. Dangerous materials or substances, such as poisons, acids, caustics, infected materials, radioactive materials, and explosives.
  2. Materials resulting from the repair, excavation, or construction of buildings and structures.
  3. Solid wastes resulting from industrial processes.
  4. Animals exceeding 75 pounds in weight, condemned animals, animals from a slaughterhouse, or other animals normally considered industrial waste.
  5. Manure.

**Historical Note**

Section recodified from A.A.C. R18-8-505, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-306. Notices**

- A.** All collection agencies shall provide each householder, or business establishment served, with a copy of the requirements governing the storage and collection of refuse which shall cover at least the following items:
1. Definitions.
  2. Places to be served.
  3. Places not to be served.
  4. Scheduled day or days of collection.
  5. Materials acceptable for collection.
  6. Materials not acceptable for collection.
  7. Preparation of refuse for collection.
  8. Types and size of containers permitted.
  9. Points from which collections will be made.
  10. Necessary safeguards for collectors.
- B.** All such notices governing storage and collection shall conform to these rules.

**Historical Note**

Section recodified from A.A.C. R18-8-506, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-307. Storage**

- A.** All refuse shall be stored in accordance with the requirements of this Section. The owner, agent, or occupant of every dwelling, business establishment, or other premises where refuse accumulates shall provide a sufficient number of suitable and approved containers for receiving and storing of refuse, and shall keep all refuse therein, except as otherwise provided by this Chapter.
- B.** Garbage shall be stored in durable, rust resistant, nonabsorbent, watertight, and easily cleanable containers, with close fitting covers and having adequate handles or bails to facilitate handling. The size of the container shall be determined by the collection agency.
- C.** Rubbish and ashes shall be stored in durable containers. Bulky rubbish such as tree trimmings, newspapers, weeds, and large cardboard boxes shall be handled as directed by the collection agency. Where garbage separation is not required, containers for the storage of mixed rubbish and garbage shall meet the requirements specified in subsection (B).
- D.** Containers for the storage of refuse shall be maintained in such a manner as to prevent the creation of a nuisance or a menace

to public health. Containers that are broken or otherwise fail to meet the requirements of the rules shall be replaced, by the owner of said containers, with approved containers.

- E.** Manure and droppings shall be removed from pens, stables, yards, cages, conveyances, and other enclosures as often as necessary to prevent a health hazard or the creation of a nuisance. All material removed shall be handled and stored in a manner that will maintain the premises nuisance free.

**Historical Note**

Section recodified from A.A.C. R18-8-507, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-308. Frequency of Collection; Variance**

- A.** The collection of garbage, refuse, rubbish, and ashes shall be in accordance with rules of the collection agency except that the frequency of collection shall not be less than once per week.
- B.** A variance from the required frequency of collection in subsection (A) may be granted by the county department designated by the county to approve variances to allow for collection less than once weekly. The variance may be granted upon submission of an acceptable plan by the collection agency to the designated county department demonstrating that no public health hazards or nuisances will exist and that fly breeding will be controlled by either biological, chemical, or mechanical means. The variance may be revoked whenever the designated county department determines that the circumstances warranting the variance no longer exist.
- C.** A county may request the Department of Environmental Quality to assume the functions of granting and revoking variances under this Section.
- D.** For the purposes of this Section, "collection agency" means a city, town, person, or commercial service that offers collection or transportation of garbage, refuse, rubbish, and ashes as a service.

**Historical Note**

Section recodified from A.A.C. R18-8-508, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Section amended by final rulemaking at 30 A.A.R. 3900 (December 27, 2024), effective February 4, 2025 (Supp. 24-4).

**R18-13-309. Place of Collection**

- A.** All refuse shall be properly placed on the premises for convenient collection as designated by the collection agency.
- B.** Where alleys are provided, collection shall be made on the alley side of the premises.

**Historical Note**

Section recodified from A.A.C. R18-8-509, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-310. Vehicles**

- A.** Vehicles used for collection and transportation of garbage, or refuse containing garbage, shall have covered, watertight, metal bodies of easily cleanable construction, shall be cleaned frequently to prevent a nuisance or insect breeding, and shall be maintained in good repair.
- B.** Vehicles used for collection and transportation of refuse shall be loaded and moved in such a manner that the contents, including ashes, will not fall, leak, or spill therefrom. Where spillage does occur, it shall be picked up immediately by the collector and returned to the vehicle or container.

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- C. Vehicles used for collection and transportation of rubbish or manure shall be of such construction as to prevent leakage or spillage, and shall provide a cover to prevent blowing of materials or creating a nuisance.

**Historical Note**

Section recodified from A.A.C. R18-8-510, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-311. Disposal; General**

- A. All refuse shall be disposed of by a method or methods included in these rules and shall include rodent, insect, and nuisance control at the place or places of disposal. Approval must be obtained from the Department for all new disposal sites and may change in the method of disposal prior to use.
- B. Carcasses of large dead animals shall be buried or cremated, unless satisfactory arrangements have been made for disposal by rendering or other approved methods.
- C. All public "dumping grounds", provided in compliance with A.R.S. § 9-441, shall be maintained and operated in accordance with the requirements of these rules.
- D. Manure shall be disposed of by sanitary landfill, composting, incineration, or used as fertilizer in such a manner as not to create insect breeding or a nuisance.

**Historical Note**

Section recodified from A.A.C. R18-8-511, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-312. Methods of Disposal**

Approval must be obtained from the Department for any method or methods used for the disposal of refuse prior to the start of operations, and shall be accomplished by one or more of the methods listed below:

1. Sanitary landfill -- Consists of the disposal of refuse on land and the daily compaction and covering of the refuse with 6 to 12 inches of earth so as to prevent a health hazard or nuisance. The final compacted earth cover shall be a minimum of 2 feet in depth. Where sanitary landfill operations are proposed, the Department will require the following:
  - a. The landfill shall be located so that seepage will not create a health hazard, nuisance, or cause pollution of any watercourse or water bearing strata.
  - b. Adequate and proper surface drainage shall be provided to prevent ponding or erosion by rainwater of the finished fill.
  - c. Provision shall be made for the control of insects, rodents, wind blown refuse, and accidental fire.
  - d. Burning of refuse is prohibited.
  - e. An all weather access road is required.
  - f. Suitable equipment and operating personnel shall be provided.
  - g. Salvaging, if permitted, shall be rigidly controlled.
  - h. A variance from the daily compaction and covering requirement may be granted for sites serving less than 2,000 people by the Department of Environmental Quality upon submission of an acceptable plan approved by the local health department demonstrating that no public health hazards or nuisances will exist. The variance will allow for compaction and cover every two weeks at sites serving less than 500 people; weekly compaction and cover for sites serving from 500 to 1,000 people; and twice

weekly compaction and cover for sites serving from 1,000 to 2,000 people. The variance may be revoked whenever the Department of Environmental Quality determines that the circumstances warranting the variance no longer exist.

2. Incineration -- Where incineration is to be employed, the plans and specifications, along with any other information necessary to evaluate the project, shall be submitted to the Department and approval received prior to construction. In addition, an approved method for the disposal of non-combustible refuse is required. Where incineration is proposed, the following items shall be provided:
  - a. The capacity of the incinerator shall be sufficient for the maximum production of refuse expected.
  - b. Noncombustible refuse shall be disposed of by methods approved by the Department.
  - c. Skilled personnel to assure the proper operation and maintenance of the facilities in a nuisance-free manner.
3. Composting -- This method of disposal is acceptable to the Department under the following conditions:
  - a. That plans and specifications and other information necessary to evaluate the project are submitted to the Department and approval received prior to start of construction.
  - b. That provisions are made for the proper disposal of all refuse not considered suitable for composting.
  - c. Skilled personnel shall be provided to assure the proper operation and maintenance of the facilities in a nuisance-free manner.
4. Garbage grinding -- This method, involving the separate collection and disposal of garbage into a community sewerage system through commercial type grinders or mandatory community-wide installation of individual household grinders, will be acceptable to the Department provided that suitable means shall be provided for the disposal of all remaining refuse.
5. Hog feeding -- This method of disposal will only be approved under the following conditions:
  - a. The garbage is collected and stored in suitable containers.
  - b. Only approved type vehicles are used for collection.
  - c. All garbage is effectively heat-treated in accordance with Title 24, Chapter 7, Article 3 (A.R.S. §§ 24-941 through 24-949).
  - d. All remaining refuse, including nonedible garbage, is collected and disposed of separately by methods approved by the Department.
6. Manure disposal -- Manure shall be disposed of by sanitary landfill, composting, incinerating, or used as a fertilizer in such a manner as not to create insect breeding or a nuisance.

**Historical Note**

Section recodified from A.A.C. R18-8-512, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**ARTICLE 4. SOLID WASTE FACILITIES SUBJECT TO BEST MANAGEMENT PRACTICES****R18-13-401. Definitions**

- A. "Department" means the Arizona Department of Environmental Quality.

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- B.** “Material recovery facility” means a transfer facility that collects, compacts, repackages, sorts, or processes commingled recyclable solid waste generated offsite for the purpose of recycling and transport, or where source separated recyclable solid waste is processed for sale to various markets, and where the incoming materials are predominantly recyclable solid waste.
- C.** “Recyclable solid waste” means a product or material described in subsection (C)(1) or (2), and for which subsection (C)(3) is true:
1. A product with no useful life remaining for the purposes for which it was produced, or if useful life remains, the product will not, due to location, quantity, or owner choice, remain in use or be reused for a purpose for which it was produced.
  2. A material that is a result of a process or activity whose purpose was to produce something else.
  3. The product or material retains some economic value, with or without further processing, as a raw material or feedstock in some process other than incineration or combustion.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-402. Solid Waste Facilities Subject to Best Management Practices; Fees**

- A.** The following solid waste facilities subject to best management practices under A.R.S. § 49-762.02 shall register with the Department and pay registration fees as provided in this Section:
1. A transfer facility, as defined in A.R.S. § 49-701, with a daily throughput of 180 cubic yards or less, but not including:
    - a. A material recovery facility where the incoming materials are primarily source separated recyclables; or
    - b. Community or neighborhood recycling bins including drop boxes, roll off containers, and plastic containers used to collect residential, business, or governmental recyclable solid waste.
  2. A site at which more than 500 and fewer than 5,000 waste tires are stored on any day that is not required to obtain plan approval pursuant to A.R.S. § 49-762.
- B.** Initial registration. A new solid waste facility listed in subsection (A) shall not begin operation until the owner or operator registers with the Department on a form approved by the Department. The owner or operator of a new solid waste facility listed in subsection (A) shall submit an initial registration fee of \$1,800 at the time of registration under this subsection.
- C.** Annual registration fee. The Department shall bill an annual registration fee of \$1,500 to a registered solid waste facility listed in subsection (A) that has not filed a notice of termination of registration with the Department. The owner or operator of a registered solid waste facility listed in subsection (A) shall pay the annual registration fee within 30 days of invoice receipt.
- D.** Registration as a waste tire collection site under R18-13-1211 shall satisfy registration and fee requirements pursuant to this Section for a site under subsection (A)(2) of this Section.
- E.** Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (B) and (C) of this Section annually by the following method, except that no adjustment in any year

shall exceed four percent of the fee amount of the preceding year:

1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
2. Round the result from subsection (E)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**ARTICLE 5. REQUIREMENTS FOR SOLID WASTE FACILITIES SUBJECT TO SELF-CERTIFICATION****R18-13-501. Solid Waste Facilities Requiring Self-Certification; Registration Fees**

- A.** The following solid waste facilities requiring self-certification under A.R.S. § 49-762.01 shall register with the Department and pay annual registration fees as provided in this Section:
1. A transfer facility, as defined in A.R.S. § 49-701, with a daily throughput of more than 180 cubic yards, including a material recovery facility, but not including:
    - a. A material recovery facility where the incoming materials are primarily source separated recyclables; or
    - b. Community or neighborhood recycling bins including drop boxes, roll off containers, and plastic containers used to collect residential, business, or governmental recyclable solid waste.
  2. A facility storing 5,000 or more waste tires on any one day and not required to obtain plan approval.
  3. A waste tire shredding and processing facility.
- B.** Initial registration for a new facility. The owner or operator of a planned new facility identified in subsection (A) of this Section shall submit the following information to the Department before beginning construction:
1. The name of the solid waste facility.
  2. The name, mailing address and telephone number of each owner and operator of the solid waste facility.
  3. The physical location of the solid waste facility by physical address, latitude and longitude, or legal description. If none of these are practical, by driving directions from the nearest city or town.
  4. A brief description of operations, including waste management methods, types and volumes of waste handled, waste storage and treatment equipment, and the length of time the waste remains onsite.
  5. A diagram of the property showing its approximate size and the planned location of the solid waste facility or facilities.
  6. Documentation that the facility will comply with local zoning laws or, if the owner is an agency or political subdivision of this state, with A.R.S. § 49-767.
  7. Documentation that the facility has any other environmental permit that is required by statute.
  8. A copy of the public notice in a newspaper of general circulation in the area where the facility will be located stat-

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ing the intent to construct and operate a new solid waste facility pursuant to A.R.S. § 49-762.05.

- C. Initial and annual registration for an existing facility. The owner or operator of an existing facility identified in subsection (A) of this Section shall submit the following information to the Department annually on a form approved by the Department and note any changes since the last registration:
1. The name of the solid waste facility.
  2. The name, address and telephone number of each owner and operator of the solid waste facility.
  3. The physical location of the solid waste facility by physical address, latitude and longitude, or legal description. If none of these are practical, by driving directions from the nearest city or town.
  4. A brief description of operations, including waste management methods, types and volumes of waste handled, waste storage and treatment equipment, and the length of time the waste remains onsite.
  5. A diagram of the property showing its approximate size and the location of the solid waste facility or facilities.
  6. Documentation that the facility remains in compliance with the most current local zoning laws or with A.R.S. § 49-767, as applicable.
  7. Documentation that the facility continues to hold any other environmental permit that is required by statute.
- D. Self-certification. With each registration under subsection (B) or (C) of this Section, the owner or operator shall certify that the information submitted is true, accurate, and complete to the best of the person's knowledge and belief.
- E. Registration fees. The owner or operator of a solid waste facility under subsection (A) shall pay the Department \$3,600 for the initial registration of a new facility, and \$3,000 for each annual registration thereafter. The Department shall bill the annual registration fee to a solid waste facility under subsection (A) that has not filed a notice of termination of registration with the Department and the solid waste facility shall pay within 30 days of invoice receipt.
- F. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (E) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (F)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.
- G. As used in this Section:
1. "Department" means the Arizona Department of Environmental Quality.
  2. "Material recovery facility" means a transfer facility that collects, compacts, repackages, sorts, or processes commingled recyclable solid waste generated offsite for the purpose of recycling and transport, or where source separated recyclable solid waste is processed for sale to various markets, and where the incoming materials are predominantly recyclable solid waste.

3. "Recyclable solid waste" means a product or material described in subsection (G)(3)(a) or (b), and for which subsection (G)(3)(c) is true:

- a. A product with no useful life remaining for the purposes for which it was produced, or if useful life remains, the product will not, due to location, quantity, or owner choice, remain in use or be reused for a purpose for which it was produced.
- b. A material that is a result of a process or activity whose purpose was to produce something else.
- c. The product or material retains some economic value, with or without further processing, as a raw material or feedstock in some process other than incineration or combustion.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**ARTICLE 6. RESERVED****ARTICLE 7. SOLID WASTE FACILITY PLAN REVIEW FEES****R18-13-701. Definitions**

In addition to the definitions provided in A.R.S. §§ 49-701, 49-701.01, and 49-851, and 18 A.A.C. 13, the following definitions apply in this Article:

1. "Aquifer Protection Permit" or "APP" means the permit that is required pursuant to A.R.S. § 49-241.
2. "MSWLF" means a municipal solid waste landfill as defined in A.R.S. § 49-701.
3. "Non-APP requirements for Non-MSWLFs" means 40 CFR 257 requirements and the restrictive covenant and location restrictions required in A.R.S. Title 49, Chapter 4.
4. "Non-MSWLF" means a landfill that is not a municipal solid waste landfill as defined in A.R.S. § 49-701.
5. "RD&D" means research, development, and demonstration.
6. "Review hours" means the hours or portions of hours that the Department's staff spends on a request for a plan review. Review hours include the time spent by the project manager and technical review team members, and if requested by the applicant, the supervisor or unit manager.
7. "Review-related costs" means any of the following costs applicable to a specific plan review:
  - a. Presiding officer services for public hearings on a plan review decision,
  - b. Court reporter services for public hearings on a plan review decision,
  - c. Facility rentals for public hearings on a plan review decision,
  - d. Charges for laboratory analyses performed during the plan review,
  - e. Other reasonable and necessary review-related expenses documented in writing by the Department and agreed to by an applicant.
8. "Solid waste facility plan" means a plan or the individual components of a plan, such as the design, operational, closure, or post-closure plan, or the demonstration of financial responsibility as required by A.R.S. § 49-770,



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submitted to the Department for review and plan approval.

**Historical Note**

Adopted effective July 1, 1996; filed in the Office of the Secretary of State December 1, 1995 (Supp. 95-4). Amended effective May 15, 1997 (Supp. 97-2). Amended by exempt rulemaking at 8 A.A.R. 3747, effective November 1, 2002 (Supp. 02-3). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2).

**R18-13-702. Solid Waste Facility Plan Review Fees**

- A. With each application submitted for approval pursuant to A.R.S. § 49-762.03, the applicant shall remit an initial fee in accordance with one of the fee tables in this subsection, unless otherwise provided in subsection (B) of this Section. This subsection also lists the maximum fees that the Department will bill the applicant. All fees paid shall be payable to the state of Arizona. The Department shall deposit the fees paid into the Solid Waste Fee Fund established pursuant to A.R.S. § 49-881, unless otherwise authorized or required by law.

**Fee Tables****Fees for Plan Review of New Solid Waste Facilities**

	Initial	Maximum
Solid Waste Landfills	\$20,000	\$297,047
Non-APP requirements for Non-MSWLFs operating under an APP	\$2,000	\$74,262
Other Solid Waste Facilities Subject to Plan Approval	\$10,000	\$148,524

**Fees for Modifications to Solid Waste Facility Plans**

	Initial	Maximum
Solid Waste Landfills – Type IV	\$1,500	\$222,786
Solid Waste Landfills – Type III	\$750	\$111,393
Other Solid Waste Facilities Subject to Plan Approval - Type IV	\$750	\$111,393
Other Solid Waste Facilities Subject to Plan Approval - Type III	\$500	\$74,262

**Fees for Review of Financial Responsibility Plans for Solid Waste Facilities**

	Initial	Maximum
Annual Review for Solid Waste Landfills	\$891 Flat Fee	N/A
Other Solid Waste Facilities	\$200	\$7,426

- B. The Department shall bill an applicant for plan review services, subject to an hourly rate, no more than monthly, but at least semi-annually. The following information shall be included in each bill:
1. The dates of the billing period;
  2. After January 1, 2013, the date and number of review hours performed during the billing period itemized by employee name, position type and specifically describing:
    - a. Each review task performed,
    - b. The facility and operational unit involved, and
    - c. The hourly rate;
  3. A description and amount of any other reasonable review-related cost; and
  4. The total fees paid to date, the total fees due for the billing period, the date when the fees are due, and the maximum fee for the project.

- C. Within 30 days after the Department makes a final determination whether to approve or disapprove of the facility plan, or when an applicant withdraws or closes the application for review, the Department shall prepare and issue a final itemized bill of its review. If the Department determines that the actual cost of reviewing the plan is less than the initial fee and any interim fees paid, the Department shall refund the difference to the applicant within 30 days after the issuance of the approval or disapproval of the application. If the Department determines that the actual cost of plan review is greater than the corresponding amount listed, the Department shall list the amount that the applicant owes on the final itemized bill, except that the final itemized bill shall not exceed the applicable maximum fee specified in subsection (A). The applicant shall pay in full the amount due within 30 days of receipt of the final itemized bill.
- D. If the final bill is not paid within the 30 days, the Department shall mail a second notice to the applicant. Failure to pay the amount due within 60 days of receipt of the notice shall result in the Department initiation of proceedings for suspension of the approval, in accordance with A.R.S. § 49-782. The suspension shall continue until full payment is received at the Department. If full payment is not received at the Department within 365 days of the date of the approval, the approval shall be revoked in accordance with A.R.S. § 49-782. The Department shall not review any further plans for an entity which has not paid all fees due for a previous review of a solid waste facility plan.
- F. The hourly rate is \$181.
- G. Beginning July 1, 2026, the Director shall adjust the fee amounts in the columns of the Fee Tables titled "Maximum", the annual review for solid waste landfills flat fee in the Fee Table - Fees for Review of Financial Responsibility Plans for Solid Waste Facilities, and the hourly rate amount in subsection (F) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (G)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

Adopted effective July 1, 1996; filed in the Office of the Secretary of State December 1, 1995 (Supp. 95-4). Corrected typographical error "facilities" in Schedules A, B, and C, to reflect Section filed in the Office of the Secretary of State December 1, 1995. Section amended effective May 15, 1997; except for special waste management plan component fees listed in Schedules A, B, and C, which become effective July 1, 1997 (Supp. 97-2). Amended by exempt rulemaking at 5 A.A.R. 3869, effective October 1, 1999 (Supp. 99-3). Amended by exempt rulemaking at 8 A.A.R. 3747, effective November 1, 2002 (Supp. 02-3). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January

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24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-703. Review of Bill**

- A.** An applicant who disagrees with the final bill received from the Department for plan review and issuance or denial of a solid waste facility plan approval under this Article may make a written request to the Director for a review of the bill and may pay the bill under protest. The request for review shall specify the matters in dispute and shall be received by the Department within 10 working days of the date of receipt of the final bill.
- B.** Unless the Department and applicant agree otherwise, the review shall take place within 30 days of receipt by the Department of the request. The Director shall make a final decision as to whether the time and costs billed are correct and reasonable. The final decision shall be mailed to the applicant within 10 working days after the date of the review and is subject to appeal pursuant to A.R.S. §§ 41-1092 through 1092.12.

**Historical Note**

Adopted effective July 1, 1996; filed in the Office of the Secretary of State December 1, 1995 (Supp. 95-4). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-704. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 3747, effective November 1, 2002 (Supp. 02-3). Section repealed by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2).

**R18-13-705. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 3747, effective November 1, 2002 (Supp. 02-3). Section repealed by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2).

**R18-13-706. Repealed****Historical Note**

New Section made by exempt rulemaking at 8 A.A.R. 3747, effective November 1, 2002 (Supp. 02-3). Section repealed by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2).

**ARTICLE 8. GENERAL PERMITS****R18-13-801. General Permit Fees**

- A.** The Department shall assess annual fees for operation under a general permit established in rule as described in the Table below. Beginning July 1, 2026, the Director shall adjust the fee amounts in the Table below annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.

2. Round the result from subsection (A)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.
- B.** In addition to the technical requirements proposed for any general permit to be included in this Article, the Department shall propose the category to be assigned to the permit according to the Table below.
- C.** An applicant shall pay the initial fee when approval to operate is requested. The Department shall bill an annual fee to facilities that have not notified the Department that they are no longer operating and have met the closure requirements of this Chapter.
- D.** For the purpose of this Article, "complex" has the meaning in A.A.C. R18-1-501. "Standard" is any facility that is not complex.

**Table. Solid Waste General Permits**

Category	Initial Fee	Annual Fee
Collection, Storage and Transfer-Standard	\$1,114	\$149
Collection, Storage and Transfer-Complex	\$11,139	\$1,485
Treatment-Standard	\$1,485	\$149
Treatment-Complex	\$14,852	\$1,485
Disposal	\$22,279	N/A

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-802. Disposal General Permit: Non-Municipal Solid Waste Landfills at Mining Operations**

- A.** This general permit is adopted pursuant to A.R.S. § 49-706 as an alternative to plan approvals for facilities identified in A.R.S. § 49-762(A)(1). This general permit authorizes disposal of solid waste in a landfill at a mining operation if the landfill meets one of the following criteria:
1. The landfill is identified as a discharging facility in an area-wide aquifer protection permit and is located within the pollutant management area developed for that permit; or
  2. The landfill is located within the pollutant management area of an area-wide aquifer protection permit but is exempt from the permit requirement because it contains only inert material as defined in A.R.S. § 49-201; or
  3. The landfill is located at a site qualifying as a groundwater protection permit facility as defined in A.R.S. § 49-241.01(C) and the site has submitted an administratively complete application for an aquifer protection permit that has not been denied. Landfills that are located at mining operations and that are subject to best management practices under A.R.S. § 49-762.02(6) are required to comply with those practices and do not require coverage under this general permit.
- B.** Authorized and prohibited materials.
1. Disposal of the following is allowed under this general permit:
    - a. Solid waste generated at the mining operation where the landfill is located; and
    - b. Incidental amounts of putrescible waste generated at the mining operation where the landfill is located. For the purposes of this Section, "putrescible waste"

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means solid waste which contains organic matter capable of being decomposed by microorganisms and of such a character and proportion as to be capable of attracting or providing food for birds.

2. Disposal of the following is prohibited under this general permit:
  - a. Used oil as defined in A.R.S. § 49-801(3).
  - b. Human excreta as defined in R18-13-1102.
  - c. Special waste as defined in A.R.S. § 49-851(A)(5).
  - d. Biohazardous medical waste as defined in R18-13-1401.
  - e. Radioactive waste material regulated for disposal pursuant to Title 12, Chapter 1 of the Arizona Administrative Code.
  - f. Hazardous waste as defined in A.R.S. § 49-921(5), including hazardous waste generated by a conditionally exempt small quantity generator.
  - g. Bulk or noncontainerized liquid waste.
  - h. Waste containing polychlorinated biphenyls regulated for disposal pursuant to 40 CFR 761.
- C. A person may operate a landfill at a mining operation under this general permit if:
  1. Operation of the landfill complies with the requirements of this Section;
  2. The person files a Notice of Intent to Operate that complies with subsections (D) and (E);
  3. The person satisfies any requests for additional information from the Department regarding the Notice of Intent to Operate landfill operation and receives a written Authorization to Operate from the Director; and
  4. The person submits the applicable fee established in R18-13-801 for the Disposal category.
- D. Notice of Intent to Operate. An applicant shall submit to the Department a Notice of Intent to Operate under this general permit. The Notice shall contain:
  1. The name, address, and telephone number of the applicant;
  2. The name, address, and telephone number of a contact person familiar with the operation of the facility;
  3. The legal description of the landfill area, latitude and longitude coordinates, a detailed figure(s) showing both the existing landfill boundary and the anticipated future waste footprint of the landfill at the time of closure, and a map showing the location of the landfill within the mining operation;
  4. A description of how the applicant will meet the public access restrictions in subsection (H)(3);
  5. A description of how the applicant will meet the cover requirements in subsection (H)(4);
  6. A description of how the applicant will meet the methane requirements in subsection (H)(5). For landfills that have accepted waste prior to the effective date of this Section only, the applicant shall include recent methane monitoring sampling results from either:
    - a. One (1) measurement per acre of landfill waste footprint; or
    - b. A minimum of four (4) monitoring probes installed to the depth of refuse around the perimeter of the landfill and measured quarterly for the presence of methane gas for a period of one (1) year;
  7. A narrative description of the landfill, including whether the landfill is existing or planned, the acreage of the current and planned waste footprint, estimated disposal capacity in cubic yards, expected lifespan, projected rate of waste disposal in tons per day or per week, and sources of solid waste generation;
8. A listing of any other federal or state environmental permits issued for or needed by the landfill, including any individual plan approval, APP, Groundwater Quality Protection Permit, or Notice of Disposal; and
9. A signature on the Notice of Intent to Operate certifying that the applicant agrees to comply with all terms of this general permit.
- E. Existing facility application deadline. Existing facilities that qualify for coverage under subsections (A)(1), (A)(2), or (A)(3) on the effective date of this rule shall submit a Notice of Intent to Operate within 2 years of the effective date of this rule to obtain coverage. The Director may extend this date in individual cases if the facility could not have submitted an administratively complete Notice in time with reasonable diligence.
- F. Authorization review.
  1. Inspection. The Department may inspect the facility to determine that the applicable terms of this general permit are being met.
  2. Authority to Operate issuance.
    - a. If the Department determines, based on its review and an inspection, if conducted, that the facility conforms to the requirements of this general permit, the Director shall issue an Authority to Operate.
    - b. The Authority to Operate authorizes the person to operate the landfill under the terms of this general permit.
  3. Authority to Operate denial. If the Department determines, based on its review and an inspection, if conducted, that the facility does not conform to the requirements of this general permit, the Director shall notify the person of the decision not to issue the Authority to Operate and the person shall not operate the landfill under this general permit. The notification shall inform the person of:
    - a. The reason for the denial with reference to the statute or rule on which the denial is based;
    - b. The person's right to appeal the denial, including the number of days the applicant has to file a protest challenging the denial and the name and telephone number of the Department contact person who can answer questions regarding the appeals process; and
    - c. The person's right to request an informal settlement conference under A.R.S. §§ 41-1092.03(A) and 41-1092.06.
- G. Statutory requirements. The landfill shall be:
  1. Located according to the applicable location restrictions in A.R.S. § 49-772; and
  2. Subject to a restrictive covenant recorded pursuant to A.R.S. § 49-771.
- H. Operational requirements.
  1. Inspect the landfill at least quarterly and after large storm events for overall integrity and condition of the facility, including stormwater diversions, and conduct maintenance and repairs as needed. For the purposes of this Section, a "large storm event" is defined as one-half inch of precipitation in any 24-hour period.
  2. Direct storm water runoff from surrounding areas away from the landfill.
  3. Restrict public access to the landfill or to the mining operation site by signs or physical barriers, including natural barriers.

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4. Apply cover at such frequencies and in such a manner as to control windblown dispersion of waste, reduce the risk of fire and impede disease vectors' access to the waste, taking into account the types and volumes of waste placed in the landfill, the frequency of disposal, and other relevant considerations. The Department may allow other techniques that are demonstrated to be equally protective as applying cover material.
5. Concentrations of methane gas shall not exceed 25% of the lower explosive limit in facility structures within 100 feet of the landfill boundary and shall not exceed the lower explosive limit beyond the landfill boundary.
6. Methane monitoring.
  - a. For landfills that have accepted waste prior to the effective date of this Section only, the applicant shall include recent methane monitoring data as described in subsection (D)(6) with the Notice of Intent to Operate.
    - i. If the data demonstrate that concentrations of methane gas do not exceed 25% of the lower explosive limit, then no methane monitoring is required in order to operate under this permit.
    - ii. If the data demonstrate that concentrations of methane gas exceed 25% of the lower explosive limit, then annual methane monitoring using one of the data gathering methods described in subsection (D)(6) is required in order to operate under this permit. Results of such annual methane monitoring shall be submitted to the Department.
      - (1) A person operating a landfill subject to annual methane monitoring may reduce monitoring to once every five years if the results of three consecutive annual sampling events demonstrate that concentrations of methane gas do not exceed 25% of the lower explosive limit.
      - (2) A person operating a landfill subject to annual methane monitoring may request the Department to reduce or eliminate such monitoring based on any other methods approved by the Department, including consideration of the potential for methane gas to be present in facility structures within 100 feet of the landfill boundary at concentrations exceeding 25% of the lower explosive limit.
  - b. For landfills that have not accepted waste prior to the effective date of this Section, no methane monitoring is required in order to obtain coverage or operate under this permit.
7. Maintain an operating record that documents compliance with the conditions in this permit.
- I. Recordkeeping. A permittee shall maintain the following information for at least 10 years and make it available to the Department upon request:
  1. Landfill construction drawings and as-built plans, if available;
  2. The operating record required by subsection (H)(7); and
  3. Methane monitoring results, if any, obtained under subsection (H)(6).
- J. Reporting requirements. A permittee shall report the following to the Department:
  1. Methane monitoring concentrations that exceed those listed in subsection (H)(5) within 7 days of the determination.
  2. A change in ownership or expansion of the planned waste footprint as soon as practicable. These events shall require the filing of a new Notice of Intent to Operate.
- K. General applicability. Landfills covered under this general permit:
  1. Are not subject to rules adopted by the Department under A.R.S. § 49-761.
  2. Are exempt from the solid waste facility plan requirements in A.R.S. §§ 49-762.03 and 49-762.04 as provided in A.R.S. § 49-762(B).
- L. For the purposes of this Section, "mining" has the definition at A.R.S. § 27-301.

**Historical Note**

New Section made by final rulemaking at 20 A.A.R. 2679, effective November 9, 2014 (Supp. 14-3).

**ARTICLE 9. SOLID WASTE MANAGEMENT PLANNING**

**R18-13-901. Reserved**

**R18-13-902. Expired**

**Historical Note**

Section recodified from A.A.C. R18-8-402, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 2983, effective September 15, 2016 (Supp. 16-3).

**ARTICLE 10. RESERVED****ARTICLE 11. COLLECTION, TRANSPORTATION, AND DISPOSAL OF HUMAN EXCRETA**

*Article 11 recodified from existing Sections in 18 A.A.C. 8, Article 6 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).*

**R18-13-1101. Reserved**

**R18-13-1102. Definitions**

- A. "Chemical toilet" means a toilet with a watertight, impervious pail or tank that contains a chemical solution placed directly under the seat and a pipe or conduit that connects the riser to the tank.
- B. "Department" means the Department of Environmental Quality or a local health department designated by the Department.
- C. "Earth-pit privy" means a device for disposal of human excreta in a pit in the earth.
- D. "Human excreta" means human fecal and urinary discharges and includes any waste that contains this material.
- E. "License" means a stamp, seal, or numbered certificate issued by the Department.
- F. "Pail or can type privy" means a privy equipped with a watertight container, located directly under the seat for receiving deposits of human excreta, that provides for removal of a waste receptacle that can be emptied and cleaned.
- G. "Person" means the state, a municipality, district or other political subdivision, a cooperative, institution, corporation, company, firm, partnership, or individual.
- H. "Sewage" means the waste from toilets, baths, sinks, lavatories, laundries, and other plumbing fixtures in residences, institutions, public and business buildings, mobile homes, and other places of human habitation, employment, or recreation.

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**Historical Note**

Recodified from R18-8-602 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1103. General Requirements; License Fees**

- A.** Any person owning or operating a vehicle or appurtenant equipment used to store, collect, transport, or dispose of sewage or human excreta that is removed from a septic tank or other onsite wastewater treatment facility; earth pit privy, pail or can type privy, or other type of privy; sewage vault; or fixed or transportable chemical toilet shall obtain a license for each vehicle from the Department. The person shall apply on a form approved by the Department and shall demonstrate that each vehicle is designed and constructed to meet the requirements of this Article.
- B.** A person shall operate and maintain the vehicle and equipment so that a health hazard, environmental nuisance, or violation of a water quality standard established under 18 A.A.C. 11 is not created.
- C.** License terms.
  1. For each newly licensed vehicle:
    - a. Subject to inspection conducted by the Department pursuant to this Article, the initial license fee shall be \$660, to be submitted with the license application, and the annual license fee shall be \$550; or
    - b. Subject to inspection conducted by a county pursuant to a delegation agreement with the Department, the initial license fee shall be \$270, to be submitted with the license application, and the annual license fee shall be \$225.
  2. After initial licensure of a vehicle, the Department will renew the license annually after payment of the annual fee according to subsection (C)(3). The licensee shall renew by completing a renewal form approved by the Department and submitting the annual license fee to the Department no later than 30 days before expiration.
  3. Each vehicle license may be renewed if:
    - a. The annual license fee is paid,
    - b. The owner or operator is in compliance with subsection (D) of this Section,
    - c. The vehicle is operated by the same person for the same purpose,
    - d. The vehicle has been inspected within the last 12 months pursuant to any inspection required under this Article and found in compliance with this Article, and
    - e. The vehicle is maintained according to this Article.
- D.** Any person owning or operating a vehicle or appurtenant equipment used to collect, store, transport, or dispose of sewage or human excreta shall obtain any required permit from the local county authority in each county in which the person proposes to operate.
- E.** Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (C) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
  1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.

2. Round the result from subsection (E)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

Recodified from R18-8-603 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1104. Repealed****Historical Note**

Recodified from R18-8-604 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1105. Reserved****R18-13-1106. Inspection**

The Department may inspect vehicles and appurtenant equipment used to collect, store, transport, or dispose sewage or human excreta as necessary to assure compliance with this Article.

**Historical Note**

Recodified from R18-8-606 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1107. Reserved****R18-13-1108. Repealed****Historical Note**

Recodified from R18-8-608 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1109. Reserved****R18-13-1110. Reserved****R18-13-1111. Reserved****R18-13-1112. Sanitary Requirements**

- A.** A person owning or operating a vehicle or appurtenant equipment to collect, store, transport, or dispose of sewage or human excreta shall ensure that:
  1. Sewage and human excreta is collected, stored, transported, and disposed of in a sanitary manner and does not endanger the public health or create an environmental nuisance;
  2. The vehicle is equipped with a leak-proof and fly-tight container that has a capacity of at least 750 gallons and all portable containers, pumps, hoses, tools, and other implements are stored within a covered and fly-tight enclosure when not in use;
  3. Contents intended for removal are transferred as quickly as possible by means of a portable fly-tight container or suction pump and hose to the transportation container.

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4. The transportation container is tightly closed and made fly-tight immediately after the contents have been transferred,
  5. Portable containers are kept fly-tight while being transported to and from the vehicle,
  6. Any waste dropped or spilled in the process of collection is cleaned up immediately and the area disinfected;
  7. The vehicle, tools, and equipment are maintained in good repair at all times and, at the end of each day's work, all portable containers, transportation containers, suction pumps, hose, and other tools are cleaned and disinfected; and
  8. All wastes collected are disposed of according to the recommendations of the local county health department and that no change in the recommended method of disposal is made without its prior approval. The local county health department shall recommend disposal by one of the following methods:
    - a. At a designated point into a sewage treatment facility or sewage collection system with the approval of the owner or operator of the facility or system,
    - b. By burying all wastes from chemical toilets in an area approved by the local county health department, or
    - c. Into a sanitary landfill with approval of the owner or operator of the landfill and following any precautions designated by the owner and operator to protect the health of the workers and the public.
- B.** Open dumping is prohibited except in designated areas approved by the local county health department.

**Historical Note**

Recodified from R18-8-612 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1113. Repealed****Historical Note**

Recodified from R18-8-613 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1114. Repealed****Historical Note**

Recodified from R18-8-614 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1115. Repealed****Historical Note**

Recodified from R18-8-615 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1116. Suspension and Revocation**

- A.** If a Department inspection indicates that a licensed vehicle is not maintained and operated or work cannot be performed according to this Article, the Department shall notify the owner in writing of all violations noted.
- B.** The Department shall give the owner a reasonable period of time to correct the violations and comply with the provisions

of this Article. If the owner fails to comply within the time limit specified, the Department may suspend or revoke the vehicle license based on the number and severity of violations. The Department shall follow the provisions of A.R.S. Title 41, Chapter, Article 10 in any suspension or revocation proceeding.

- C.** The Department shall consider the revocation or suspension of a permit by a local health department for violation of this Article as grounds for revocation of the vehicle license. The local health department shall immediately suspend both the vehicle license and the permit issued by the local health department for gross violation of this Article if in the opinion of the local health department a serious health hazard or environmental nuisance exists.
- D.** The owner of the vehicle whose license is suspended or revoked may appeal the final administrative decision as permitted under A.R.S. § 41-1092.08.

**Historical Note**

Recodified from R18-8-616 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1117. Reinstatement**

- A.** Upon request of the vehicle owner, the Department may reinstate a suspended or revoked vehicle license following a Department reinspection and based on an evaluation of compliance with the requirements of this Article.
- B.** Upon request of a vehicle owner that fails to complete a renewal form approved by the Department and submit the annual license fee to the Department no later than 30 days before expiration, the Department may reinstate an expired vehicle license after completion of a renewal form, submitting the appropriate annual license fee, and following a Department determination of compliance with the requirements of this Article.

**Historical Note**

Recodified from R18-8-617 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1118. Repealed****Historical Note**

Recodified from R18-8-618 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1119. Repealed****Historical Note**

Recodified from R18-8-619 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by final rulemaking at 9 A.A.R. 1356, effective June 7, 2003 (Supp. 03-2).

**R18-13-1120. Repealed****Historical Note**

Recodified from R18-8-620 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Section repealed by

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final rulemaking at 9 A.A.R. 1356, effective June 7, 2003  
(Supp. 03-2).

**ARTICLE 12. WASTE TIRES; USED TIRES****R18-13-1201. Definitions**

In addition to the definitions provided in A.R.S. § 44-1301, the following definitions apply in this Article:

1. "Aquifer protection permit" means an authorization issued by the Department under A.R.S. § 49-241 et seq.
2. "Burial cell" means an area where mining waste tires are placed in or on the land for burial.
3. "Mining" means activities dedicated to the exploration, extraction, beneficiation, and processing, including smelting and refining, of metallic ores.
4. "Mining facility" means any land, building, installation, structure, equipment, device, conveyance, or area dedicated to mining.
5. "Mining waste tire" means an off-road tire that is greater than three feet in outside diameter that was used in mining.
6. "Operator" means an owner, part owner, management agency, or lessee of a mining facility, a person responsible for the overall operation or control of a mining facility, or an authorized representative of the operator.
7. "Person" is defined in A.R.S. § 49-201.
8. "Waste tire collection site" is defined in A.R.S. § 44-1301.
9. "Waste tire cover" means waste tires that are chopped or shredded into pieces that do not exceed four inches in diameter used for cover at a solid waste landfill.

**Historical Note**

Section recodified from A.A.C. R18-8-701, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final rulemaking at 7 A.A.R. 5695, effective November 27, 2001 (Supp. 01-4). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1202. Burial of Mining Waste Tires**

- A. The operator shall file with the Director a one-time notice within 24 hours after commencement of burial of mining waste tires consisting of a map of the mining facility that clearly identifies the locations and dimensions of each burial cell and the estimated number of mining waste tires that will be buried in each cell. The operator shall identify each burial cell using an alphabetical or numeric identifier. If a mining facility uses a new burial cell not included in the commencement of burial notice, the operator shall notify the Department within 24 hours after commencement of burial in that cell.
- B. An operator shall only permit burial of mining waste tires in areas that are, or will be, included in an aquifer protection permit issued for the mining facility. An operator shall not permit burial of mining waste tires in leach areas unless prior to burial the Department issues an aquifer protection permit covering the leach area.
- C. An operator shall not permit a burial cell to be located within 10 feet of another burial cell.
- D. An operator shall not permit the burial of mining waste tires unless the tires are waste generated at the mining facility or another mining facility of the same owner.

**Historical Note**

Section recodified from A.A.C. R18-8-702, filed in the Office of the Secretary of State September 29, 2000

(Supp. 00-3). Amended by final rulemaking at 7 A.A.R. 5695, effective November 27, 2001 (Supp. 01-4).

**R18-13-1203. Cover Requirements**

- A. The operator shall cover all mining industry off-road motor vehicle waste tires buried pursuant to this Article with a minimum of 6 inches of earthen material within 50 days of placement, or sooner if necessary, to prevent vector breeding or fire.
- B. The operator shall place final cover over the off-road motor vehicle waste tires within 180 days after placement of the last tire which will be buried in a cell. The final cover shall consist of earthen material which is at least 3 feet deep or which complies with the requirements of the aquifer protection permit for the area where the burial cell is located.
- C. The operator shall maintain final cover in compliance with this Section for as long as the mining industry off-road motor vehicle waste tires remain in the burial cell.

**Historical Note**

Section recodified from A.A.C. R18-8-703, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-1204. Annual Report**

By March 30 of each year, until a burial cell closure certification is filed with the Department, the operator of the mining facility shall file an annual report with the Director which documents the location of each burial cell established during the preceding calendar year, the alphabetical or numerical identifier of each burial cell, and the number of off-road motor vehicle waste tires which were placed in each burial cell for burial during the preceding calendar year. If no tires were placed in the burial cell for burial during the preceding year, the annual report shall so indicate.

**Historical Note**

Section recodified from A.A.C. R18-8-704, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-1205. Burial Cell Closure Certification**

An operator shall file with the Director a burial cell closure certification within 30 days after placing final cover over the mining waste tires under R18-13-1203(B). The certificate shall contain a statement by the operator that no additional tires will be buried in the burial cell and a statement by an Arizona registered engineer certifying that the cover requirements of R18-13-1203 have been met.

**Historical Note**

Section recodified from A.A.C. R18-8-705, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final rulemaking at 7 A.A.R. 5695, effective November 27, 2001 (Supp. 01-4).

**R18-13-1206. Storage**

At no time shall more than 500 mining industry off-road motor vehicle waste tires be stored at the mining facility outside of a burial cell unless the mining facility has Department approval to operate a waste tire collection facility, pursuant to A.R.S. §§ 44-1304 and 49-762.

**Historical Note**

Section recodified from A.A.C. R18-8-706, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-1207. Maintenance of Records**

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For at least three years after the burial cell closure certification is filed with the Department, the mining facility operator shall maintain, at the mining facility, records which document the number of tires buried in each cell.

**Historical Note**

Section recodified from A.A.C. R18-8-707, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-1208. Inspections**

The Department may inspect a mining facility, during regular operating hours, to determine whether mining industry off-road motor vehicle waste tire burial is in compliance with this Article.

**Historical Note**

Section recodified from A.A.C. R18-8-708, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-1209. Repealed****Historical Note**

Section recodified from A.A.C. R18-8-709, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Section repealed by final rulemaking at 7 A.A.R. 5695, effective November 27, 2001 (Supp. 01-4).

**R18-13-1210. Waste Tire Cover**

Waste tires used as cover at a solid waste landfill shall be used according to the solid waste facility plan required by A.R.S. § 49-762. An operator shall not permit mining waste tires to be used as cover at a solid waste landfill for more than two consecutive days at a time.

**Historical Note**

Section recodified from A.A.C. R18-8-710, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final rulemaking at 7 A.A.R. 5695, effective November 27, 2001 (Supp. 01-4).

**R18-13-1211. Registration of New Waste Tire Collection Sites; Fee**

- A. A new waste tire collection site shall not begin operation until the owner or operator registers with the Department. The owner or operator shall register on a form approved by the Department that includes a statement that the site is in compliance with A.R.S. § 49-762.07(F) and A.R.S. Title 44, Chapter 9, Article 8, as applicable. The owner or operator of a new waste tire collection site shall pay an initial registration fee of \$2,400 within 30 days of invoice receipt.
- B. The owner or operator shall pay a \$2,000 registration fee annually thereafter within 30 days of invoice receipt.
- C. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (A) and (B) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
  1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (C)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage

and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1212. Registration of Outdoor Used Tire Sites; Fee**

- A. A person shall not store 100 or more used tires outdoors until the person registers with the Department. A person that stores 100 or more used tires outdoors shall pay an initial registration fee of \$1,800 within 30 days of invoice receipt. The person shall register on a form approved by the Department that includes a statement that the site is in compliance with A.R.S. § 49-762.07(F) and A.R.S. Title 44, Chapter 9, Article 8, as applicable.
- B. A \$1,500 registration fee shall be paid annually thereafter within 30 days of invoice receipt.
- C. For the purposes of this Section:
  1. "Used tire" means any tire which has been used for more than one day on a motor vehicle.
  2. "Outdoors" means other than inside a building with a weatherproof roof.
- D. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (A) and (B) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
  1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (D)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1212.01. Waste Tire Collection Site Subject to Plan Approval; Fees**

- A. Initial registration. A waste tire collection site that is required to obtain plan approval under A.R.S. § 49-762(A)(7) shall not begin operation until the owner or operator registers with the Department on a form approved by the Department.
- B. Annual registration fee. The Department shall bill an annual registration fee of \$5,000 to a registered waste tire collection site that is required to obtain plan approval under A.R.S. § 49-762(A)(7) that has not filed a notice of termination of registration with the Department. The owner or operator of the waste tire collection site that is required to obtain plan approval under A.R.S. § 49-762(A)(7) shall pay the annual registration fee within 30 days of invoice receipt.
- C. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (B) of this Section annually by the fol-



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lowing method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:

1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
2. Round the result from subsection (C)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1213. Facilities Subject to More Than One Tire Site Registration; Single Fee**

A person who is required to register a tire facility under more than one of the Sections listed in subsections (1) through (4) shall register and follow procedures under each Section, but is only required to pay the registration fees under the Section with the highest fees.

1. R18-13-1211.
2. R18-13-1212.
3. R18-13-1212.01.
4. R18-13-501.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**ARTICLE 13. SPECIAL WASTE AND BEST MANAGEMENT PRACTICES FOR SHREDDER RESIDUE****R18-13-1301. Definitions**

In addition to the terms prescribed in A.R.S. § 49-851, the terms in this Article shall have the following meanings:

1. "Disposal" means discharging, depositing, injecting, dumping, spilling, leaking, or placing special waste into or on land or water so that the special waste or any constituent of the special waste may enter the environment, be emitted into the air, or discharged into any waters, including groundwater.
2. "Exception report" means a report that a generator shall submit to the Director which notifies the Director that the generator has not received a copy of the special waste manifest from the primary or alternate special waste receiving facility to which the special waste was sent pursuant to the generator's instructions on the special waste manifest, or from any special waste receiving facility to which special waste was sent.
3. "Generator" means a person whose act or process onsite produces a special waste listed in, or designated pursuant to, A.R.S. §§ 49-852, 49-854, and 49-855, or whose act or process first causes such special waste to be subject to regulation.
4. "Identification number" means an alphanumeric identifier issued by the Department to each generator, special shipper, and special waste receiving facility to be used on documents, as required pursuant to this Article, in conjunction with shipment of special waste.

5. "Off-site consignment" means a generator's delivery of materials or wastes for transport off-site to a special waste receiving facility within Arizona for treatment, storage, recycling, or disposal.
6. "Off-site" means any property located within Arizona that is not onsite as defined in A.R.S. § 49-851(3).
7. "Operator" means a person who owns and controls all or part of a special waste receiving facility, or who leases, operates, or controls such facility, a person responsible for the overall operation of such a facility, a management agency, or an authorized representative.
8. "Recycling" means recycling as defined in A.R.S. § 49-831(21).
9. "Shredder residue" means waste from the shredding of motor vehicles.
10. "Significant manifest discrepancy" means a difference of more than 10% by weight for bulk shipments, any variation in a piece count for a batch delivery, or any difference in the type of special waste received as compared to the type of special waste listed on the manifest.
11. "Special waste receiving facility" means an off-site location to which special waste is sent to be treated, recycled, stored, or disposed.
12. "Special waste manifest" means a form provided by the Department, shown as Appendix B to this Article, and used to identify the origin, quantity, composition, routing, and destination of special waste during its transportation from a generator's facility to a special waste receiving facility.
13. "Special waste shipper" means a person who transports special waste for off-site treatment, recycling, storage, or disposal.
14. "Treatment" means any method, technique, or process designed to change the physical, chemical, or biological character or composition of special waste.

**Historical Note**

Section recodified from A.A.C. R18-8-301, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1302. Special Waste Generator Manifesting Requirements**

- A. A generator shall request a generator identification number on a form provided by the Director, and shown as Appendix A to this Article, prior to shipping special waste. Within 30 days of receiving the completed form, the Director shall issue the identification number to the generator.
- B. Prior to off-site consignment of special waste, the generator shall do all of the following:
  1. Complete and sign the "Generator" section of a special waste manifest.
  2. Obtain the handwritten signature of the special waste shipper on the special waste manifest.
  3. Retain the generator's copy of the special waste manifest.
  4. Give the special waste manifest and the remaining attached copies to the special waste shipper or forward it to the receiving facility.
- C. Within 14 days after shipment was accepted by a special waste shipper for off-site consignment, the generator shall submit to the Director one legible copy of each special waste manifest with the generator's section completed and containing signatures of the generator and special waste shipper.

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- D. If, within 35 days after the date the waste was accepted by the initial special waste shipper, the generator does not receive a completed copy of this special waste manifest with the handwritten signature of the special waste receiving facility operator, the generator shall contact the special waste shipper and the special waste receiving facility operator to determine the status of the special waste.
- E. The generator shall submit an exception report to the Director if the generator does not receive a completed, signed, legible copy of the special waste manifest within 45 days of the date the waste was accepted by the initial special waste shipper for off-site consignment. The exception report shall contain both of the following:
  1. A cover letter, signed by the generator, which explains the efforts made to locate the special waste and the results of those efforts.
  2. A legible copy of the special waste manifest which was signed by the generator and the special waste shipper and retained by the generator.
- F. The generator shall retain a legible copy of each signed special waste manifest for at least three years from the date of acceptance of a shipment of special waste for off-site consignment.
- G. If a person is required to have a manifest, shipping paper or shipping record under federal law for the special waste, the federal manifest, shipping paper, or shipping record may be used in lieu of the Arizona special waste manifest form so long as the federal manifest, shipping paper, or shipping record includes all the information required on the Arizona special waste manifest form.

**Historical Note**

Section recodified from A.A.C. R18-8-302, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1303. Special Waste Shipper Manifesting Requirements**

- A. A special waste shipper who receives special waste in Arizona for transport to a special waste receiving facility in Arizona shall request a special waste shipper identification number on a form provided by the Director and shown as Appendix A to this Article. The Director shall issue an identification number within 30 days of receipt of the completed form.
- B. A special waste shipper shall:
  1. Accept special waste for intrastate shipment to a special waste receiving facility only if the waste is accompanied by a special waste manifest which is completed and signed in accordance with the provisions of R18-13-1302.
  2. Deliver the entire shipment of special waste to a special waste receiving facility as designated on the special waste manifest. If unable to deliver the special waste to the primary or alternate special waste receiving facility designated on the special waste manifest:
    - a. Return the special waste to the generator, or
    - b. Contact the generator and obtain instructions for an alternate special waste receiving facility and deliver the waste accordingly.
- C. Shipments of special waste between facilities owned by the same generator shall be exempt from the requirements of rules adopted pursuant to A.R.S. § 49-856.

**Historical Note**

Section recodified from A.A.C. R18-8-303, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1304. Special Waste Receiving Facility Manifesting Requirements**

- A. A special waste receiving facility shall request an identification number on a form provided by the Director, and shown as Appendix A to this Article, and obtain the number prior to receiving special waste. The Department shall issue the identification number within 30 days of receipt of the completed form.
- B. A special waste receiving facility shall receive only special waste for which it has a special waste manifest signed and dated by the generator and special waste shipper. In the "Facility" section of the special waste manifest, the operator of the special waste receiving facility shall do all of the following:
  1. Enter the identification number.
  2. Sign and date each copy of a special waste manifest to certify that the type and amount of special waste, as stated on the special waste manifest, was received.
  3. Indicate on the special waste manifest any significant discrepancies between the description, volume, or weight of the special waste as stated on the special waste manifest and the special waste received.
- C. After completing the "Facility" portion of the special waste manifest, the operator of the special waste receiving facility shall send one legible copy each of the signed special waste manifest to the Director and the generator within 30 days of the delivery of the special waste.
- D. Upon discovery of a significant manifest discrepancy in the special waste manifest and the special waste received, the operator of the special waste receiving facility shall:
  1. Contact the generator and special waste shipper to attempt to reconcile the discrepancy.
  2. If the discrepancy cannot be resolved within 15 days after receiving the waste, submit a letter to the Director, along with the special waste manifest within five days. The letter shall describe the significant manifest discrepancy and all attempts to reconcile it.

**Historical Note**

Section recodified from A.A.C. R18-8-304, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1305. Records**

All records required by this Article shall be retained for at least three years. If notification of an enforcement action by the Department has been received, the records shall be retained until a final determination has been made in the matter or in accordance with the final determination.

**Historical Note**

Section recodified from A.A.C. R18-8-305, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**R18-13-1306. Fees**

- A. Initial registration fee. Upon making a request for a special waste identification number on a form as provided by the Director, and shown as Appendix A to this Article, an appli-

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cant shall submit to the Department an initial registration fee for each operation as follows:

1. For a generator of shredder residue, \$3,600; and
  2. For a special waste shipper, \$1,800.
- B.** Annual registration fee. The Department shall bill an annual registration to a generator of shredder residue, a special waste receiving facility, and a special waste shipper that has a special waste identification number that has not filed a notice of termination of registration with the Department for each operation as follows:
1. For a generator of shredder residue, \$3,000;
  2. For a special waste receiving facility, \$5,000; and
  3. For a special waste shipper, \$1,500.
- C.** A generator of shredder residue, special waste receiving facility, or special waste shipper shall pay the annual registration fee within 30 days of invoice receipt.
- D.** In accordance with A.R.S. § 49-855(G), a solid waste landfill that pays registration fees under A.R.S. § 49-747 is exempt from the fees under subsections (A) and (B) of this Section.
- E.** Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (A) and (B) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (E)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1307. Best Management Practices for Waste from Shredding Motor Vehicles; Fees**

- A.** A generator of shredder residue shall follow sampling protocol as follows or submit to the Department for review and approval, at least two weeks prior to the sampling event, an alternative written sampling plan which is consistent with requirements set forth in "Test Methods for Evaluating Solid Waste," EPA SW-846, 3rd Edition, Volume II, Chapter Nine, Sampling Plan, Physical/Chemical Method, EPA, Office of Solid Waste and Emergency Response, Washington, D.C., September 1986, and updated November 1990, and no future editions or amendments, ("EPA Sampling Plan"), herein incorporated by reference and on file with the Department and the Office of the Secretary of State:
1. Sample collection shall be done in accordance with one of the following:
    - a. Sampling procedure 1, consisting of both of the following steps:
      - i. The generator shall collect samples from a shredder residue sampling pile which shall consist of the average amount of shredder residue from eight hours of operation of the shredder. The shredder residue sampling pile shall be formed into a square shape for sampling purposes. Refer to Exhibit 1.
      - ii. One 2,000-gram sample shall be collected from each sample point as indicated in Exhibit 1. Samples from sample points A-1, B-1, and C-1 shall be collected from the top of the pile. Samples from sample points A-2, B-2, and C-2 shall be collected from the base of the pile. A sample from sample point C-3 shall be collected at the vertical midpoint at the center of the pile. The seven 2,000-gram samples shall be numbered consecutively. Three of the seven 2,000-gram samples shall then be chosen at random by selecting numbers from a calculator programmed to generate random numbers. The samples shall be analyzed for the constituents and at the frequencies listed in Table A of this Section.
  - b. Sampling procedure 2, consisting of both of the following steps:
    - i. The generator shall collect seven 2,000-gram samples during or immediately following the normal generation of shredder residue. For each sample, shredder residue shall be collected for 8 to 12 minutes, during which a minimum of 500 pounds shall be generated. This process shall be performed seven times to create seven 500-pound amounts. Each 500-pound amount shall be formed into a square shape for sampling purposes. Refer to Exhibit 1.
    - ii. Twenty 100-gram samples shall be collected from throughout each of the seven 500-pound piles generated. Upon completion of collection, all 20 samples from each of the seven 500-pound piles shall be combined together into seven separate 2,000-gram samples and numbered consecutively. Three of the seven 2,000-gram samples shall then be chosen at random by selecting numbers from a calculator programmed to generate random numbers. The samples shall be analyzed for the constituents and at the frequencies listed in Table A of this Section.
2. Each 2,000 grams of shredder residue collected shall include both large and small particles, in proportion to shredder residue generated. The generator shall use a container which is large enough to hold the entire amount of shredder residue collected from each sample point.
3. The generator shall comply with requirements for sample preservation, temperature, and holding times, as set forth in the EPA Sampling Plan.
4. Each one of the three 2,000-gram samples selected at random shall be divided into four equal 500-gram portions and a 200-gram subsample shall be taken from each of the four equal 500-gram portions. Each subsample shall then be passed through a 9.5mm screen. All particles which do not pass through the 9.5mm screen shall be hand cut until small enough to pass through the screen. All four 200-gram subsamples shall then be remixed together and redivided into four equal 200-gram portions. The following amounts shall be taken for constituent sampling:
  - a. 10-15 grams per 200-gram subsample for a total of 40-60 grams per 2,000-gram sample for Polychlori-

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nated Biphenyls (PCB) analysis as set forth in subsection (A)(10).

- b. 25 grams per 200-gram subsample for a total of 100 grams per sample for toxicity characteristic leaching procedure extractions for contaminants as set forth in 40 CFR 261.24, Table 1 (incorporated by reference in R18-8-261(A)), as set forth in subsection (A)(7).
  - c. 1.25 grams per 200-gram subsample for a total of 5 grams per 2,000-gram sample for extraction fluid determination.
5. Each constituent sample shall be put into a container. Container labeling and chain-of-custody documentation shall be consistent with the requirements in the EPA Sampling Plan.
  6. The constituent samples shall be analyzed by a laboratory licensed by the Arizona Department of Health Services in accordance with A.R.S. § 36-495.
  7. Of the three samples selected at random, one sample amount required by subsection (A)(4)(b) shall be analyzed for the extractable heavy metals arsenic, barium, cadmium, chromium, lead, mercury, selenium, and silver, as set forth in 40 CFR 261.24, Table 1. The remaining two samples shall each be analyzed for extractable cadmium and lead.
  8. If the results of all three of the analyses for any extractable heavy metal in subsection (A)(7) are below the Regulatory Level of the Maximum Concentration of Contaminants for the Toxicity Characteristic as set forth in 40 CFR 261.24, Table 1, the simple arithmetic mean of the extractable cadmium and lead and the single analysis for the remaining six extractable heavy metals shall be used to determine if the sampled shredder residue will be classified as hazardous waste.
  9. If the analyses of any one of three selected samples exceeds the regulatory level as set forth in 40 CFR 261.24, Table 1, an additional subsample from the sample in question shall be subjected to confirmation analysis. If the confirmation sample analysis totals are in excess of the regulatory level as set forth in 40 CFR 261.24, Table 1, the remaining four of the original seven samples shall be analyzed for those extractable heavy metals which exceed the regulatory level as set forth in 40 CFR 261.24, Table 1. The simple arithmetic mean of the results of all seven samples shall be used to determine if the sampled shredder residue will be classified as hazardous waste.
  10. The three samples selected at random shall be analyzed for PCB concentration in the amounts required by subsection (A)(4)(a). If the samples contain concentrations of PCB less than 50 mg/kg, the simple arithmetic mean of the three samples shall be used for reporting to the Director. If any one of the three samples contains concentrations of PCB greater than 50 mg/kg, an additional subsample from the sample in question shall be subjected to confirmation analysis. If the PCB concentration for that sample exceeds 50 mg/kg, the remaining four of the original seven samples shall be analyzed for PCB, in amounts required by subsection (A)(4)(a), and the simple arithmetic mean of all the samples shall be used to determine if the sampled shredder residue will be classified as hazardous waste.
- B.** Shredder residue determined to be hazardous waste shall be managed in accordance with A.R.S. § 49-921 et seq. and R18-8-260 et seq.
- C.** The generator shall do all of the following:
1. Secure the facility to prevent unauthorized entry;
  2. Cover or otherwise manage the shredder residue pile to prevent wind dispersal;
  3. Place the shredder residue pile on a surface with a permeability coefficient equal to or less than  $1 \times 10^{-7}$  cm/s;
  4. Design, construct, operate, and maintain a run-on control system capable of preventing flow onto the waste pile during peak discharge from, at a minimum, a 25-year storm;
  5. Design, construct, operate, and maintain a run-off management system to collect and control at a minimum, the water volume resulting from a 24-hour, 25-year storm;
  6. Provide collection and holding facilities for run-on and run-off control systems, which shall have a permeability coefficient equal to or less than  $1 \times 10^{-7}$  cm/s;
  7. Record the date accumulation of shredder residue begins.
- D.** Shredder residue shall be treated, recycled, sorted, stored, or disposed at a Department-approved special waste facility approved in accordance with A.R.S. § 49-857. A facility which seeks to become a special waste facility shall submit a special waste management plan to the Department to ensure compliance with subsection (C).
- E.** A generator shall not store shredder residue for longer than 90 days. A special waste facility shall not store shredder residue for longer than one year.
- F.** Shredder residue which has been determined to be nonhazardous pursuant to this Section shall be transported in accordance with the requirements for transportation of garbage as set forth in R18-13-310.
- G.** The owner or operator of a special waste facility shall pay, to the Department, the fees required by A.R.S. §§ 49-855(C)(2) and 49-863 as follows:
1. \$6.68 per ton of shredder residue received; and
  2. Not more than \$66,835.67 per generator site per year for shredder residue that is transported to a facility regulated by the Department for treatment, storage or disposal.
- H.** Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (G) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (H)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

Section recodified from A.A.C. R18-8-307, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

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**Table A. Target Analyses and Sampling Frequency**

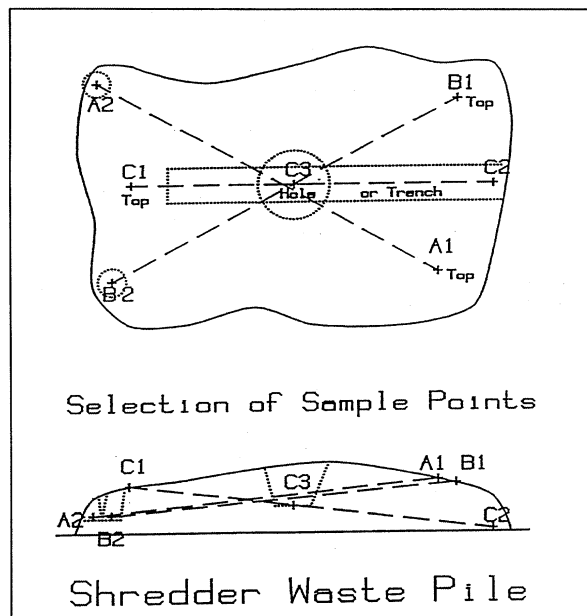
Constituents	Frequency
* TCLP Metals	Quarterly
* TCLP Volatiles	Annually
* TCLP Semi-volatiles	Annually
Polychlorinated Biphenyls (PCB)	Quarterly

\* Toxicity Characteristic Leaching Procedure (TCLP)

**Historical Note**

Table A recodified from 18 A.A.C. 8, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**Exhibit 1. Selection of Sample Points, Shredder Waste Pile**



**Historical Note**

Exhibit 1 recodified from 18 A.A.C. 8, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

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## Appendix A. Application for Arizona Special Waste Identification Number

Please refer to the instructions on the accompanying page before completing this form.	<h1 style="margin: 0;">ADEQ</h1>	Application for Arizona Special Waste Identification Number	Date Received: (Do not write here official use only)
1. Mark Appropriate Box: <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span><input type="checkbox"/> Generator</span> <span><input type="checkbox"/> Shipper</span> <span><input type="checkbox"/> Receiving Facility</span> <span><input type="checkbox"/> Multiple</span> </div>			
2. Company/Agency Name			
3. Company/Agency Address (Physical Address, not P.O. Box or Route Number).			
4. Company/Agency Mailing Address (If different than above).			
5. Company/Agency Contact (Person to contact regarding special waste activities). Name:			
<div style="display: flex; justify-content: space-between; margin-top: 20px;"> <span>Job Title:</span> <span>Phone Number: (   )</span> </div>			
6. Company/Agency Contact Address.			
7. Name and Address of Company's/Agency's Legal Owner.   <div style="margin-top: 20px;">Phone Number: (   )</div>			
Certification: I certify under penalty of law that I have personally examined and am familiar with the information submitted in this form and that, based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of civil penalties.			
<div style="display: flex; justify-content: space-between;"> <span>8. Signature:</span> <span>9. Name and Official Title: (Type or Print)</span> <span>10. Date Signed:</span> </div>			
11. Please list special wastes generated, transported, stored, or received by applicant.			

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**Instructions for the Completion of the ADEQ Application for the Arizona Special Waste Identification Number.**

1. Place an "X" in the appropriate box indicating which type of operation you will be performing.
2. Enter the complete company/agency name.
3. Enter the complete address. Do not use P.O. Box or Route Number.
4. Enter the complete address if it is different than the address listed in item 3.
5. Enter the name, job title, and complete phone number of the person who will act as the company/agency contact.
6. Enter the complete address of the company/agency contact listed in item 5.
7. Enter the name, complete address, and phone number of the company's/agency's legal owner.
8. Enter the signature of the person who will assume the responsibility of completion of this form and its contents.
9. Enter the name and title of the responsible person listed in item 8.
10. Enter the date that the responsible person signed the document.
11. List all special wastes that the applicant generates, transports, stores, or receives.

**Historical Note**

Appendix A recodified from 18 A.A.C. 8, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

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## Appendix B. Special Waste Manifest

ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY  
SPECIAL WASTE MANIFEST

G e n e r a t o r	1. Generator's AZ ID No.		Emergency Response Notification Phone Number		
	3. Generator's Name and Mailing Address				
	Generator's Phone Number and Area Code				
	4. Transporter 1 Company Name and Mailing Address		Transporter's AZ ID No.		
			Transporter's Phone No.		
	5. Transporter 2 Company Name and Mailing Address		Transporter's AZ ID No.		
			Transporter's Phone No.		
	6. Primary Receiving Facility Name and Address (physical site location, if different)		Facility's AZ ID No.		
			Facility's Phone No.		
	7. Alternate Receiving Facility Name and Address (physical site location, if different)		Facility's AZ ID No.		
		Facility's Phone No.			
	8. U.S. DOT description, (if applicable) (Non-DOT regulated materials enter shipping name, physical state and description of all contents of waste)		Containers No.	Total Quantity	Unit Wt/Vol
			Mark "X" if Haz Mat		
9. Additional information on transportation, treatment, storage, or disposal					
10. GENERATOR'S CERTIFICATION: I hereby declare that the contents of this consignment are fully and accurately described above by proper shipping name and are classified, packed, marked, and labeled and are in all respects in proper condition for transport by highway according to applicable international and governmental regulations.					
Printed/Typed Name				Signature	
T r a n s p o r t	11. Transporter 1 Acknowledgment of Receipt of Materials				Date
	Printed/Typed Name		Signature		
	12. Transporter 2 Acknowledgment of Receipt of Materials				Date
	Printed/Typed Name		Signature		
F a c i l i t y	13. Discrepancy Indication Space				
	14. Facility Owner or Operator: Certification of receipt of special waste materials covered by this manifest except as noted in above item.				
	Printed/Typed Name				Signature



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**Instructions for the Completion of the ADEQ Special Waste Manifest**

1. Enter the generator's Arizona Identification Number in box 1.
2. Enter the Emergency Response Notification Phone Number in box 2.
3. Enter the generator's name and complete mailing address, including city, state, and zip code, along with the generator's phone number, including the area code, in box 3.
4. Enter the transporter's name, transporter's Arizona identification number, and telephone number, including the area code, in box 4.
5. Complete this box if a second transporter is to be used to transport the special waste to the receiving facility, following the instructions outlined in number 4 in box 5.
6. Enter the name, address, and physical site location of the primary special waste receiving facility. In the appropriate spaces, include the facility's Arizona identification number and the telephone number, including the area code, in box 6.
7. Enter the name, address, and physical site location of the alternate special waste receiving facility. In the appropriate spaces, include the facility's Arizona identification number and the telephone number, including the area code, in box 7.
8. Enter United States Department of Transportation description (Including proper shipping name, hazard class, and identification number, if applicable) (For all non-Department of Transportation-regulated materials, enter the proper name, physical state, and description of all contents of the waste).

Mark an "X" in this column if waste is classified as a hazardous material.

Container Number

Enter the number of containers being shipped for each waste.

Total Quantity

Numerical value representing the number of containers multiplied by the container size. Answer will be listed in pounds, gallons, or cubic yards.

Unit weight or volume

P - Pounds

G - Gallons

Y - Cubic Yards

9. Use this space to indicate special transportation, treatment, storage, or disposal information. Emergency response telephone numbers or similar information may be included here in box 9.
10. Print or type the generator's name followed by their signature and date in box 10.
11. Print or type the primary transporter's name followed by their signature and date in box 11.
12. Print or type the secondary transporter's name followed by their signature and date in box 12.
13. Indicate significant discrepancies in this box. Significant manifest discrepancy is defined as "a difference of more than 10% by weight for bulk shipments, any variation in a piece count for batch deliveries, or an obvious difference in a special waste type is discovered by inspection or analysis between the type or amount of a special waste designated in a special waste manifest, and the type or amount received by a special waste receiving facility" in box 13.
14. Print or type the receiving facility's owner or operator name followed by their signature and date in box 14.

**Historical Note**

Appendix B recodified from 18 A.A.C. 8, Article 3, filed in the Office of the Secretary of State September 29, 2000 (Supp. 00-3).

**ARTICLE 14. BIOHAZARDOUS MEDICAL WASTE AND DISCARDED DRUGS****R18-13-1401. Definitions**

In addition to the definitions in A.R.S. § 49-701, the following definitions apply in this Article:

1. "Alternative treatment technology" means a treatment method other than autoclaving or incineration that achieves the treatment standards described in R18-13-1415.
2. "Approved medical waste facility plan" means the document that has been approved by the Department under A.R.S. § 49-762.04, and that authorizes the operator to accept biohazardous medical waste at its solid waste facility.
3. "Autoclaving," means using a combination of heat, steam, pressure, and time to achieve sterile conditions.
4. "Biohazardous medical waste" is composed of one or more of the following:
  - a. Cultures and stocks: Discarded cultures and stocks generated in the diagnosis, treatment or immunization of a human being or animal or in any research relating to that diagnosis, treatment or immunization, or in the production or testing of biologicals.
  - b. Human blood and blood products: Discarded products and materials that are saturated and/or dripping with human blood or caked with dried human blood, including items that would release blood in a liquid or semi-liquid form if compressed or broken, and items that contain serum, plasma, and other blood components. An item would be considered caked if it could release flakes or particles when handled.
  - c. Human pathological wastes: Discarded organs, tissues, and body parts, including cerebrospinal fluid,

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- synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid and amniotic fluid, removed during surgery or other medical procedures, including autopsy, obstetrics, or emergency care. Human pathological wastes do not include the head, spinal column, hair, nails, or teeth.
- d. Medical sharps: Discarded sharps that pose a stick hazard that have come into contact with blood, blood products, or pathological waste. Examples include hypodermic needles; scalpel blades; and needles attached to tubing or syringes.
  - e. Research animal wastes: Animal carcasses, body parts, and bedding of animals that have been infected with agents that produce, or may produce, human infection.
  - f. Tattoo and body modification waste: any waste generated during the course of physically altering a human being, including tattooing, ear piercing, or any other process where a foreign object is used to cut or pierce the skin.
  - g. Trauma scene waste: any crime scene, accident, or trauma clean-up wastes generated by individuals or commercial entities hired to clean crime scenes or accidents, such as sharps and materials that contain human blood and blood products.
5. "Biologicals" means preparations made from living organisms or their products, including vaccines, cultures, or other biological products intended for use in diagnosing, immunizing, or treating humans or animals or in research pertaining to these activities.
  6. "Biological indicator" means a representative microorganism used to evaluate treatment efficacy.
  7. "CFR" means the Code of Federal Regulations.
  8. "Chemotherapy waste" means any discarded material that has come in contact with an agent that kills or prevents the reproduction of malignant cells.
    - a. Trace contaminated chemotherapy waste includes: masks, empty drug vials, gloves, gowns, IV tubing, empty IV bags/bottles, and spill clean-up materials.
    - b. Bulk chemotherapy waste, such as full expired vials of chemotherapy drugs, is not biohazardous medical waste. Bulk chemotherapy waste may be considered hazardous wastes and must be handled according to the hazardous waste regulations if deemed a hazardous waste by the generator.
  9. "Dedicated vehicle" means a motor vehicle or trailer that is pulled by a motor vehicle used by a transporter for the purpose of transporting biohazardous medical waste in conjunction with other compatible waste according to the USDOT requirements, listed at 49 CFR 177.848, revised as of October 1, 2020, and no future editions or later amendments, is incorporated by reference in this Section and on file with ADEQ.
  10. "Department-approved facility" means a storage, transfer, treatment, or disposal facility that has undergone plan approval as described in R18-13-1410.
  11. "Discarded drug" means any prescription medicine or over-the-counter medicine used in the diagnosis, treatment, or immunization of a human being or animal, that the generator intends to abandon. The term does not include hazardous waste or controlled substances regulated by the United States Drug Enforcement Agency.
  12. "Disposal facility" means a municipal solid waste landfill that has been approved by the Department under A.R.S. § 49-762.04 to accept untreated biohazardous medical waste for disposal.
  13. "Emergency situations" include those situations where following location restrictions may result in an imminent threat to human health and the environment.
  14. "Facility plan" has the meaning given to it in A.R.S. § 49-701.
  15. "Generator" means a person whose act or process produces biohazardous medical waste, or a discarded drug, or whose act first causes medical waste or a discarded drug to become subject to regulation.
  16. "Hazardous waste" has the meaning prescribed in A.R.S. § 49-921.
  17. "Health care worker" means, with respect to R18-13-1403(B)(5), a person who provides health care services at an off-site location that is none of the following: a residence, a facility where health care is normally provided, or a facility licensed by the Arizona Department of Health Services.
  18. "Improper disposal of biohazardous medical waste" means the disposal by a person of untreated or inadequately treated biohazardous medical waste at any place that is not approved to accept untreated biohazardous medical waste.
  19. "Independent testing laboratory" means a testing laboratory independent of oversight activities by a provider of alternative treatment technology.
  20. "Medical sharps container" means a vessel that is rigid, puncture resistant, leak proof, and equipped with a cap capable of being securely closed.
  21. "Medical waste," as defined in A.R.S. § 49-701, means *"any solid waste which is generated in the diagnosis, treatment or immunization of a human being or animal or in any research relating to that diagnosis, treatment or immunization, or in the production or testing of biologicals, and includes discarded drugs but does not include hazardous waste as defined in A.R.S. § 49-921 other than conditionally exempt small quantity generator waste."*
  22. "Medical waste treatment facility" or "treatment facility" means a solid waste facility approved by the Department under A.R.S. § 49-762.04 to accept and treat biohazardous medical waste from off-site generators.
  23. "Multi-purpose vehicle" means any motor vehicle operated by a health care worker in the course of providing health care services, where the general purpose is the non-commercial transporting of people and the hauling of goods and supplies, but not solid waste. A multi-purpose vehicle is limited to hauling biohazardous medical waste generated at a location other than a hospital or clinic.
  24. "Off site" means a location that does not fall within the definition of "on site" contained in A.R.S. § 49-701.
  25. "Packaging" or "properly packaged" means the use of a container or a practice under R18-13-1407.
  26. "Putrescible waste" means waste materials capable of being decomposed rapidly by microorganisms.
  27. "Radioactive material" has the meaning under A.R.S. § 30-651.
  28. "Secure" means to lock out or otherwise restrict access to unauthorized personnel.
  29. "Spill" means either of the following:
    - a. Any release of biohazardous medical waste from its package while in the generator's storage area.
    - b. Any release of biohazardous medical waste from its package or the release of packaged biohazardous

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medical waste by the transporter at a place or site that is not a medical waste treatment or disposal facility.

30. "Store" or "storage" means, in addition to the meaning under A.R.S. § 49-701, either of the following:
  - a. The temporary holding of properly packaged biohazardous medical waste by a generator in a designated accumulation area awaiting collection by a transporter.
  - b. The temporary holding of properly packaged biohazardous medical waste by a transporter or a treater at an approved medical waste storage facility or treatment facility.
31. "Technology provider" means a person that manufactures or a vendor who supplies alternative medical waste treatment technology.
32. "Tracking document" means the written instrument that signifies acceptance of biohazardous medical waste by a transporter, or a transfer, storage, treatment, or disposal facility operator.
33. "Transportation management plan" means the transporter's written plan consisting of both of the following:
  - a. The procedures used by the transporter to minimize the exposure to employees and the general public to biohazardous medical waste throughout the process of collecting, transporting, and handling.
  - b. The emergency procedures used by the transporter for handling spills or accidents.
34. "Transporter" means a person engaged in the business of hauling of biohazardous medical waste from the point of generation to a Department-approved storage facility or to a Department-approved treatment or disposal facility.
35. "Treat" or "treatment" means, with respect to the methods used to render biohazardous medical waste less infectious: incinerating, autoclaving, or using the alternative treatment technologies prescribed in this Article.
36. "Treated medical waste" means biohazardous medical waste that has been treated and that meets the treatment standards of R18-13-1415. Treated medical waste that requires no further processing is considered solid waste.
37. "Treater" means a person, also known as an operator, who receives solid waste facility plan approval for the purpose of operating a medical waste treatment facility to treat biohazardous medical waste that is generated off site.
38. "Treatment certification statement" means the written document provided by either a generator who treats biohazardous medical waste on site or by a treater to inform a solid waste disposal or recycling facility that biohazardous medical waste has been treated as prescribed in this Article, and therefore is no longer subject to regulation under this Article.
39. "Treatment standards" mean the levels of microbial inactivation, prescribed in R18-13-1415, to be achieved for a specific type of biohazardous medical waste.
40. "USDOT" means the United States Department of Transportation.
41. "Universal biohazard symbol" or "biohazard symbol" means a representation that conforms to the design shown in 29 CFR 1910.145(f)(8)(ii) (Office of the Federal Register, National Archives and Records Administration, July 1, 1998) and which is incorporated by reference in this rule. This incorporation does not include any later amendments or editions. Copies of the incorporated

material are available for inspection at the Department of Environmental Quality and the Office of the Secretary of State.

42. "Vehicle not dedicated to the transportation of biohazardous medical waste but which is engaged in commerce" means a motor vehicle or a trailer pulled by a motor vehicle whose primary purpose is the transporting of goods that are not solid waste or biohazardous medical waste and that is used by a transporter for the temporary transportation of biohazardous medical waste.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1402. Applicability**

- A. This Article applies to the following:
  1. A generator who treats biohazardous medical waste on site, before disposing of it as treated medical waste, and to any equipment used for that purpose. Specific requirements for a generator who treats on site are prescribed in R18-13-1405.
  2. A generator who contracts with a medical waste treatment facility for the purpose of treating biohazardous medical waste. Specific requirements for such a generator are prescribed in R18-13-1406.
  3. A person who transports biohazardous medical waste and any motor vehicle used for that purpose.
  4. A medical waste treatment facility operator, a medical waste treatment facility, and any equipment used for medical waste treatment.
  5. A person who provides alternative medical waste treatment technology for the purpose of treatment, and to any technology used for treatment.
  6. A person in possession of biohazardous medical waste if the waste does not meet the treatment standards in R18-13-1415.
  7. An operator of a Department-approved disposal facility who accepts untreated biohazardous medical waste.
  8. A person who generates medical sharps in the preparation of human remains.
  9. A person who generates medical sharps in the treatment of humans or animals.
  10. A generator of discarded drugs not returned to the manufacturer.
- B. The requirements for biohazardous medical waste set out for collection do not apply to the manner in which the generator collects or handles material prior to that material becoming biohazardous medical waste.
- C. Provisions in this Article requiring placement in Department-approved facilities do not restrict the right to place materials in facilities that are out of state or in Indian Country.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1403. Exemptions; Partial Exemptions**

- A. The following persons are exempt from the requirements of this Article:

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1. Law enforcement personnel handling biohazardous medical waste for law enforcement purposes.
  2. A person in possession of medical waste that is regulated by a state or federal agency due to its radioactive nature.
  3. A person who returns unused medical sharps to the manufacturer.
  4. A household generator residing in a private, public, or semi-public residence who generates biohazardous medical waste in the administration of self care or the agent of the household generator who administers the medical care. This exemption does not apply to the facility in which the person resides if that facility is licensed by the Arizona Department of Health Services.
  5. A generator that separates medical devices from the medical waste stream that are sent out for re-processing and returned to the generator.
  6. A person in possession of human bodies regulated by A.R.S. Title 36.
- B.** The following are conditionally exempt from the requirements of this Article:
1. A person who prepares human corpses, remains, and anatomical parts that are intended for interment or cremation. However, medical sharps must be disposed of as prescribed by this Article.
  2. A person who operates an emergency rescue vehicle, an ambulance, or a blood service collection vehicle in the course of providing medical services if the biohazardous medical waste is returned to the home facility for disposal. This facility is considered to be the point of generation for packaging, treatment, and disposal.
  3. A person who discharges liquid and semi-liquid biohazardous medical wastes, excluding cultures and stocks, to the sanitary sewer system if the operator of the wastewater sewer system and treatment facility allows, permits, authorizes, or otherwise approves of the discharges.
  4. Hazardous waste regulated by A.R.S. Title 49, Chapter 5.
  5. A health care worker who uses a multi-purpose vehicle in the conduct of routine health care business other than transporting waste is exempt from the requirements of R18-13-1409 if the health care worker complies with all of the following:
    - a. Packages the biohazardous medical waste according to R18-13-1407.
    - b. Secures the packaged biohazardous medical waste within the vehicle so as to minimize spills.
    - c. Transports the biohazardous medical waste to the place of business or to a medical waste treatment or disposal facility.
    - d. Cleans the vehicle when it shows visible signs of contamination.
    - e. Secures the vehicle to prevent unauthorized contact with the biohazardous medical waste.
  6. A person who transports biohazardous medical waste between multiple properties separated by a public thoroughfare and which is owned or operated by the same owner or governmental entity is exempt from the requirements of R18-13-1409 if the person complies with R18-13-1403(B)(5)(a) through (e).
  7. A hospital that chooses to accept medical sharps from staff physicians who generate medical sharps in a private practice is exempt from the requirement to obtain facility plan approval as long as the hospital collects medical sharps for off-site treatment or disposal.
- C.** The following are exempt from some of the requirements of this Article:
1. A generator who treats biohazardous medical waste on site and who accepts for treatment medical waste described in R18-13-1403(A)(4) is exempt from the requirement to obtain solid waste facility plan approval prescribed in R18-13-1410.
  2. A generator who self-hauls biohazardous medical waste to a Department-approved medical waste treatment, storage, transfer, or disposal facility is exempt from the requirements of R18-13-1409 if the generator complies with R18-13-1403(B)(5)(a) through (e).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).

Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1404. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).

Repealed by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1405. Biohazardous Medical Waste Treated On Site**

- A.** A person who treats biohazardous medical waste on site shall use incineration, autoclaving, or an alternative medical waste treatment method that meets the treatment standards prescribed in R18-13-1415.
- B.** A generator who uses:
1. Incineration shall follow the requirements of subsections (C), (F), (G), and (H),
  2. Autoclaving shall follow the requirements of subsections (D), (F), (G) and (H), or
  3. An alternative treatment method shall follow the requirements of subsections (E), (F), (G), and (H).
- C.** A generator who incinerates biohazardous medical waste on site shall comply with all of the following requirements:
1. Obtain a permit if required by the local or state air quality agency having jurisdiction.
  2. Reduce the biohazardous medical waste, excluding metallic items, into carbonized or mineralized ash.
  3. Determine whether incinerator ash is hazardous waste as required by hazardous waste rules promulgated under A.R.S. Title 49, Chapter 5.
  4. Dispose of the non-hazardous waste incinerator ash at a Department-approved municipal solid waste landfill.
- D.** A generator who autoclaves biohazardous medical waste on site shall comply with all of the following requirements:
1. Further process by grinding, shredding, or any other process, any recognizable animals and human tissue, organs, or body parts, to render such waste non-recognizable and ensure effective treatment.
  2. Operate the autoclave at the manufacturer's specifications appropriate for the quantity and density of the load.
  3. Keep records of operational performance levels for six months after each treatment cycle. Operational performance level recordkeeping includes all of the following:
    - a. Duration of time for each treatment cycle.
    - b. The temperature and pressure maintained in the treatment unit during each cycle.

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- c. The method used to determine treatment parameters in the manufacturer's specifications.
  - d. The method in manufacturer's specifications used to confirm microbial inactivation and the test results.
  - e. Any other operating parameters in the manufacturer's specifications for each treatment cycle.
4. Keep records of equipment maintenance for the duration of equipment use that include the date and result of all equipment calibration and maintenance.
- E.** A generator who uses an alternative treatment method on site shall comply with all of the following requirements:
- 1. Use only alternative treatment methods registered under R18-13-1414.
  - 2. Further process by grinding, shredding, or any other process, any recognizable animals and human tissue, organs, or body parts, to render this waste non-recognizable and ensure effective treatment.
  - 3. Follow the manufacturer's specifications for equipment operation.
  - 4. Supply upon request all of the following:
    - a. The Departmental registration number for the alternative medical waste treatment technology and the type of biohazardous medical waste that the equipment is registered to treat.
    - b. The equipment specifications that include all of the following:
      - i. The operating procedures for the equipment that enable the treater to comply with the treatment standards described in this Article for the type of waste treated.
      - ii. The instructions for equipment maintenance, testing, and calibration that enable the treater to comply with the treatment standards described in this Article for the type of waste treated.
  - 5. Maintain a training manual regarding the proper operation of the equipment.
  - 6. Maintain a treatment record consisting of a log of the volume of medical waste treated and a schedule of calibration and maintenance performed under the manufacturer's specifications.
  - 7. Maintain treatment records for six months after the treatment date for each load treated.
  - 8. Maintain the equipment specifications for the duration of equipment use.
- F.** A generator shall do all of the following:
- 1. Package the treated medical waste according to the waste collection agency's requirements;
  - 2. Attach to the package or container a label, placard, or tag with the following words: "This medical waste has been treated as required by the Arizona Department of Environmental Quality standards" before placing the treated medical waste out for collection as a general solid waste. The generator shall ensure that the treated medical waste meets the standards of R18-13-1415.
  - 3. Upon request of the solid waste collection agency or municipal solid waste landfill, provide a certification that the treated medical waste meets the standards of R18-13-1415.
  - 4. Make treatment records available for Departmental inspection upon request.
- G.** A generator of medical sharps shall handle medical sharps as prescribed in R18-13-1419.
- H.** A generator of chemotherapy waste, cultures and stocks, or animal waste shall handle that waste as prescribed in R18-13-1420.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).

**R18-13-1406. Biohazardous Medical Waste Transported Off Site for Treatment**

- A.** A generator of biohazardous medical waste shall cause the waste to first be packaged as prescribed in this Article and shall subsequently either self-haul or store the waste as provided under R18-13-1408 and set the waste out for collection by a properly licensed transporter under R18-13-1409.
- B.** A generator shall obtain a copy of the tracking document signed by the transporter signifying acceptance of the biohazardous medical waste. A generator shall keep a copy of the tracking document for the period required under the USDOT requirements, as listed in 49 CFR 172.201, revised as of October 1, 2020, and no future editions or later amendments, is incorporated by reference in this Section and on file with ADEQ. The tracking document shall contain all of the following information:
- 1. Name and address of the generator, transporter, and medical waste treatment, storage, transfer, or disposal facility, as applicable.
  - 2. Quantity of biohazardous medical waste collected by weight, volume, or number of containers.
  - 3. Identification number attached to bags or containers, as specified as by the USDOT requirements, as listed in 49 CFR 172.300 through 172.338, revised as of October 1, 2020, and no future editions or later amendments, is incorporated by reference in this Section and on file with ADEQ.
  - 4. Date the biohazardous medical waste is collected.
- C.** A generator of chemotherapy waste, cultures and stocks, or animal waste shall handle the waste as prescribed in R18-13-1420.
- D.** A generator of medical sharps shall handle the waste as prescribed in R18-13-1419.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1407. Non-Sharps Packaging**

- A.** A generator who sets biohazardous medical waste that does not include sharps out for collection for off-site treatment or disposal shall package the biohazardous medical waste in either of the following:
- 1. A red disposable plastic bag that is:
    - a. Leak resistant,
    - b. Impervious to moisture,
    - c. Of sufficient strength to prevent tearing or bursting under normal conditions of use and handling,
    - d. Sealed to prevent leakage during transport, and
    - e. Placed in a secondary container. This container shall be constructed of materials that will prevent breakage of the bag in storage and handling during collection and transportation and bear the universal biohazard symbol. The secondary container may be either disposable or reusable.

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2. A reusable container that bears the universal biohazard symbol and that is:
    - a. Leak-proof on all sides and bottom, closed with a fitted lid, and constructed of smooth, easily cleanable materials that are impervious to liquids and resistant to corrosion by disinfection agents and hot water, and
    - b. Used for the storage or transport of biohazardous medical waste and cleaned after each use unless the inner surfaces of the container have been protected by disposable liners, bags, or other devices removed with the waste. "Cleaning" means agitation to remove visible particles combined with one of the following:
      - i. Exposure to hot water at a temperature of at least 180° F for a minimum of 15 seconds.
      - ii. Exposure to an EPA-approved chemical disinfectant used under established protocols and regulations.
      - iii. Any other method that the Department determines is acceptable, if the determination of acceptability is made in advance of the cleaning.
  - B. A generator shall handle any container used for the storage or transport of biohazardous medical waste that is not capable of being cleaned as described in subsection (A)(2)(b), or that is disposable packaging, as biohazardous medical waste.
  - C. A generator shall not use reusable containers described in subsection (A)(2) for any purpose other than the storage of biohazardous medical waste.
  - D. A generator shall not reuse disposable packaging and liners and shall manage such items as biohazardous medical waste.
1. Putrescible biohazardous medical waste may be kept unrefrigerated up to 72 hours if it would not otherwise cause odor detectable beyond the property line or attract vermin.
  2. Refrigerate at 40° F or less from hour 72 through day 90 putrescible biohazardous medical waste kept for up to 90 days.
  3. Nonputrescible biohazardous medical waste may be kept unrefrigerated for up to 90 days.
  4. Store biohazardous medical waste for 90 days or less unless the generator has obtained facility plan approval under A.R.S. § 49-762.04 and is in compliance with the design and operational requirements prescribed in R18-13-1412.
  5. Keep the storage area free of visible contamination.
  6. Protect biohazardous medical waste from contact with water, precipitation, wind, or animals. A generator shall ensure that the waste does not provide a breeding place or a food source for insects or rodents.
  7. Handle spills by re-packaging the biohazardous medical waste, re-labeling the containers and cleaning any soiled surface as prescribed in R18-13-1407(A)(2)(b).
  8. Notwithstanding subsections (C)(1) and (2), a generator shall minimize the off-site migration of odors and the presence of vermin. If the Department determines that a generator has not acted or adequately addressed odors or vermin, the Department shall require the waste to be removed or refrigerated at 40° F or less.
- D. Trace chemotherapy waste shall be clearly identified as such by its label.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).

Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).

Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1408. Storage**

- A. A generator may place a container of biohazardous medical waste alongside a container of solid waste if the biohazardous medical waste is identified and not allowed to co-mingle with the solid waste. The storage area shall not be used to store substances for human consumption or for medical supplies.
- B. Once biohazardous medical waste has been packaged for shipment off site, a generator shall provide a storage area for biohazardous medical waste until the waste is collected and shall comply with both of the following requirements:
  1. Secure the storage area in a manner that restricts access to, or contact with the biohazardous medical waste to authorized persons.
  2. Display the universal biohazard symbol and post warning signs worded as follows for medical waste storage areas: (in English) "CAUTION -- BIOHAZARDOUS MEDICAL WASTE STORAGE AREA -- UNAUTHORIZED PERSONS KEEP OUT" and (in Spanish) "PRECAUCION -- ZONA DE ALMACENAMIENTO DE DESPERDICIOS BIOLÓGICOS PELIGROSOS -- PROHIBIDA LA ENTRADA A PERSONAS NO AUTORIZADAS."
- C. Beginning at the time the waste is set out for collection, a generator who stores biohazardous medical waste shall comply with all of the following requirements:

**R18-13-1409. Transporter License; Fees; Transportation**

- A. A transporter shall obtain a transporter license from the Department as provided under subsections (B) and (C) of this Section in addition to possessing a permit, license, or approval if required by a local health department, environmental agency, or other governmental agency with jurisdiction.
- B. A transporter license is valid for five years after issuance. To renew the license, the licensee shall submit an application no later than 60 days prior to the license's expiration, and shall pay the license renewal fee, as provided in subsection (B)(1). With each application submitted for approval, the applicant shall remit an initial transporter license application fee as provided in subsection (B)(1). All fees paid shall be payable to the state of Arizona. The Department shall deposit the fees paid into the Solid Waste Fee Fund established pursuant to A.R.S. § 49-881, unless otherwise authorized or required by law.
  1. To apply for or to renew a transporter license, an applicant shall submit all of the following in a Department-approved format:
    - a. The name, address, and telephone number of the transportation company or entity.
    - b. All owners' names, addresses, and telephone numbers.
    - c. All names, addresses, and telephone numbers of any agents authorized to act on behalf of the owner.

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- d. A copy of either the certificate of disclosure required by A.R.S. § 49-109 or a written acknowledgment that this disclosure is not required.
  - e. Photocopies or other evidence of the issuance of a permit, license, or approval if required by a local health department, environmental agency, or other governmental agency with jurisdiction.
  - f. A copy of the transportation management plan as defined in R18-13-1401.
  - g. A list identifying each dedicated vehicle.
  - h. For an initial transporter license application, a fee of \$1,800, and for a license renewal, a fee of \$1,500.
2. The Department may only issue a transporter license, including a renewal, if all of the items in subsection (B)(1)(a) through (h) have been received and determined to be correct and complete, and a Department inspection of each transporting vehicle shows that the vehicle is in compliance with this Article.
- C.** Transporters shall pay by the invoice due date an annual fee of \$1,500 for each calendar year following payment of the new or renewal application license fee and subsequent years in which a renewal application license fee is not charged and paid, indicated in Table 2. Fee Table, Transporters Annual Fee.
- D.** Amendments. After issuance, the licensee shall submit to the Department any change to the information listed in subsections (B)(1)(a) through (g) of this Section within 30 days of its occurrence. Vehicles may only be added to the license after a Department inspection shows that the vehicle is in compliance with this Article. Amendments adding vehicles to the license shall be processed after payment of inspection fees and other expenses, except that the application fee shall be \$350.
- E.** A person who transports biohazardous medical waste shall maintain in each transporting vehicle at all times a transportation management plan.
- F.** A transporter who accepts biohazardous medical waste from a generator shall transmit electronically or leave a physical copy of the tracking document described in R18-13-1406(B) with the person from whom the waste is accepted. A transporter shall ensure that a copy of the tracking document accompanies the person who has physical possession of the biohazardous medical waste. Upon delivery to a Department-approved transfer, storage, treatment, or disposal facility, the transporter shall obtain a copy of the tracking document, signed by a person representing the receiving facility, signifying acceptance of the biohazardous medical waste.
- G.** A transporter who transports biohazardous medical waste in a dedicated vehicle shall ensure that the cargo box, trailer, or compartment can be secured to limit access to authorized persons at all times except during loading and unloading. In addition, the cargo box, trailer, or compartment shall be constructed in compliance with one of the following:
- 1. Have a fully enclosed, leak-proof cargo compartment consisting of a floor, sides, and a roof that are made of a non-porous material impervious to biohazardous medical waste and physically separated from the driver's compartment.
  - 2. Haul a fully enclosed, leak-proof cargo box made of a non-porous material impervious to biohazardous medical waste.
  - 3. Tow a fully enclosed leak-proof trailer made of a non-porous material impervious to biohazardous medical waste.
- H.** A person who transports biohazardous medical waste in a vehicle not dedicated to the transportation of biohazardous medical waste, but that is used at least once weekly for a month, shall comply with the following:
- 1. Subsections (A), (E) through (G), and (I) of this Section.
  - 2. Clean the vehicle as prescribed in R18-13-1407(A)(2)(b) before it is used for another purpose.
- I.** A transporter of biohazardous medical waste shall comply with all of the following:
- 1. Accept only biohazardous medical waste packaged as prescribed in R18-13-1407.
  - 2. Accept biohazardous medical waste only after providing the generator with a signed tracking document as prescribed in R18-13-1406(B), and keep a copy of the tracking document for the period required under the USDOT requirements, as listed in 49 CFR 172.201.
  - 3. Deliver biohazardous medical waste to a Department-approved biohazardous medical waste storage, transfer, treatment, or disposal facility within the following timeframes:
    - a. 72 hours of collection, if putrescible and unrefrigerated; or
    - b. 90 days of collection, if putrescible and refrigerated at 40° F or less from hour 72 through day 90; or
    - c. 90 days of collection, if nonputrescible and unrefrigerated.
  - 4. Not hold biohazardous medical waste longer than specified under subsection (I)(3) unless the vehicle is parked at a Department-approved facility.
  - 5. Except in emergency situations, not unload, reload, or transfer the biohazardous medical waste to another vehicle in any location other than a Department-approved facility. Combination vehicles or trailers may be uncoupled and coupled to another cargo vehicle or truck trailer as long as the biohazardous medical waste is not removed from the cargo compartment.
- J.** Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (B), (C), and (D) of this Section, and Table 2. Fee Table, Transporters Annual Fee, annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
- 1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  - 2. Round the result from subsection (J)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
 Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

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**Table 1. Frequency of Application for Transporter License**

Year	Type of Application	Frequency
1	New	Once
6, 11, 16, etc.	Renewal	Every 5th Year

**Historical Note**

Table 1. Fee Table, Transporter License Fees; Frequency of Application for Transporter License Fees made by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**Table 2. Fee Table – Transporter Annual Fee**

Years	Amount
2, 3, 4, 5, 7, 8, 9, 10, 12, 13, etc.	\$1,500

**Historical Note**

Table 2. Fee Table, Transporter Annual Fee made by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1410. Storage, Transfer, Treatment, and Disposal Facilities; Facility Plan Approval; Fees**

- A. A person shall obtain solid waste facility plan approval from the Department as prescribed in A.R.S. § 49-762.04 and pursuant to R18-13-702 to construct any facility that will be used to store, transfer, treat, or dispose of biohazardous medical waste that was generated off site. Plan approval shall be obtained before starting construction of the medical waste treatment or disposal facility. This requirement also applies to solid waste facilities for which an operator self-certifies under A.R.S. § 49-762.05, if the facility also will receive biohazardous medical waste.
- B. If an air quality permit is required for the facility under A.R.S. Title 49, Chapter 3, the person shall include evidence of that air quality permit, or evidence of an air quality permit application with the application for solid waste facility plan approval.
- C. A person applying for facility plan approval shall ensure that the plan contains information demonstrating how the plan will comply with this Article.
- D. Annual registration fee. The Department shall bill an annual registration fee to a biohazardous medical waste facility described in subsection (A) of this Section as follows:
  1. For a disposal or treatment facility, \$12,500;
  2. For a storage facility, \$7,500; and
  3. For a transfer facility, \$3,000.
- E. A facility subject to more than one fee under subsection (D) of this Section shall only pay the highest fee amount.
- F. The biohazardous medical waste facility shall pay the annual registration fee within 30 days of invoice receipt.
- G. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (D) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
  1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States

Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.

2. Round the result from subsection (G)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1411. Storage and Transfer Facilities; Design and Operation**

An operator of a storage facility or transfer facility shall comply with all of the following design and operation requirements:

1. Design the facility so that biohazardous medical waste is always handled and stored separately from other types of solid waste if accepted at the facility.
2. Display prominently the universal biohazard symbol as prescribed in R18-13-1401.
3. Construct the storage area from smooth, easily cleanable non-porous material that is impervious to liquids and resistant to corrosion by disinfecting agents and hot water.
4. Protect biohazardous medical waste from contact with water, precipitation, wind, or animals.
5. Specify in the application for facility plan approval the maximum storage time that biohazardous medical waste will remain at the facility. If putrescible biohazardous medical waste will be stored for more than 72 hours, the operator shall equip the facility with a refrigerator to refrigerate putrescible biohazardous medical waste. The operator of the facility shall maintain the temperature in the refrigerator at 40° F or less.
6. Accept biohazardous medical waste only if it is accompanied by the tracking document. The operator shall sign the tracking document and keep a copy of the acceptance documentation for the period required under the USDOT requirements, as listed in 49 CFR 172.201.
7. Accept biohazardous medical waste if it is packaged as described in R18-13-1407. If a biohazardous medical waste container is damaged or leaking, improperly labeled, or otherwise unacceptable, a transfer facility operator shall do one of the following:
  - a. Reject the waste and return it to the transporter or self-hauling generator.
  - b. Accept the waste and immediately repackage it as prescribed in R18-13-1407(A).
8. Clean the storage area daily. "Clean" means to remove visible particles combined with one of the following:
  - a. Exposure to hot water at a temperature of at least 180° F for a minimum of 15 seconds.
  - b. Exposure to an EPA-approved chemical disinfectant used under established protocols and regulations.
  - c. Any other method that the Department determines is acceptable, if the determination of acceptability is made in advance of the cleaning.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3). Amended by final rulemaking at 27 A.A.R. 2801



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(December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1412. Treatment Facilities; Application Requirements; Design and Operation**

- A.** An operator who applies for facility plan approval shall comply with subsections (A)(1) and (2) as well as all of the requirements in subsections (B)(1) through (11):
1. Submit to the Department the following documentation:
    - a. Equipment specifications that identify the proper type of medical waste to be treated in the equipment and any design or equipment restrictions.
    - b. Manufacturer's specifications and operating procedures for the equipment that describe the type and volume of waste to be treated, monitoring data of the treatment process, and calibration and testing of the equipment, providing specific details about the capability of the equipment to achieve the treatment standards prescribed in R18-13-1415.
    - c. Instructions for equipment maintenance, testing, and calibration that ensure the equipment achieves the treatment standards prescribed in R18-13-1415.
    - d. Training manual for the equipment.
    - e. Written certification from the manufacturer stating that the equipment, when operated properly, is capable of achieving the treatment standards prescribed in R18-13-1415.
  2. Submit to the Department and have readily available at the facility, an operations procedure manual describing how the waste will be handled from the time it is accepted by the treater through the treatment process and final disposition of the treated waste. The operations procedure manual shall include all of the following:
    - a. Provisions for treating biohazardous medical waste within 72 hours of receipt or refrigerating at 40° F or less upon determination that treatment or disposal will not occur within 72 hours. Nonputrescible biohazardous medical waste that is not immediately treated may be stored for up to 90 days unrefrigerated.
    - b. A contingency plan if the treatment equipment is out of service for an extended period of time. The plan shall address the manner and length of time for storage of the waste. An operator shall not store biohazardous medical waste more than 90 days. The plan shall be based on the capacity of the treatment equipment to treat all waste at the facility, including any backlog of stored waste and any new waste intake. If the 90-day time-frame will be exceeded, the operator shall either stop accepting waste until the backlog is treated, or contract with another treatment facility for treating the waste.
    - c. Procedures for handling hazardous chemicals, radioactive waste, and chemotherapy waste. The plan shall provide for scanning biohazardous medical waste with a Geiger counter and handling waste that measures above background level in a manner that complies with state and federal law.
- B.** An operator of a Department-approved facility shall comply with all of the following:
1. Have readily accessible written procedures stating that biohazardous medical waste is to be accepted from a transporter only if the waste is accompanied by a tracking document, and written procedures that require compliance with both of the following:
    - a. The treater or the treater's authorized agent shall sign the tracking document and keep a copy of the acceptance documentation for the period required under the USDOT requirements, as listed in 49 CFR 172.201.
    - b. If a biohazardous medical waste container is damaged or leaking, improperly labeled, or otherwise unacceptable, a treater shall do one of the following:
      - i. Reject the waste and return it to the transporter or self-hauling generator.
      - ii. Accept the waste and transfer it directly from the transporting vehicle to the treatment processing unit.
      - iii. If the waste will not be treated immediately, repack the waste for storage.
  2. Assure that the facility is designed to meet both of the following requirements:
    - a. Any floor or wall surface in the processing area of the facility which may come into contact with biohazardous medical waste is constructed of a smooth, easily cleanable non-porous material that is impervious to liquids.
    - b. The floor surface in the treatment and storage area either has a curb of sufficient height to contain spills or slopes to a drain that connects to an approved sanitary sewage system, septic tank system, or collection device.
  3. Store biohazardous medical waste as required in R18-13-1408.
  4. Comply with all of the following if the treatment method is incineration:
    - a. Reduce the incinerated medical waste, excluding metallic items, into carbonized or mineralized ash by incineration.
    - b. Determine whether the ash is hazardous waste as required under R18-8-262.
  5. Conduct any autoclaving according to the manufacturer's specifications for the unit.
  6. Use only alternative medical waste treatment methods that achieve the treatment standards in R18-13-1415(A).
  7. Treat animal waste, chemotherapy waste, and cultures and stocks as prescribed in R18-13-1420.
  8. Render medical sharps incapable of creating a stick hazard by using an encapsulation agent or any other process that prevents a stick hazard.
  9. Keep records of equipment maintenance and operational performance levels for three years. The records shall include the date and result of all equipment calibration and maintenance. Operational performance level records shall indicate the duration of time for each treatment cycle and:
    - a. For steam treatment and microwaving treatment records, both the temperature and pressure maintained in the treatment unit during each cycle and the method used for confirmation of temperature and pressure.
    - b. For chemical treatment, a description of the solution used.
    - c. For incineration, the temperature is maintained in the treatment unit during operation.
    - d. Any other operating parameters in the manufacturer's specifications.
    - e. A description of the treatment method used and a copy of the maintenance test results.

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10. Not open a sealed biohazardous medical waste container prior to treatment unless opening the container is required to treat the contents. Transfer of the entire contents, when performed as part of the treatment process, is permitted.
  11. Clean the storage and treatment areas as necessary to protect the public health and employee health and safety.
- C. The treater shall make treatment records available for Departmental inspection upon request.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1413. Changes to Approved Medical Waste Facility Plans**

- A. As required by A.R.S. § 49-762.06, before making any change to an approved facility plan, a facility owner or operator shall submit a notice to the Department stating the type of change requested, including but not limited to:
1. A Type I change to an approved medical waste facility plan is a change not described in subsections (A)(2), (3), or (4).
  2. A Type II change to an approved medical waste facility plan is a change in which treatment equipment is replaced with equal or like equipment, resulting in either no increase to treatment capacity or the addition of equipment that is not directly used in the treatment process.
  3. A Type III change to an approved medical waste facility plan is a change described by one of the following:
    - a. Treatment equipment is added, resulting in less than a 25% increase in treatment capacity.
    - b. The storage area is enlarged resulting in less than a 25% increase in storage capacity.
    - c. Treatment technology is changed.
  4. A Type IV change to an approved medical waste facility plan is a change described by one of the following:
    - a. Treatment equipment is added, resulting in a 25% or more increase in treatment capacity.
    - b. The storage area is enlarged resulting in a 25% or more increase in storage capacity.
    - c. Treatment equipment is added that requires an environmental permit.
    - d. An expansion of the treatment facility onto land not previously described in the approved plan.
- B. As required by A.R.S. § 49-762.06, a treatment facility operator who has identified a change under subsection (A) shall comply with one of the following:
1. For a Type I change, make the change without notice to, or approval by the Department.
  2. For a Type II change, before making any change, provide written notification that describes the change to the Department. The addition of refrigeration units only for compliance with this Article is a Type II change for which no Departmental approval is required.
  3. For a Type III or Type IV change, submit an amended plan to the Department for approval before making any change. Departmental approval is required prior to making any change.
- C. An owner or operator of an existing municipal solid waste landfill who intends to accept untreated biohazardous medical waste shall submit a notice of a Type III change and an amended facility plan.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1414. Alternative Medical Waste Treatment Methods: Registration and Equipment Specifications**

- A. A manufacturer or its agent who applies for alternative medical waste treatment method registration shall submit to the Department all of the following:
1. The manufacturer or company name and address.
  2. The name, address, and telephone number of the person who submits the application.
  3. A description of the alternative medical waste treatment method.
  4. A list of any other states in which the treatment method is used, including a copy of any state approvals.
  5. A description of by-products generated as result of the alternative treatment method.
  6. A certification statement that the contents of the application are true and accurate to the knowledge and belief of the applicant.
  7. Written documentation demonstrating that the alternative medical waste treatment method is capable of compliance with the treatment standards in this Article for the type of waste treated. The manufacturer shall employ a laboratory independent of any oversight activities by the manufacturer to provide this analysis.
  8. The manufacturer's equipment specifications for the alternative medical waste treatment method being registered, including all of the following:
    - a. Unit model number, or serial number.
    - b. Equipment specifications that identify the proper type of biohazardous medical waste to be treated by the equipment and any design or equipment restrictions.
    - c. Operating procedures for the equipment that ensure the equipment complies with the treatment standards prescribed in this Article for the type of waste treated.
    - d. Instructions for equipment maintenance, testing, and calibration that ensure the equipment complies with the treatment standards prescribed in this Article for the type of waste treated.
  9. Written documentation of registration if required by A.R.S. § 3-351.
- B. The Department shall make a determination whether to approve the registration application. If the Department approves the application, it shall issue to the applicant a certification of registration containing an alternative medical waste treatment method registration number. Only an alternative technology method with a valid Department issued registration number meets the requirements of this Article.
- C. If documentation of Departmental registration is not on file with a generator utilizing alternative medical waste treatment technology, the Department shall classify biohazardous medical waste treated using the unregistered alternative treatment technology as untreated biohazardous medical waste.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801

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(December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1415. Treatment Standards, Quantification of Microbial Inactivation and Efficacy Testing Protocols**

A. A treater using an alternative treatment technology shall ensure that treatment achieves either of the following treatment standards:

1. A 6  $\log_{10}$  inactivation in the concentration of vegetative microorganisms.
2. A 4  $\log_{10}$  inactivation in the concentration of *Bacillus stearothermophilus* or *Bacillus subtilis* as is appropriate to the technology.

B. A treater utilizing an alternative treatment method shall conduct efficacy studies to demonstrate that the treatment mechanisms are capable of achieving the standards in subsection (A) through either of the following:

1. Mycobacterial species used as indicators of vegetative microorganisms:
  - a. *Mycobacterium phlei*, or
  - b. *Mycobacterium bovis* (BOG) (ATCC 35743)
2. Spore suspensions of one of the following two bacterial species, as appropriate to the technology, used as biological indicators in efficacy tests of thermal, chemical, and irradiation treatment systems. Studies shall demonstrate a 4  $\log_{10}$  reduction in the concentration of viable spores, through the use of an initial inoculum suspension of 5  $\log_{10}$  or greater of:
  - a. *Bacillus stearothermophilus* (ATCC 7953), or
  - b. *Bacillus subtilis* (ATCC 19659).

C. A treater utilizing an alternative treatment method shall quantify microbial inactivation as follows:

1. Microbial inactivation, or "kill" efficacy is equated to "Log<sub>10</sub> Kill" that is defined as the difference between the logarithms of the number of viable test microorganisms before and after treatment. This definition is stated as:  
 $\text{Log}_{10}\text{Kill} = \text{Log}_{10}(\text{cfu/g "I"}) - \text{Log}_{10}(\text{cfu/g "R"})$   
 where:  
 $\text{Log}_{10}\text{Kill}$  is equivalent to the term  $\text{Log}_{10}$  reduction,  
 "I" is the number of viable test microorganisms introduced into the treatment unit,  
 "R" is the number of viable test microorganisms recovered from the treatment unit, and  
 "cfu/g" are colony forming units per gram of waste solids.
2. For those treatment processes that can maintain the integrity of the biological indicator carrier of the desired microbiological test strain, biological indicators of the required strain and concentration may be used to demonstrate microbial inactivation. Quantification is evaluated by growth or no growth of the cultured biological indicator.
3. For those treatment mechanisms that cannot ensure or provide integrity of the biological indicator, quantitative measurement of microbial inactivation requires a two-step approach: Step 1 "Control" and Step 2 "Test". The purpose of Step 1 is to account for the reduction of test microorganisms due to loss by dilution or physical entrapment.
  - a. Step 1:
    - i. Use microbial cultures of a predetermined concentration necessary to ensure a sufficient microbial recovery at the end of this step.
    - ii. Add suspension to a standardized medical waste load that is to be processed under normal

operating conditions without the addition of the treatment agent (that is, heat, chemicals).

- iii. Collect and wash waste samples after processing to recover the biological indicator organisms in the sample.
- iv. Plate the recovered microorganism suspensions to quantify microbial recovery. The number of viable microorganisms recovered serves as a baseline quantity for comparison to the number of recovered microorganisms from wastes processed with the treatment agent.
- v. The required number of recovered viable indicator microorganisms from Step 1 must be equal to or greater than the number of microorganisms required to demonstrate the prescribed Log reduction, either a 6  $\text{Log}_{10}$  reduction for vegetative microorganisms or a 4  $\text{Log}_{10}$  reduction for bacterial spores. This can be defined by the following equation:

$$\text{Log}_{10}\text{RC} = \text{Log}_{10}\text{IC} - \text{Log}_{10}\text{NR}$$

or

$$\text{Log}_{10}\text{NR} = \text{Log}_{10}\text{IC} - \text{Log}_{10}\text{RC}$$

where:

$\text{Log}_{10}\text{RC}$  is greater than 6 for vegetative microorganisms and greater than 4 for bacterial spores and where:

$\text{Log}_{10}\text{RC}$  is the number of viable "control" microorganisms in colony forming units per gram of waste solids recovered in the non-treated, processed waste residue;

$\text{Log}_{10}\text{IC}$  is the number of viable "control" microorganisms in colony forming units per gram of waste solids introduced into the treatment unit;

$\text{Log}_{10}\text{NR}$  is the number of "control" microorganisms in colony forming units per gram of waste solids which were not recovered in the non-treated, processed waste residue.  $\text{Log}_{10}\text{NR}$  represents an accountability factor for microbial loss.

- b. Step 2:
  - i. Use microbial cultures of the same concentration as in Step 1.
  - ii. Add suspension to the standardized medical waste load that is to be processed under normal operating conditions with the addition of the treatment agent.
  - iii. Collect and wash waste samples after processing to recover the biological indicator organisms in the sample.
  - iv. Plate recovered microorganism suspensions to quantify microbial recovery.
  - v. From data collected from Step 1 and Step 2, the level of microbial inactivation, "Log<sub>10</sub> Kill", is calculated by employing the following equation:  
 $\text{Log}_{10}\text{Kill} = \text{Log}_{10}\text{IT} - \text{Log}_{10}\text{NR} - \text{Log}_{10}\text{RT}$   
 where:  
 $\text{Log}_{10}\text{Kill}$  is equivalent to the term  $\text{Log}_{10}$  reduction;  
 $\text{Log}_{10}\text{IT}$  is the number of viable "Test" microorganisms in colony forming units per gram of waste solids introduced into the treatment unit.  
 $\text{Log}_{10}\text{IT} = \text{Log}_{10}\text{IC};$

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Log<sub>10</sub>NR is the number of "Control" microorganisms in colony forming units per gram of waste solids which were not recovered in the non-treated, processed waste residue;  
Log<sub>10</sub>RT is the number of viable "Test" microorganisms in colony forming units per gram of waste solids recovered in treated, processed waste residue.

- D. A treater shall employ the appropriate methodology to determine efficacy of the treatment technology following the protocols in subsection (C) that are congruent with the treatment method.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1416. Recycled Materials**

- A. Once a generator places biohazardous medical waste in a red bag as required in R18-13-1407, a person shall not remove any of the biohazardous medical waste from the bag until the biohazardous medical waste has been treated as required in R18-13-1415.
- B. A generator of biohazardous medical waste intending to recycle any portion of the biohazardous medical waste shall segregate that portion of biohazardous medical waste from the portion of biohazardous medical waste that will not be recycled. The generator shall do either of the following:
1. Treat the biohazardous medical waste intended for recycling as required in R18-13-1415 before sending the treated medical waste to a recycler.
  2. Follow the requirements in R18-13-1406, R18-13-1407, and R18-13-1408, before either contracting with a transporter to haul or self-hauling the biohazardous medical waste to a treatment facility for treatment. After treatment, the treated medical waste may be sent to a recycler.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).

**R18-13-1417. Disposal Facilities: Design and Operation**

An operator of a municipal solid waste landfill that accepts untreated biohazardous medical waste shall comply with all of the following in design and operational requirements:

1. Accept biohazardous medical waste only if packaged according to R18-13-1407.
2. Keep the biohazardous medical waste disposal area separate from the general purpose disposal area.
3. Clearly label the biohazardous medical waste disposal area, informing persons that the disposal area contains untreated medical waste.
4. Not drive directly over deposited medical waste. The operator shall achieve compaction by first spreading a layer of soil that is sufficiently thick to prevent compaction equipment from coming into direct contact with the waste, or dragging waste over the area.
5. Cover the biohazardous medical waste with 6 inches of compacted soil at the end of the working day or more often as necessary to prevent vector breeding and odors.
6. Not allow salvaging of untreated biohazardous medical waste from the landfill.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1418. Discarded Drugs**

Discarded drugs that are not hazardous waste, not returned to the manufacturer, and not segregated and labeled on site for transport to a treatment facility shall be destroyed on site by the generator of such drugs by any method that prevents the drugs' use prior to placing the waste out for collection. If federal or state law prescribes a specific method for destruction of discarded drugs, the generator shall comply with that law.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1419. Medical Sharps**

- A. Medical sharps shall be handled as follows:
1. A generator who treats biohazardous medical waste on site shall place medical sharps in a sharps container after rendering them incapable of creating a stick hazard by using an encapsulation agent or any other process that prevents a stick hazard. Medical sharps encapsulated or processed in this manner are considered to be solid waste.
  2. A generator who ships biohazardous medical waste off site for treatment shall either:
    - a. Place medical sharps in a medical sharps container and follow the requirements of R18-13-1406, or
    - b. Package and send medical sharps to a treatment facility via a mail-back system as prescribed by the instructions provided by the mail-back system operator. The generator shall retain proof of shipping.
- B. Notwithstanding subsections (A)(1) and (2), the following syringes do not have to be placed in a medical sharps container:
1. Syringes that have never had a needle (sharp) attached.
  2. Syringes where a needle or sharp had been attached and has been separated from the syringe so that no stick or puncture hazard remains with the syringe.
- C. Syringes that are exempted by subsections (B)(1) and (2) from being placed in a medical sharps container are not biohazardous medical waste, and may be treated as a solid waste, if they are not composed of biohazardous items listed in R18-13-1401(4) and do not contain discarded drugs or another regulated substance.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).  
Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**R18-13-1420. Additional Handling Requirements for Certain Wastes**

- A. A person who treats the following biohazardous medical waste categories shall meet the following additional requirements:
1. Cultures and stocks shall be incinerated, autoclaved, or treated by an alternative medical waste treatment method that meets the treatment standards set forth in R18-13-

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1415(A). If cultures and stocks are shipped off site for treatment or disposal, they shall be packaged inside a watertight primary container with absorbent packing materials. The primary container shall be placed inside a watertight secondary inner container that is then placed inside an outer container with sufficient cushioning material to prevent shifting between the secondary inner container and the outer container. If federal or state law prescribes specific requirements for packaging and transporting this waste, the treater shall comply with that law.

2. Trace chemotherapy waste shall be incinerated or disposed of in either an approved solid waste or hazardous waste disposal facility.
3. Experimental or research animal waste shall be handled as follows:
  - a. Autoclave bedding on site or package as described in R18-13-1407 for off-site treatment or landfilling.
  - b. Incinerate animal carcasses on site, or if taken off site for treatment, comply with one of the following requirements:
    - i. Package the waste in a leakproof, covered container, label the contents and send to an incinerator or a Department-approved landfill, or
    - ii. If treated by a method other than incineration, pre-process by grinding, then treat by a method that achieves the standards of R18-13-1415(A).
- B. If a treater uses grinding in combination with another treatment method described in this Article, the treater shall conduct it in a closed system to prevent humans from being exposed to the release of the waste into the environment. If grinding is used for medical sharps, the grinding shall render the medical sharps incapable of creating a stick hazard.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 3776, effective September 17, 1999 (Supp. 99-3).

Amended by final rulemaking at 27 A.A.R. 2801 (December 3, 2021), effective January 4, 2022 (Supp. 21-4).

**ARTICLE 15. RECODIFIED**

*Editor's Note: The recodification at 7 A.A.R. 2522 described below erroneously moved Sections into 18 A.A.C. 9, Article 9. Those Sections were actually recodified to 18 A.A.C. 9, Article 10. See the Historical Notes for more information (Supp. 01-4).*

*Article 15, consisting of Sections R18-13-1501 through R18-13-1514 and Appendix A, recodified to 18 A.A.C. 9, Article 9 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2).*

**R18-13-1501. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-902 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1002 (Supp. 01-4).

**R18-13-1502. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-901 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1001 (Supp. 01-4).

**R18-13-1503. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-903 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1003 (Supp. 01-4).

**R18-13-1504. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-904 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1004 (Supp. 01-4).

**R18-13-1505. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-905 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1005 (Supp. 01-4).

**R18-13-1506. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-906 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1006 (Supp. 01-4).

**R18-13-1507. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-907 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1007 (Supp. 01-4).

**R18-13-1508. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-908 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1008 (Supp. 01-4).

**R18-13-1509. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-909 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1009 (Supp. 01-4).

**R18-13-1510. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-910 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1010 (Supp. 01-4).

**R18-13-1511. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-911 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1011 (Supp. 01-4).

**R18-13-1512. Recodified**

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**Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-912 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1012 (Supp. 01-4).

**R18-13-1513. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-913 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1013 (Supp. 01-4).

**R18-13-1514. Recodified****Historical Note**

Adopted effective April 23, 1996 (Supp. 96-2). Section recodified to R18-9-914 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to R18-9-1014 (Supp. 01-4).

**Appendix A. Recodified****Historical Note**

Appendix A, "Procedures to Determine Annual Biosolids Application Rates", adopted effective April 23, 1996 (Supp. 96-2). Appendix A recodified to 18 A.A.C. 9, Article 9 at 7 A.A.R. 2522, effective May 24, 2001 (Supp. 01-2). Previous note correction: Section actually recodified to 18 A.A.C. 9, Article 10 (Supp. 01-4).

**ARTICLE 16. BEST MANAGEMENT PRACTICES FOR PETROLEUM CONTAMINATED SOIL**

*Article 16, consisting of Sections R18-13-1601 through R18-13-1614, recodified from 18 A.A.C. 8, Article 16 at 8 A.A.R. 5172, effective November 27, 2002; Section and subsection citations within this Article were also updated under A.R.S. § 41-1011(C) (Supp. 02-4).*

**R18-13-1601. Definitions**

In addition to definitions in A.R.S. § 49-851 and A.A.C. R18-13-1301, the terms in this Article shall have the following meanings:

1. "Accumulation site" means an area or site at which PCS from one or more points of generation under the control of the generator of PCS is accumulated for more than 12 hours but less than 90 days prior to treatment, storage, or disposal.
2. "Containment system" means a system designed to contain an accumulation of special waste which meets the design and performance standards in R18-13-1608 and either R18-13-1609 or R18-13-1611.
3. "Excavated" means removed from the earth by scraping or digging a hole or cavity in the earth's surface or otherwise removed from the earth's surface.
4. "Facility" or "special waste receiving facility" means a treatment facility, storage facility, or disposal facility which has been approved by the Director in accordance with A.R.S. § 49-857 or has qualified for Interim Use Facility status pursuant to A.R.S. § 49-858.
5. "Hazardous waste" means hazardous waste as defined in A.R.S. § 49-921(5).
6. "Non-fuel, non-solvent petroleum product" means a petroleum-based substance refined from virgin crude oil that is not used as a solvent or fuel including mineral oils and hydraulic oils.
7. "Non-regulated soils" means soils that are neither hazardous waste, PCS, nor solid waste PCS, and which do not

constitute an environmental nuisance pursuant to A.R.S. §§ 49-141 through 49-144.

8. "PCS" or "petroleum-contaminated soils" means soils excavated for storage, treatment or disposal containing one or more of the contaminants in the list below at the following concentrations:
  - a. Benzene greater than or equal to 1.4 mg/kg,
  - b. Toluene greater than or equal to 650 mg/kg,
  - c. Ethylbenzene greater than or equal to 400 mg/kg,
  - d. Total Xylenes greater than or equal to 420 mg/kg,
  - e. Anthracene greater than or equal to 240,000 mg/kg,
  - f. Benz(A)anthracene greater than or equal to 21 mg/kg,
  - g. Benzo(A)pyrene greater than or equal to 2.1 mg/kg,
  - h. Benzo(B)fluoranthene greater than or equal to 21 mg/kg,
  - i. Benzo(K)fluoranthene greater than or equal to 210 mg/kg,
  - j. Chrysene greater than or equal to 2,000 mg/kg,
  - k. Dibenz(A,H)anthracene greater than or equal to 2.1 mg/kg,
  - l. Fluoranthene greater than or equal to 22,000 mg/kg,
  - m. Fluorene greater than or equal to 26,000 mg/kg,
  - n. Indenopyrene greater than or equal to 21 mg/kg,
  - o. Naphthalene greater than or equal to 190 mg/kg,
  - p. Pyrene greater than or equal to 29,000 mg/kg.
9. "PCS disposal facility" means a site or special waste receiving facility at which the disposal of PCS has been approved by the Director pursuant to A.R.S. § 49-857 or has qualified for Interim Use Facility status pursuant to A.R.S. § 49-858.
10. "Petroleum" means petroleum as defined in A.R.S. § 49-1001(11).
11. "Point of compliance" means point of compliance as defined in A.R.S. § 49-244.
12. "Special waste shipper" means a person who transports special waste for off-site treatment, storage, or disposal.
13. "Solid waste PCS" means excavated soils contaminated with petroleum that are not hazardous waste and not PCS but that contain one or more of the contaminants in the list below at the following concentrations:
  - a. Benzene greater than or equal to 0.65 but less than 1.4 mg/kg;
  - b. Toluene greater than or equal to 650 mg/kg;
  - c. Ethylbenzene greater than or equal to 400 mg/kg;
  - d. Total Xylenes greater than or equal to 270 but less than 420 mg/kg;
  - e. Anthracene greater than or equal to 22,000 but less than 240,000 mg/kg;
  - f. Benz(A)anthracene greater than or equal to 6.9 but less than 21 mg/kg;
  - g. Benzo(A)pyrene greater than or equal to 0.69 but less than 2.1 mg/kg;
  - h. Benzo(B)fluoranthene greater than or equal to 6.9 but less than 21 mg/kg;
  - i. Benzo(K)fluoranthene greater than or equal to 69 but less than 210 mg/kg;
  - j. Chrysene greater than or equal to 680 but less than 2,000 mg/kg;
  - k. Dibenz(A,H)anthracene greater than or equal to 0.69 but less than 2.1 mg/kg;
  - l. Fluoranthene greater than or equal to 2,300 but less than 22,000 mg/kg;

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- m. Fluorene greater than or equal to 2,700 but less than 26,000 mg/kg;
  - n. Indenopyrene greater than or equal to 6.9 but less than 21 mg/kg;
  - o. Naphthalene greater than or equal to 56 but less than 190 mg/kg;
  - p. Pyrene greater than or equal to 2,300 but less than 29,000 mg/kg.
14. "Storage" means the holding of PCS for a period of more than 90 days but less than one year.
  15. "Storage facility" means a special waste receiving facility which engages in storage and which has been approved by the Director pursuant to A.R.S. § 49-857 or has qualified for Interim Use Facility status pursuant to A.R.S. § 49-858.
  16. "Temporary treatment facility" means an on-site treatment facility, or an off-site treatment facility owned or operated by the generator of PCS, where the PCS is treated to reduce the contaminants that make it PCS and which complies with the requirements of R18-13-1610.
  17. "Treatability study" means a study in which a special waste is subjected to a treatment process to determine any one or more of the following:
    - a. Whether the waste is amenable to the treatment process,
    - b. What pretreatment is required,
    - c. The optimal process conditions needed to achieve the desired treatment,
    - d. The efficiency of a treatment process,
    - e. The characteristics and volumes of residual contaminants from a particular treatment process,
    - f. Toxicological and health effects.
  18. "Treatment facility" means a special waste receiving facility at which PCS is treated to reduce the PCS contaminants and, if in the state of Arizona, has been Department-approved pursuant to A.R.S. § 49-857 or has qualified for Interim Use Facility status pursuant to A.R.S. § 49-858.
3. The owner or operator of the facility shall maintain records detailing the treatability study and the results obtained in accordance with R18-13-1614.
  4. The treatability study shall be completed and the PCS shall be removed from the site within one year from commencement of the study.
  5. Upon completion of the treatability study, the owner or operator of a facility shall dispose of the PCS used in the treatability study in accordance with this Article.
  6. Sampling of the PCS shall be conducted in accordance with R18-13-1604(B) and (C) before and after the treatability study is performed.
  7. The performance of the treatability study shall not result in an environmental nuisance pursuant to A.R.S. §§ 49-141 through 49-144.
- C. PCS which is excavated pursuant to the requirements of A.R.S. Title 49, Chapter 6, Underground Storage Tank Regulation, and which is not removed from the site, shall comply with the requirements of R18-13-1610 and R18-13-1612.
  - D. PCS incorporated into asphalt for use in paving is not subject to other provisions of this Article if the owner or operator of the facility where the asphalt is produced does all of the following:
    1. Notifies the Department in writing at least 30 days prior to commencing such incorporation,
    2. Maintains records in accordance with R18-13-1614,
    3. Stores the PCS prior to incorporation in accordance with R18-13-1611.
  - E. Requirements in this Article for Department-approved facilities do not apply to facilities that are out of state or in Indian Country.

**Historical Note**

Recodified from R18-8-1602 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1603. Exemptions**

- A. Solid waste PCS are exempt from the provisions of this Article, except for the requirements in R18-13-1604, and are subject to A.R.S. § 49-761 et seq.
- B. Non-regulated soils are exempt from the provisions of this Article, except for the requirements in R18-13-1604, and are exempt from the requirements of A.R.S. § 49-761 et seq.
- C. Asphaltic cement which is not hazardous waste is exempt from the requirements of this Article.
- D. Soils which are contaminated with petroleum, which have been generated by households, and which are not hazardous waste, shall be exempt from the requirements of this Article.

**Historical Note**

Recodified from R18-8-1603 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1604. Waste Determination**

- A. A generator of excavated soil contaminated with petroleum shall determine whether the soil is PCS, solid waste PCS, or non-regulated soil. The basis for the determination shall be maintained for at least three years and shall be made available to the Department upon request. The generator shall make such determination using either of the following methods:
  1. Testing the soil pursuant to subsection (B) of this Section. Laboratory analysis of these samples shall be performed

**Historical Note**

Recodified from R18-8-1601 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1602. Applicability**

- A. The Director declares that PCS, as defined in R18-13-1601(8), constitutes a special waste as defined in A.R.S. § 49-851(A)(9). Except as otherwise provided in this Section and R18-13-1603, PCS shall be treated, stored, and disposed of in accordance with this Article. PCS shall not be diluted with any material or substance for purposes of avoiding applicability of these rules.
- B. PCS which is used in a treatability study shall comply with all of the following:
  1. The owner or operator of the facility where a treatability study is to be conducted shall notify the Department of its intent to conduct a treatability study at least 30 days prior to the commencement of the treatability study.
  2. The total quantity of PCS used in the treatability study shall not exceed 5000 kilograms, unless evidence is provided which justifies the need for a larger quantity and permission to use a larger amount is granted by the Director.

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by a laboratory licensed by the Arizona Department of Health Services. Approved testing methods, which identify concentrations for total recoverable extraction of contaminants, shall be used.

2. Application of knowledge of the characteristics of the contaminated soil in light of the known or potential source of the contamination. The Department may require sampling to confirm the accuracy of applied knowledge.
- B. Sampling of soils contaminated with petroleum shall be performed in accordance with a site-specific written sampling plan which is consistent with the requirements set forth in either of the following:
  1. "Test Methods for Evaluating Solid Waste", EPA SW-846, 3rd Edition Volume II: Field Manual, Physical/Chemical Method, Chapter Nine (SW-846 Third Edition), 1986, Environmental Protection Agency, Washington, D.C. and no future editions or amendments, incorporated herein by reference and on file with the Department and the Office of the Secretary of State.
  2. "Quality Assurance Project Plan", Chapter 9, May 1991 Edition, Arizona Department of Environmental Quality, Phoenix, Arizona and no future editions or amendments incorporated herein by reference and on file with the Department and the Office of the Secretary of State.
- C. If soil excavated during the initial investigation of a site to determine the extent of contamination is PCS, the PCS may be returned into the excavation site from which the soil was removed if all of the following conditions are met:
  1. There is no freestanding liquid within the excavation, unless the State Fire Marshal or other jurisdictional fire authority directs otherwise, and the requirements of subsections (C)(2) and (3) are met.
  2. The owner or operator provides notification to the Department that the PCS has been returned to the excavation within 14 days after the return of the PCS to the excavation.
  3. The owner or operator completes a site characterization within 120 days and implements remediation within 150 days after the date the site characterization began.

**Historical Note**

Recodified from R18-8-1604 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1605. Transportation**

- A. PCS transported to a special waste receiving facility in Arizona shall be transported by a special waste shipper which has met the requirements of R18-13-1303.
- B. A special waste shipper shall transport the PCS in closed containers pursuant to R18-13-1611(E) or shall ensure that any vehicle used to transport the PCS is loaded and covered in such a manner that the contents will not blow, fall, leak, or spill from the vehicle.
- C. A special waste shipper transporting PCS to a special waste receiving facility in Arizona, except a facility located on Indian country, shall deliver PCS to a special waste receiving facility approved by the Department.

**Historical Note**

Recodified from R18-8-1605 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

**R18-13-1606. Fees**

- A. In accordance with A.R.S. §§ 49-855(C)(2) and 49-863, the treatment, storage, or disposal facility in this state that first receives a shipment of PCS shall remit to the Department a fee of \$6.68 per ton but not more than \$66,835.67 per generator site per year for PCS that is transported to the facility.
- B. Initial registration fee. Upon making a request for a special waste identification number on a form as provided by the Director pursuant to Article 13, A generator of PCS shall submit to the Department an initial registration fee of \$900.
- C. Annual registration fee. The Department shall bill an annual registration fee to a generator of PCS or special waste receiving facility that has received facility approval under R18-13-1607 that has not filed a notice of termination of registration with the Department as follows:
  1. For a generator of PCS, \$750; and
  2. For a special waste receiving facility, \$5,000.
- D. The generator of PCS or special waste receiving facility shall pay the annual registration fee within 30 days of invoice receipt.
- E. In accordance with A.R.S. § 49-855(G), a solid waste landfill that pays registration fees under A.R.S. § 49-747 is exempt from the annual registration fee under subsection (C) of this Section.
- F. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (A), (B), and (C) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
  1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (F)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

Recodified from R18-8-1606 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-1607. Facility Approval; Application**

- A. PCS shall be treated, stored, or disposed only at a PCS disposal facility, storage facility, treatment facility, or temporary treatment facility. A facility located in Arizona shall not be constructed or operated prior to obtaining written approval from the Department, except as provided for in A.R.S. § 49-858.
- B. The owner or operator of a PCS treatment, storage, or disposal facility shall submit an application to the Department which contains all of the information required in accordance with A.R.S. § 49-762.
- C. In addition to the requirements specified in A.R.S. § 49-762, the application shall contain all of the following:
  1. A vicinity map, in a scale not over 1:24,000, which shows where the facility is located with respect to the surroundings, including an indication of the use of the adjacent properties.



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2. An engineering report which includes all of the following:
    - a. Detailed plans and specifications for the entire facility including manufacturer's performance data and design features of treatment, pollution control, and monitoring equipment.
    - b. A site description which includes general information on the geology, hydrogeology, soils, and land use. If a facility is located within the pollution management area of a facility for which an aquifer protection permit has been issued under A.R.S. § 49-241 et seq., then the applicant may resubmit or incorporate by reference the general information.
    - c. A background soil sampling plan and results which characterize the site, including the rationale used to determine the locations, depths, and number of samples.
  3. A site map, in a scale not to exceed 1:2,400, which clearly identifies where the PCS shall be deposited, containment berms, fencing and security measures, access roads, any improvements, wells, and location of surface water courses.
  4. An operational plan which includes all of the following:
    - a. General description of the daily operations of the facility and the processes, techniques, or methods to be employed;
    - b. The source, amount, concentration of contaminants, and any other relevant information concerning the PCS to be handled;
    - c. The schedule for sampling the PCS during treatment to evaluate treatment methods;
    - d. Description of plans for final use and disposal of PCS and remediated soil, liners, piping, carbon canisters, and any other contaminated equipment;
    - e. Procedures to ensure that only waste which has been characterized is received and that hazardous waste is not received;
    - f. Procedures for random inspection of incoming loads to verify that only waste which has been characterized is accepted;
    - g. Procedures for collecting and managing run-off which comes in contact with PCS;
    - h. Procedures for recordkeeping of all inspection results, training of personnel, and sampling results;
    - i. Procedures to control public access, and prevent unauthorized entry and illegal dumping.
  5. A contingency plan for emergency preparedness which describes alternatives for storage, treatment, or disposal.
  6. A closure plan which includes:
    - a. A description of the steps necessary to close the facility, the specific proposed closure activities, and an implementation schedule;
    - b. Information on site conditions and characterization of the waste received during the life of the facility;
    - c. A description of the sampling plan utilized to sample background soil beneath the site following closure;
    - d. A description of plans for use of the land site after closure;
    - e. A description of post-closure care.
  7. An affidavit that the proposed facility is in compliance with local zoning requirements in effect at the time the application is submitted.
- D.** Following completion of construction of a facility and prior to placement of PCS on the site, the owner or operator shall submit to the Department a construction certification report, including as-built plans which indicate any changes to the design or operational plans for the facility.
- E.** Plans required in accordance with this Section shall be sealed by a professional engineer registered in the state of Arizona, if required by statute.
  - F.** A facility shall be in compliance with all other applicable federal, state, and local approvals or permits which are required for the design, construction, and operation of the facility.
- Historical Note**  
 Recodified from R18-8-1607 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).
- R18-13-1608. General Design and Performance Standards**
- A.** A facility which receives PCS for treatment, storage, or disposal shall be designed and operated to ensure compliance with the following performance standards relating to aquifer protection:
    1. Pollutants discharged shall in no event cause or contribute to a violation of Aquifer Water Quality Standards, at the applicable point of compliance, or, if the facility is a municipal solid waste landfill, it shall comply with the requirements of A.R.S. § 49-761.01(C).
    2. Any pollutant discharged shall not further degrade, at the applicable point of compliance, the quality of any aquifer that already violates an Aquifer Water Quality Standard for that pollutant.
  - B.** A facility which receives PCS for treatment, storage, or disposal shall meet the general design criteria of either subsection (B)(1) or (2) as follows:
    1. The PCS shall be held within a containment system designed and constructed to preclude the migration of contaminants into subsurface soil, groundwater, or surface water. The containment system shall meet the following criteria:
      - a. Maintain a maximum permeability coefficient of no more than  $1 \times 10^{-7}$  cm/sec;
      - b. Be designed to provide structural integrity throughout the life of the facility;
      - c. Be designed in accordance with the applicable design criteria set forth in subsection (C) of this Section and R18-13-1609 through R18-13-1613; or
    2. An alternative design shall contain, at a minimum, all of the following and shall demonstrate that the design will limit discharges listed in A.R.S. § 49-243(D) to the maximum extent practicable:
      - a. The hydrogeologic setting of the facility and the capacity of the liner and soils to preclude discharge to groundwater or surface water;
      - b. The operating methods, processes, or other alternatives to be used at the facility;
      - c. Additional factors which would influence the quality and mobility of the leachate produced and the potential for that leachate to migrate to groundwater or surface water.
  - C.** A PCS treatment, storage, or disposal facility shall meet the following general design criteria:
    1. The facility shall be designed to prevent run-on and run-off. The design shall provide run-on control for the peak discharge from a 24-hour, 25-year storm event. Run-off shall be collected and controlled for at least the water volume resulting from a 24-hour, 25-year storm event.

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2. The facility shall not restrict the flow of the 100-year floodplain, reduce temporary water storage capacity of the floodplain, or be maintained in a manner which results in a washout or inundation of the PCS.
  3. The owner or operator shall control public access and shall prevent unauthorized vehicular traffic and illegal dumping.
  4. The owner or operator shall manage any standing water that has come into contact with the PCS in accordance with rules promulgated pursuant to A.R.S. § 49-761 et seq.
- D.** A facility which manages PCS in accordance with the requirements of this Article shall be exempt from the aquifer protection permit requirements in accordance with A.R.S. § 49-250(B)(21).
- E.** A facility which has been issued an aquifer protection permit from the Department shall be exempt from the requirements of subsections (A) and (B) of this Section but shall comply with the requirements of subsection (C).

**Historical note**

Recodified from R18-8-1608 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1609. Treatment Facility**

- A.** The owner or operator of a PCS treatment facility shall obtain approval from the Department prior to commencement of construction or operation and shall comply with all of the following:
1. Not dilute PCS as a method of treatment, except as allowed in the approved plan for the facility;
  2. Treat the PCS or, if the chosen treatment process fails to remediate the soil to below the regulatory thresholds, dispose of the PCS pursuant to R18-13-1613.
  3. Sample the treated soil and provide the results of the sampling to the Department within 45 days of completion of the treatment.
- B.** A PCS treatment facility designed in accordance with R18-13-1608(B)(1) shall comply with the following specific design criteria:
1. At a minimum, a containment system shall include a clay, synthetic, concrete, or asphalt liner component which is placed upon a foundation or prepared subgrade which supports the liner, and resists pressure gradients above and below the liner, to prevent failure due to settlement, compression, or uplift.
  2. During construction or installation of a containment system, liners and cover systems shall be inspected for uniformity, damage, and imperfections. Immediately after construction or installation is completed, and prior to placement of PCS within the containment system, the systems shall be checked for both of the following:
    - a. Synthetic liners and covers shall be inspected to ensure tight seams and joints and the absence of tears, punctures, or blisters.
    - b. Concrete, asphalt, and soil-based liners and covers shall be inspected for imperfections including lenses, cracks, channels, root holes, or other structural non-uniformities that may cause an increase in the permeability of the liner or cover.
  3. The liner component shall consist of one of the following:

- a. A synthetic liner which is compatible with the waste and which has a minimum 6" buffer layer of sand or soil between the liner and the PCS.
  - b. A compacted soil or admixed liner provided with a minimum 6" buffer layer of sand or soil between the liner and the PCS.
  - c. An asphalt or reinforced concrete liner which is not in the drainage area of a dry well and is free of unsealed cracks and seams.
4. Aeration equipment shall be limited to the area above the buffer layers indicated in subsections (B)(2)(a) and (b).
  5. The owner or operator of the facility shall utilize protective measures to ensure containment system integrity during placement, treatment, or removal of the PCS.
  6. PCS stored at a treatment facility prior to treatment shall be stored in accordance with the requirements of R18-13-1611.

**Historical Note**

Recodified from R18-8-1609 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

**R18-13-1610. Temporary Treatment Facility**

- A.** The owner or operator of a temporary treatment facility shall treat and remove all PCS from the temporary treatment facility within one year from the date of commencement of receipt of PCS for treatment. PCS shall not be diluted to meet any treatment requirement, except in accordance with the approved plan.
- B.** A temporary treatment facility shall obtain approval from the Department prior to commencing construction or operation. In lieu of the requirements of R18-13-1607(C), an application for approval shall contain all of the following:
1. An affidavit signed by the owner or operator of the temporary treatment facility which states that the facility will comply with the requirements of this Article;
  2. An affidavit that the proposed facility is in compliance with local zoning requirements in effect at the time the application is submitted;
  3. Application information required pursuant to A.R.S. § 49-762.03(C)) for plan approval for temporary treatment facilities;
  4. A vicinity map, in a scale not over 1:24,000, which shows where the facility is located with respect to the surroundings, including an indication of the use of the adjacent properties;
  5. A site description which includes general information on the geology, hydrogeology, soils, and land use;
  6. A background soil sampling plan and results which characterize the site, including the rationale used to determine the locations, depths and number of samples;
  7. A site map, in a scale not to exceed 1:2,400, which clearly identifies where the PCS shall be deposited, containment berms, fencing and security measures, access roads, any improvements, wells, and location of surface water courses;
  8. An operational plan which includes all of the following:
    - a. General description of the daily operations of the facility and the processes, techniques, or methods to be employed;
    - b. The source, amount, concentration of contaminants, and any other relevant information concerning the PCS to be handled;
    - c. The schedule for sampling the PCS during treatment to evaluate treatment methods;

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- d. Description of plans for final use and disposal of PCS and remediated soil, liners, piping, carbon canisters, and any other contaminated equipment;
- 9. A closure and post-closure care plan which includes both of the following:
  - a. A description of the steps necessary to close the facility, the specific proposed closure activities, and an implementation schedule;
  - b. A description of the sampling plan utilized to sample background soil beneath the site following closure.
- C. A temporary treatment facility shall not be operated for more than one year unless a one-time extension is granted by the Department. The Department may grant an extension of up to one additional year if all of the following are met:
  - 1. The inability to perform is caused by events beyond the control of the owner or operator, including acts of God, which include flood, tornado, earthquake, and causes beyond the owner's or operator's control including fire, explosion, unforeseen strikes or work stoppages, riot, sabotage, public enemy, war, requirements established by courts of competent jurisdiction, and other governing law. Financial inability to perform shall not be justification for an extension.
  - 2. The owner and operator submits to the Department verifiable documentation which includes all of the following:
    - a. A description of the circumstances causing any delay;
    - b. Evidence of the existence of the circumstance;
    - c. A description of past, present, and future measures taken or to be taken by the owner or operator to prevent or minimize any delay;
    - d. A timetable by which the owner and operator will resume and complete required performance.
  - 3. The request is received at least 60 days prior to the expiration of the year in which the facility first received PCS. Where the Department grants an extension, that extension shall be granted prior to the expiration of the deadline and communicated to the owner or operator in writing.
- D. A temporary treatment facility shall meet the design criteria as specified in R18-13-1608 and R18-13-1609(B).
- E. PCS stored at a temporary treatment facility prior to treatment shall be stored in accordance with the requirements of R18-13-1611.
- F. In accordance with A.R.S. §§ 49-762.03(C), a temporary treatment facility shall be exempt from the notice and public hearing requirements set forth in A.R.S. § 49-762.04(A).

**Historical Note**

Recodified from R18-8-1610 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1611. Storage Facility**

- A. A shipment of PCS shall not be stored for a period exceeding one year from the date the PCS is received.
- B. Each shipment of contaminated soil shall be identified by source and stored in a manner which does not allow commingling of different shipments until all sampling results have been obtained. PCS shall be stored within an approved containment system and shall not be commingled with treated soils.
- C. A PCS storage facility shall obtain approval from the Department prior to commencement of construction or operation. A

PCS storage facility designed in accordance with R18-13-1608(B)(1) shall comply with either of the following:

- 1. The containment system shall meet the requirements of R18-13-1609(B).
- 2. The PCS shall be stored in tanks or containers which meet the requirements of subsection (E) of this Section.
- D. A PCS storage area or each tank or container used for storage shall be marked as follows:  
 CAUTION: CONTAINS PETROLEUM-CONTAMINATED SOIL  
 GENERATOR NAME:  
 GENERATOR ID#:  
 ACCUMULATION START DATE:

The owner or operator of the storage facility shall fill in the accumulation start date at the time the PCS is placed into storage. The letters shall be legible, not obstructed from view, on a high contrast background, and sufficiently durable to equal or exceed the duration of storage. Lettering size shall be 2.5 cm (1 inch) and in Sans Serif, Gothic, or Block style.

- E. A tank or container used to store PCS shall meet all of the following requirements:
  - 1. Prevent leakage of PCS and any free liquids from the tank or container;
  - 2. Be made of, or lined with, materials which will not react with the PCS;
  - 3. Be kept closed during storage except to add or remove PCS;
  - 4. Not be opened, handled, or stored in a manner which may rupture the tank or container or cause it to leak;
  - 5. Shall be inspected monthly by the owner or operator of the storage facility for leaks and for deterioration. A written record of the inspection shall be prepared at the time of the inspection and shall document corrective action, if any, taken as a result of the inspection.
- F. A PCS storage facility at which PCS is stored in piles shall comply with both of the following:
  - 1. All storage piles shall be covered or otherwise managed to control wind dispersal of the PCS.
  - 2. Storage piles of PCS shall be inspected weekly and a written record of the inspection shall be prepared at the time of the inspection which documents any corrective action taken as a result of the inspection. The record shall document detection of any of the following:
    - a. Deterioration, malfunctions, or improper operation of run-on and run-off control systems;
    - b. Malfunctioning of wind dispersal control systems;
    - c. The presence of leachate in and the malfunctioning of any leachate collection and removal systems.

**Historical Note**

Recodified from R18-8-1611 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

**R18-13-1612. Accumulation Sites**

- A. PCS from one or more points of generation under the control of a single generator may be accumulated in an accumulation site under the control of that generator for up to 90 days prior to shipment of the PCS to a storage, disposal, or treatment facility.
- B. An accumulation site shall comply with the storage facility requirements set forth in R18-13-1611, except subsection (A) of that Section. An accumulation site shall not be required to comply with the requirements in R18-13-1607.
- C. While PCS is at an accumulation site, the owner or operator shall control public access and prevent unauthorized vehicular

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traffic and illegal dumping. PCS shall be managed to prevent the PCS from being exposed to storm water run-on or run-off.

**Historical Note**

Recodified from R18-8-1612 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

**R18-13-1613. Disposal**

- A. PCS shall be disposed at a special waste receiving facility which has been approved for the disposal of PCS, or at a hazardous waste management facility as defined in R18-13-260(E)(13).
- B. A PCS disposal facility designed in accordance with R18-13-1608(B)(1) shall comply with the following specific design criteria:
  1. The disposal facility shall be designed with a composite liner, as defined in subsection (B)(2), and a leachate collection system that is designed and constructed to maintain less than a 12-inch depth of leachate over the liner.
  2. For purposes of this Section, "composite liner" means a system consisting of two components: the upper component shall consist of a minimum 30-mil flexible membrane liner (FML) and the lower component shall consist of at least a two-foot layer of compacted soil with a permeability coefficient of no more than  $1 \times 10^{-7}$  cm/sec. FML components consisting of high density polyethylene (HDPE) shall be at least 60 mil thick. The FML component shall be installed in direct and uniform contact with the compacted soil component.

**Historical Note**

Recodified from R18-8-1613 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4). Amended by final expedited rulemaking at 27 A.A.R. 57, with an immediate effective date of January 5, 2021 (Supp. 21-1).

**R18-13-1614. Records**

Records required to be kept pursuant to this Article shall be maintained by the owner or operator and made available for inspection by the Director for a period of three years or longer during the course of an enforcement action or litigation.

**Historical Note**

Recodified from R18-8-1614 at 8 A.A.R. 5172, effective November 27, 2002 (Supp. 02-4).

**ARTICLE 17. RESERVED****ARTICLE 18. RESERVED****ARTICLE 19. LEAD ACID BATTERY RECYCLING****R18-13-1901. Collection or Recycling Facility of Lead Acid Batteries; Registration; Fees**

- A. Initial registration. The owner or operator of an existing collection or recycling facility that accepts lead acid batteries as of the effective date of this Section shall register with the Department by March 1, 2025, on a form approved by the Department. A collection or recycling facility shall not begin operation to accept lead acid batteries until the owner or operator registers with the Department on a form approved by the Department that includes a statement that the facility is in compliance with A.R.S. § 44-1322. The owner or operator of a new collection or recycling facility of lead acid batteries shall submit an initial registration fee of \$810 at the time of registration under this subsection.
- B. Annual registration fee. The Department shall bill an annual registration fee of \$675 to a registered collection or recycling facility that has not filed a notice of termination of registration

with the Department. The owner or operator of a registered collection or recycling facility shall pay the annual registration fee within 30 days of invoice receipt.

- C. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (A) and (B) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
  1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (C)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.
- D. For purposes of this Section, "lead acid battery" means a battery with a core of elemental lead and a capacity of six or more volts that is suitable for use in a vehicle or a boat.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**ARTICLE 20. USED OIL****R18-13-2001. Definitions**

- A. "40 CFR 279", and any section therein, refers to 40 CFR part 279, as amended on January 1, 1997, and no future editions or later amendments. Copies of 40 CFR 279 are available at <https://www.govinfo.gov/app/collection/cfr/>. Copies are on file with the Department.
- B. "CFR" means the Code of Federal Regulations.
- C. "Department" means the Arizona Department of Environmental Quality.
- D. "Used oil" means the same as defined in 40 CFR 279.1 and includes oil that has been contaminated as a result of handling, transportation, or storage.
- E. "Used oil collection center" means the same as defined in 40 CFR 279.1.
- F. "Used oil burner" means the same as defined in 40 CFR 279.1.
- G. "Used oil fuel marketer" means the same as defined in 40 CFR 279.1.
- H. "Used oil handler" means a used oil burner, used oil marketer, used oil transporter, or used oil processor.
- I. "Used oil processor" means the same as defined in 40 CFR 279.1.
- J. "Used oil transporter" means the same as defined in 40 CFR 279.1.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-2002. Used Oil Handler Registration; Fee**

- A. Initial registration. A new used oil handler that has received, or is required to obtain, an EPA identification number pursuant to 40 CFR 279 shall not begin operation until the owner or operator registers with the Department on a form approved by the Department. A new used oil handler shall submit an initial registration fee at the time of registration under this subsection as follows:

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1. For a used oil processor, \$9,000;
  2. For a used oil burner, \$15,000;
  3. For a used oil transporter, \$1,800; and
  4. For a used oil fuel marketer, \$1,800.
- B.** Annual registration fee. The Department shall bill an annual registration fee to a used oil handler that has received, or is required to obtain, an EPA identification number pursuant to 40 CFR 279 that has not filed a notice of termination of registration with the Department as follows:
1. For a used oil processor, \$7,500;
  2. For a used oil burner, \$12,500;
  3. For a used oil transporter, \$1,500; and
  4. For a used oil fuel marketer, \$1,500.
- C.** The registered used oil handler shall pay the annual registration fee within 30 days of invoice receipt.
- D.** Beginning July 1, 2026, the Director shall adjust the fee amounts in subsections (A) and (B) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (D)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-2003. Used Oil Collection Center Identification Number; Requirements**

- A.** A used oil collection center shall request a used oil collection center identification number on a form provided by the Director pursuant to A.R.S. § 49-802(C) that contains all of the following:
1. The company name;
  2. The name of the owner of the company;
  3. The mailing address and telephone number of the company;
  4. The location of the collection center; and
  5. A description of the type of used oil activity at the company.
- B.** Within 30 days of receiving the completed form, the Director shall issue the identification number to the used oil collection center.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**ARTICLE 21. SOLID WASTE LANDFILL REGISTRATION AND DISPOSAL FEES**

*Article 21, consisting of Sections R18-13-2101 through R18-13-2103, made by final rulemaking at 9 A.A.R. 1770, effective July 14, 2003 (Supp. 03-2).*

**R18-13-2101. Definitions**

In addition to the definitions in A.R.S. §§ 49-701 and 49-701.01, for the purpose of this Article, the terms used in this Article have the following meanings:

1. “Defined time period” means the 12-month period that begins on July 1 of a calendar year and ends on June 30 of the following calendar year and consists of the actual number of calendar days in that 12-month period.
2. “Disposal fee invoice” means the quarterly landfill disposal fee invoice the Department mails to a landfill operator, on which the landfill operator indicates the amount of waste received and the amount of the disposal fees owed to the Department as required under A.R.S. § 49-836.
3. “Local public facility” means a facility operated pursuant to A.R.S. § 49-741.
4. “Recycling residue” means waste generated from recycling:
  - a. Solid waste; or
  - b. Effluent from a secondary wastewater treatment plant or wastewaters.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1770, effective July 14, 2003 (Supp. 03-2). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-2102. Solid Waste Landfill Registration; Annual Registration Fee**

- A.** An operator of a new solid waste landfill shall register the solid waste landfill with the Department on a form approved by the Department.
- B.** An existing solid waste landfill shall pay an annual registration fee within 30 days of receipt of an invoice from the Department according to the following:
1. For solid waste landfills that received less than 60,000 tons during the defined time period, \$5,000.
  2. For solid waste landfills that received at least 60,000 tons but less than 225,000 tons during the defined time period, \$10,000.
  3. For solid waste landfills that received 225,000 tons or more during the defined time period, \$18,565.
- C.** The Department shall determine the amount of waste received by a solid waste landfill by one of the following methods:
1. As the reported tons of solid waste received on the disposal fee invoices over the defined time period; or
  2. As the reported units of compacted or uncompacted solid waste received on the disposal fee invoices and reported under R18-13-2104 over the defined time period.
- D.** Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (B) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (C)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage

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and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1770, effective July 14, 2003 (Supp. 03-2). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-2103. Landfill Closure and Post-Closure Care Obligations; Fees**

- A. The Department shall calculate and the solid waste landfill shall pay the annual landfill registration fee until the first defined time period after the solid waste landfill stops accepting waste.
- B. From the time a solid waste landfill stops accepting waste as specified in subsection (A), until the owner or operator of the solid waste landfill has completed closure and is released from its obligation for post-closure care as required by A.R.S. §§ 49-761 or 49-770, the annual registration fee is \$3,500.
- C. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (B) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:
  1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
  2. Round the result from subsection (C)(1) to the nearest cent. ADEQ shall post the new amounts on its webpage and install them in the billing software as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 9 A.A.R. 1770, effective July 14, 2003 (Supp. 03-2). Amended by final rulemaking at 18 A.A.R. 1217, effective July 1, 2012 (Supp. 12-2). Amended by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-2104. Solid Waste Landfill Disposal Fee; Exemptions**

- A. The operator of a solid waste landfill shall pay to the Department the disposal fee required by A.R.S. § 49-836 as follows:
  1. \$.58 for each six cubic yards of uncompacted solid waste;
  2. \$.58 for each three cubic yards of compacted solid waste; or
  3. \$.58 per ton of solid waste.
- B. A solid waste landfill that receives only waste generated on site shall compute the fee in subsection (A) of this Section by one of the following methods:
  1. By actual volume or weight; or
  2. By estimate based on landfill capacity use, volume or number of waste loads or any other reasonable means for approximating the volume or weight of disposed waste.
- C. Facilities that generate recycling residue shall pay the disposal fee required by A.R.S. § 49-836 as follows, to an annual maximum of \$34,942.20, for on-site disposal:
  1. \$.29 for the dry weight or volume of the recycling residue generated; or
  2. \$.29 for the dewatered weight or volume of the recycling residue generated.

- D. A person who for a fee disposes of waste in a solid waste landfill that is not regulated by the Department shall keep accurate records of the waste disposed of in those landfills and shall pay to the Department the disposal fee as prescribed in subsection (A) of this Section.
- E. The operator of a local public facility that does not have on-site operators or scales shall pay to the Department a fee that shall be calculated by multiplying the population of the political subdivision served by the local public facility by \$.16.
- F. A person who is subject to fees under this Section shall sign and submit a form prepared by the Department with each fee payment. The form shall state the total volume or weight of solid waste disposed of at that landfill during the payment period.
- G. The following are exempt from the requirements of this Section:
  1. Persons disposing of a load containing less than six cubic yards of uncompacted solid waste or three cubic yards of compacted solid waste.
  2. A site used solely for the reclamation of land through the introduction of landscaping rubble or inert material.
  3. Material produced in connection with a mining or metallurgical operation.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**ARTICLE 22. NEW TIRE SELLERS****R18-13-2201. Definitions**

- A. "Motor vehicle" means any automobile, motorcycle, truck, trailer, semitrailer, truck tractor and semitrailer combination or other vehicle operated on the roads of this state, used to transport persons or property and propelled by power other than muscular power, but motor vehicle does not include traction engines, vehicles that run only on a track, bicycles or mopeds.
- B. "Tire seller" means a retail seller of motor vehicle tires or a wholesale seller of motor vehicle tires who sells tires to the state, to a political subdivision of the state, or to a private entity not for resale, and includes a person whose retail sales of new motor vehicle tires are not in the ordinary course of business.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**R18-13-2202. New Tire Sellers; Fee**

- A. Beginning April 1, 2025, a tire seller of new motor vehicle tires shall collect a fee of 2% of the retail sales price, not including transaction privilege tax, of each tire to a maximum of \$4.66 per tire. For the sale of a new motor vehicle with a gross weight of under 10,000 pounds by a manufacturer to a wholesaler or retailer, if the sales price of the tires is not specified by the manufacturer, the tire seller shall collect a fee of \$2.33 per tire.
- B. A seller required to collect a fee under subsection (A) of this Section may credit \$.10 per tire against the fee for expenses incurred by the seller for accounting and reporting related to the fee.
- C. A seller who collects a fee under subsection (A) of this Section shall remit the fee to the Arizona Department of Revenue for deposit on a quarterly basis in the waste tire fund established pursuant to section A.R.S. § 44-1305.

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D. Beginning July 1, 2026, the Director shall adjust the fee amounts in subsection (A) of this Section annually by the following method, except that no adjustment in any year shall exceed four percent of the fee amount of the preceding year:

1. Multiply the amount by the October CPI for the most recent year and then divide by the October CPI for the year 2024. The October CPI for any year is the Consumer Price Index for All Urban Consumers, Phoenix-Mesa-Scottsdale, AZ, all items, published by the United States Department of Labor at [www.bls.gov/cpi/regional-resources.htm](http://www.bls.gov/cpi/regional-resources.htm), for October of that year.
2. Round the result from subsection (D)(1) to the nearest cent. ADEQ shall notify the Arizona Department of Revenue of the adjusted fee amounts and post the new amounts on its webpage as soon as practicable.

**Historical Note**

New Section made by final rulemaking at 31 A.A.R. 348 (January 24, 2025), with an immediate effective date of December 24, 2024 (Supp. 24-4).

**ARTICLE 23. RESERVED****ARTICLE 24. RESERVED****ARTICLE 25. EXPIRED****R18-13-2501. Expired****Historical Note**

Section adopted by final rulemaking at 5 A.A.R. 4654, effective November 15, 1999 (Supp. 99-4). Section expired under A.R.S. § 41-1056(J), at 23 A.A.R. 3429, effective October 10, 2017 (Supp. 17-4).

**ARTICLE 26. EXPIRED****R18-13-2601. Expired****Historical Note**

Section made by exempt rulemaking at 14 A.A.R. 4258, effective October 20, 2008 (Supp. 08-4). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 705, effective April 6, 2010 (Supp. 10-2).

**R18-13-2602. Expired****Historical Note**

Section made by exempt rulemaking at 14 A.A.R. 4258, effective October 20, 2008 (Supp. 08-4). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 705, effective April 6, 2010 (Supp. 10-2).

**R18-13-2603. Expired****Historical Note**

Section made by exempt rulemaking at 14 A.A.R. 4258, effective October 20, 2008 (Supp. 08-4). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 705, effective April 6, 2010 (Supp. 10-2).

**R18-13-2604. Expired****Historical Note**

Section made by exempt rulemaking at 14 A.A.R. 4258, effective October 20, 2008 (Supp. 08-4). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 705, effective April 6, 2010 (Supp. 10-2).

**ARTICLE 27. EXPIRED****R18-13-2701. Expired****Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 848, effective July 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1503, effective July 1, 2010 (Supp. 10-3). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 2984, effective September 15, 2016 (Supp. 16-3).

**R18-13-2702. Expired****Historical Note**

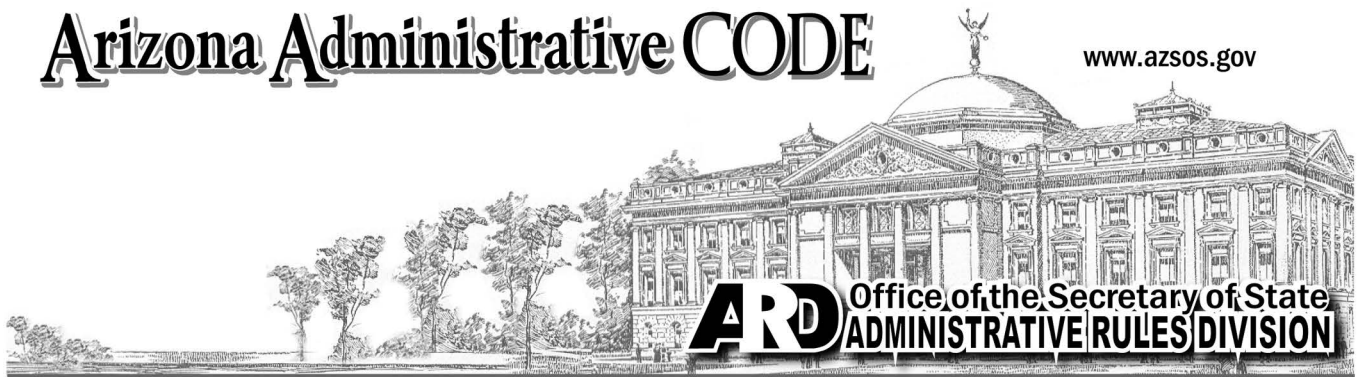
New Section made by exempt rulemaking at 16 A.A.R. 848, effective July 1, 2010 (Supp. 10-2). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 2984, effective September 15, 2016 (Supp. 16-3).

**R18-13-2703. Expired****Historical Note**

New Section made by exempt rulemaking at 16 A.A.R. 848, effective July 1, 2010 (Supp. 10-2). Section and fee table expired under A.R.S. § 41-1056(J) at 22 A.A.R. 2984, effective September 15, 2016 (Supp. 16-3).

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**TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE**  
**CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - INSURANCE**  
**DIVISION**

The table of contents on page one contains links to the referenced page numbers in this Chapter.  
Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the *Arizona Administrative Register*.

This Chapter contains rules that were filed to be codified in the *Arizona Administrative Code* between the dates of  
October 1, 2024 through December 31, 2024

<a href="#">R20-6-1902.</a>	<a href="#">Definitions.....</a>	<a href="#">155</a>	<a href="#">R20-6-2301.</a>	<a href="#">Applicability: Definitions.....</a>	<a href="#">165</a>
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**Questions about these rules? Contact:**

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[Email:](#) [mary.kosinski@difi.az.gov](mailto:mary.kosinski@difi.az.gov)

**The release of this Chapter in Supp. 24-4 replaces Supp. 24-1, 1-171 pages.**

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

## PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the *Administrative Code*. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director  
ADMINISTRATIVE RULES DIVISION

### RULES

The definition for a rule is provided for under A.R.S. § 41-1001. “Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

### THE ADMINISTRATIVE CODE

The *Arizona Administrative Code* is where the official rules of the state of Arizona are published. The *Code* is the official codification of rules that govern state agencies, boards, and commissions.

The *Code* is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the *Code*. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31  
Second Quarter: April 1 - June 30  
Third Quarter: July 1 - September 30  
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

### RULE HISTORY

Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the *Register* volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the *Register*.

### AUTHENTICATION OF PDF CODE CHAPTERS

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### HOW TO USE THE CODE

Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the *Arizona Administrative Register* for recent updates to rule Sections.

### ARIZONA REVISED STATUTE REFERENCES

The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, [www.azleg.gov](http://www.azleg.gov). An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

### SESSION LAW REFERENCES

Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, [www.azsos.gov](http://www.azsos.gov) under Services-> Legislative Filings.

### EXEMPTIONS FROM THE APA

It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the *Register* online at [www.azsos.gov/rules](http://www.azsos.gov/rules), click on the *Administrative Register* link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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*Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.*

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## Administrative Rules Division

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## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

## CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - INSURANCE DIVISION

Authority: A.R.S. § 20-101 et seq.

## Supp. 24-4

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*Editor's Note: Due to a clerical error the following Sections had incorrect effective dates as released in Supp. 23-4: R20-6-205, R20-6-604, R20-6-801, R20-6-1003 and Appendix B, R20-6-2002, R20-6-2401. The year has been corrected to 2024. Please destroy any copy of the digitally signed version of this Chapter from Date: 2024.02.05. The new version is Supp. 23-4, Ver. 2, digitally signed 2024.03.01.*

*Editor's Note: The name of the Arizona Department of Insurance was changed to the Department of Insurance and Financial Institutions - Insurance Division under Laws 2019, Ch. 252, effective July 1, 2020 (Supp. 22-2).*

*Editor's Note: 20 A.A.C. 6, consisting of R20-6-101 through R20-6-159, R20-6-201 through R20-6-218, R20-6-301 through R20-6-308, R20-6-401 through R20-6-409, R20-6-501, R20-6-601 through R20-6-607, R20-6-701 through R20-6-709, R20-6-801 through R20-6-802, R20-6-901, R20-6-1001 through R20-6-1016, R20-6-1101 through R20-6-1120, R20-6-1201 through R20-6-1205, R20-6-1401 through R20-6-1408, R20-6-1601 through R20-6-1607, and R20-6-1701 through R20-6-1704 recodified from 4 A.A.C. 14, consisting of R4-14-101 through R4-14-159, R4-14-301 through R4-14-308, R4-14-401 through R4-14-409, R4-14-501, R4-14-601 through R4-14-607, R4-14-701 through R4-14-709, R4-201 through R4-14-218, R4-14-801 through R4-14-802, R4-14-901, R4-14-1001 through R4-14-1016, R4-14-1101 through R4-14-1120, R4-14-1201 through R4-14-1205, R4-14-1401 through R4-14-1408, R4-14-1601 through R4-14-1607, and R4-14-1701 through R4-14-1704, pursuant to R1-1-102 (Supp. 95-1).*

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*Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted again by emergency effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1).*

*Article 11, consisting of Sections R4-14-1101 through R4-14-1120 and Appendices A through E, adopted by emergency effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). R20-6-1101 through R20-6-1120 recodified from R4-14-1101 through R4-14-1120 (Supp. 95-1).*

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Article 16, consisting of Sections R20-6-1601 through R20-6-1608, renumbered to Article 16, Part 1, R20-6A1601 through R20-6A1608; Article 16, consisting of Sections R20-6-1610 through R20-6-1612, renumbered to Article 16, Part 2; by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

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Article 16, Part A, consisting of Sections R20-6A1601 through R20-6A1609, renumbered from Article 16, R20-6-1601 through R20-6-1608 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

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## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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**ARTICLE 1. RULES OF PRACTICE AND PROCEDURE BEFORE THE DIRECTOR****R20-6-101. Scope of Article; Definitions****A. Scope.**

1. Administrative Hearings. This Article and Title 20 of the Arizona Revised Statutes govern administrative hearings before the Department. The Department shall use the authority of A.R.S. Title 41, Chapter 6, Article 10, the Office of Administrative Hearings' procedural rules, and this Article to govern the initiation and conduct of administrative hearings. In an administrative hearing, special procedural requirements in state statute or another Section in this Article shall also govern the proceedings unless the requirements are inconsistent with either A.R.S. Title 41, Chapter 6, Article 10, the Office of Administrative Hearings' rules or this Article.
2. Director's Hearings. Director's Hearings are governed by this Article and Title 20 of the Arizona Revised Statutes.
3. Rulemaking and Investigative Proceedings. Except as otherwise provided in Section R20-6-160 for rulemaking petitions, this Article does not apply to rulemaking or investigative proceedings before the Director.
4. Arizona Rules of Civil Procedure. Unless expressly applicable by rule or statute, the Arizona Rules of Civil Procedure do not apply to administrative or Director's hearings.

**B. Definitions.** In addition to the definitions provided in A.R.S. §§ 41-1001 and 41-1092, the following terms apply to this Article:

1. "Administrative Hearing" means an appealable agency action as defined by A.R.S. § 41-1092(3) or a contested case as defined by A.R.S. § 41-1001(5) subject to A.R.S. § 20-161 and A.R.S. Title 41, Chapter 6, Article 10.
2. "Attorney General" means the Attorney General of Arizona, and the Attorney General's assistants or special agents.
3. "Department" means the Arizona Department of Insurance and Financial Institutions, Division of Insurance.
4. "Director" has the meaning stated at A.R.S. § 20-102 or a Hearing Officer or any deputy, assistant, or examiner of the Director acting in the Director's name in accordance with A.R.S. § 20-150.
5. "Director's Hearing" means a hearing required by Title 20 to be conducted by the Director that is not an administrative hearing. A Director's hearing is not subject to the Arizona Open Meeting law. Director's hearings are required for, but not limited to, the following:
  - a. Taking comments to determine whether the cooperation among rating organizations and insurers is unfair or unreasonable or otherwise inconsistent with the provisions of Title 20 under A.R.S. § 20-365;
  - b. Taking comments to determine whether a reasonable degree of price competition exists at the consumer level with respect to a particular class of business or to determine an allowable percentage of increase in a proposed rate level for a particular line, subtitle, or class of business under A.R.S. § 20-383(B);
  - c. Taking comments to exempt rate filings or to find that a particular market is noncompetitive for purposes of rate filing under A.R.S. §§ 20-385(F) and (G);
  - d. Taking comments to determine recognized surplus lines under A.R.S. § 20-409;

- e. Taking comments regarding acquisitions within a holding company system if the acquisition would require the approval of other states under A.R.S. § 20-481.07(G);
  - f. Taking comments to establish criteria for third parties who are eligible to provide credit enhancement for separate accounts and to accept assets that are pledged under A.R.S. § 20-536.01(C);
  - g. Taking comments to prescribe standards to allow investments in separate accounts to exceed established limits under A.R.S. § 20-536.01(D);
  - h. Taking comments in order to prescribe an investment grade rating, to recognize rating agencies for purposes of investment, or to prescribe standards by which obligations of insurers who have not received an investment grade rating may be eligible for investment under A.R.S. §§ 20-544 and 20-545;
  - i. Taking comments from parties affected by a proposed corporate acquisition, merger or consolidation of title insurers under A.R.S. §§ 20-1576(A)(1) and 20-1577(A);
  - j. Taking comments to establish a loss ratio standard for credit property and credit unemployment insurance under A.R.S. § 10-1621.05(B);
  - k. Taking comments for the purpose of exempting certain forms from the application of Title 20, Chapter 6, Article 14: Cancellation or Non-Renewal of Commercial Insurance under A.R.S. § 20-1671(12); and
  - l. Taking comments to establish prima facie rates for credit life and credit disability insurance under Section R20-6-604.03(A).
6. "Hearing Officer" means a person appointed by the Director to conduct a Director's hearing.
  7. "Party" has the meaning prescribed at A.R.S. § 41-1001(16) and includes any person or entity subject to the jurisdiction of the Department under A.R.S. Title 20.

**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-101 recodified from R4-14-101 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R20-6-102. Appearance and Practice before the Director for Administrative and Director's Hearings**

- A.** A party may appear in their own behalf or through counsel. An insurer may appear through legal counsel or through a duly authorized officer of the corporation.
- B.** When an attorney other than the Attorney General appears or intends to appear before the Director or the Department, they shall promptly disclose their name and contact information and the name and contact information of the person on whose behalf they intend to appear.
- C.** Conduct at any Director's hearing which, in the discretion of the Director or Hearing Officer is deemed contemptuous shall be grounds for exclusion from the hearing. Contemptuous conduct shall include willful disruption or obstruction of any Director's hearing, or any other willful conduct during any Director's hearing which lessens the dignity or authority of the Director or Hearing Officer.
- D.** Notice of a Director's Hearing is subject to Title 20 and shall contain at a minimum:



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1. The subject matter on which the Director intends to take comments including the specific statutory sections authorizing the Director to conduct the hearing;
  2. The date, time and place of the Director's hearing;
  3. The guidelines for interested parties to submit comments to the Director and to participate in the hearing; and
  4. Any other information the Director deems appropriate.
- E. Notice of a Director's Hearing shall be posted on the Department's website and in compliance with A.R.S. § 38-431.02. The Director may additionally notify interested persons as the Director deems appropriate.

**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-102 recodified from R4-14-102 (Supp. 95-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R20-6-103. Filing; Service**

- A. A document filed by a party with the Department is filed on the date it is received by the Department as established by the Department's earliest stamped date on the face of the document or by some other method of affixing a received date by the Department.
- B. If a party is represented by an attorney, service is effectuated by service upon the attorney unless additional service upon the represented party is required by an administrative law judge or the Department.
- C. A document is served upon a party as provided for under A.R.S. § 41-1092.04 and Section R2-19-108. A party effectuating service is responsible for producing proof of service if requested by the Department.

**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-103 recodified from R4-14-103 (Supp. 95-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R20-6-104. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-104 recodified from R4-14-104 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

**R20-6-105. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-105 recodified from R4-14-105 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

**R20-6-106. Answer to Notice of an Administrative Hearing**

- A. The Department may, in a notice of hearing, direct one or more parties to file a written answer to the allegations contained in the notice of hearing. Even if not directed to do so, any party to the proceeding may file an answer.
- B. A party directed to file an answer shall do so within 20 days after issuance of a notice of hearing, unless the notice of hearing states a different period for the answer. The Department may require any party to answer, in a reasonable time, amendments to the assertions in the notice made after service of the original notice.
- C. An answer filed under this Section shall briefly state the party's position or defense to the proceeding and shall specifi-

cally admit or deny each of the allegations in the notice of hearing. An answering party who does not have, or cannot easily obtain, knowledge or information sufficient to admit or deny an allegation shall state that inability which shall have the effect of a denial. Any allegation not denied is admitted. A party who intends to deny only a part of an allegation shall expressly admit as much of that allegation as is true and shall deny the remainder.

- D. A party who fails to file an answer required by this Section within the time allowed is in default. The Director may resolve the proceeding against the defaulting party. In doing so, the Director may regard any allegations in the notice of hearing as admitted by the defaulting party.
- E. Defenses not raised in the answer are waived.

**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-106 recodified from R4-14-106 (Supp. 95-1). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R20-6-107. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-107 recodified from R4-14-107 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

**R20-6-108. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-108 recodified from R4-14-108 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

**R20-6-109. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-109 recodified from R4-14-109 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

**R20-6-110. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-110 recodified from R4-14-110 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

**R20-6-111. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-111 recodified from R4-14-111 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

**R20-6-112. Expired****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-112 recodified from R4-14-112 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

**R20-6-113. Expired**

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**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-113 recodified from R4-14-113 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

**R20-6-114. Request for Rehearing or Review**

- A. Any party aggrieved by an administrative decision may file with the Director, within time limits and other procedural guidelines contained in A.R.S. § 41-1092.09, a written motion for a rehearing or review of the decision specifying the particular reason for the request.
- B. A party filing a motion under this Section may amend the motion at any time before a response to the motion is filed. An amended motion tolls the time for filing a response and the time for rendering a decision on the motion.
- C. A request for rehearing or review which is not timely filed is deemed waived for the purpose of judicial review.
- D. A motion for rehearing shall specify which of the grounds listed in subsection (G) it is based upon and shall set forth the specific facts and laws in support of the motion. A motion may cite relevant portions of testimony from the hearing if a transcript is provided with the motion and may cite hearing exhibits by reference to the exhibit number. The motion shall specify the relief sought by the request, such as a different finding of fact, conclusion of law or order and may seek multiple forms of relief in the alternative. When a motion for rehearing or review is based on an affidavit, the moving party shall attach the affidavit to the motion.
- E. A party may file a separate request for a stay of the Director's decision pursuant to A.R.S. § 20-162(B). Filing a stay request or a motion for rehearing does not stay an order filed by the Director. The Director may stay an order pending the resolution of a motion for rehearing or review.
- F. Each party served with a motion for rehearing or review shall be permitted to file a written response within 15 days after the motion has been filed. Affidavits may be attached to and filed with a response. A response may cite relevant portions of testimony from the hearing if a transcript is provided with the response and may cite hearing exhibits by reference to the exhibit number. The Director has the discretion to hear oral argument to consider a request for rehearing or review.
- G. The Director may grant a motion for rehearing or review for any of the following causes:
  1. Irregularity in the proceedings before the Department, in any order, or any abuse of discretion that deprives the moving party of a fair hearing;
  2. Misconduct by the Department, the administrative law judge, or the prevailing party;
  3. Accident or surprise that could not have been prevented by ordinary care;
  4. Newly discovered material evidence that could not reasonably have been discovered and produced at the original hearing;
  5. Excessive or insufficient penalties;
  6. Error in admitting or rejecting evidence or other legal errors occurring at the hearing; and
  7. The decision is not justified by the evidence or is contrary to law.
- H. The Director may affirm or modify the decision or grant a rehearing as to all or any of the parties and on all or part of the issues for any reason listed in subsection (G). An order granting a rehearing shall specify the reason for granting the rehearing, and the rehearing shall cover only those matters specified.

- I. The Director, within the time for filing a motion for rehearing, may without a motion for rehearing, order a rehearing for any reason that would allow the granting of a motion for rehearing by a party. The order for rehearing, granted without a motion, shall specify the reason for granting the rehearing.
- J. The Director may grant a motion for rehearing, timely served, for a reason not stated in the motion. The order for rehearing, granted for a reason not stated in the motion, shall specify the reason for granting the rehearing.

**Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-114 recodified from R4-14-114 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**R20-6-115. Repealed****Historical Note**

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-115 recodified from R4-14-115 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Repealed by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 6, 2023 (Supp. 22-4).

- R20-6-116. Reserved
- R20-6-117. Reserved
- R20-6-118. Reserved
- R20-6-119. Reserved
- R20-6-120. Reserved
- R20-6-121. Reserved
- R20-6-122. Reserved
- R20-6-123. Reserved
- R20-6-124. Reserved
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- R20-6-127. Reserved
- R20-6-128. Reserved
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- R20-6-131. Reserved
- R20-6-132. Reserved
- R20-6-133. Reserved
- R20-6-134. Reserved
- R20-6-135. Reserved
- R20-6-136. Reserved
- R20-6-137. Reserved
- R20-6-138. Reserved
- R20-6-139. Reserved
- R20-6-140. Reserved
- R20-6-141. Reserved
- R20-6-142. Reserved

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- R20-6-143. Reserved**
- R20-6-144. Reserved**
- R20-6-145. Reserved**
- R20-6-146. Reserved**
- R20-6-147. Reserved**
- R20-6-148. Reserved**
- R20-6-149. Reserved**
- R20-6-150. Reserved**
- R20-6-151. Reserved**
- R20-6-152. Reserved**
- R20-6-153. Reserved**
- R20-6-154. Reserved**
- R20-6-155. Reserved**
- R20-6-156. Reserved**
- R20-6-157. Reserved**
- R20-6-158. Reserved**
- R20-6-159. Repealed**

**Historical Note**

Adopted effective February 17, 1977 (Supp. 77-1). R20-6-159 recodified from R4-14-159 (Supp. 95-1). Repealed effective June 15, 1998 (Supp. 98-2).

**R20-6-160. Petition for Rulemaking Action**

- A.** The following definitions apply in this Section.
  - 1. "Petitioner" means a person who petitions the Department for Rulemaking action as authorized under A.R.S. § 41-1033(A).
  - 2. "Rule" has the meaning stated at A.R.S. § 41-1001 and is enforceable by the Department.
  - 3. "Rulemaking action" means the process for formulation and finalization of a new rule, or amendment or repeal of an existing rule.
  - 4. "Substantive Policy Statement" has the meaning stated at A.R.S. § 41-1001, is advisory only, and is not enforceable by the Department.
- B.** Any person may petition the Department under A.R.S. § 41-1033(A) to either:
  - 1. Make, amend, or repeal a final Rule;
  - 2. Review an existing agency practice or Substantive Policy Statement that the Petitioner alleges to constitute a Rule.
- C.** A person who files a petition pursuant to A.R.S. § 41-1033(A), shall include the following information in the petition:
  - 1. The Petitioner's name and contact information;
  - 2. The name and address of any organization the Petitioner represents;
  - 3. Whether the Petitioner is petitioning the Department to:
    - a. Make, amend, or repeal a final Rule; or
    - b. Review an existing agency practice or Substantive Policy Statement that the Petitioner alleges to constitute a Rule;
  - 4. A detailed explanation of Petitioner's basis for submitting the petition;
  - 5. If the Petitioner is petitioning the Department to make a Rule, the language of the proposed new Section and the specific authority for the requested Rulemaking action;
- 6. If the Petitioner is petitioning the Department to amend an existing Rule, a citation to the existing Section to be amended, the language of the proposed Rule amendment, and the specific authority for the requested Rulemaking action;
- 7. If the Petitioner is petitioning the Department to repeal an existing Rule, a citation to the existing Section or subsection to be repealed, and an explanation of why the Rule should be repealed including, if applicable, how the Rule does not meet the requirements of A.R.S. § 41-1030;
- 8. If the Petitioner is petitioning the Department to review an existing agency practice that the Petitioner alleges to constitute a Rule, a description of the Department's practice, an explanation of how the Department's practice constitutes a Rule being enforced by the Department, the language of the proposed new Rule, and the specific authority for the requested Rulemaking action;
- 9. If the Petitioner is petitioning the Department to review a Substantive Policy Statement that the Petitioner alleges to constitute a Rule, a citation to the Substantive Policy Statement, an explanation of how the Substantive Policy Statement is being enforced by the Department as a Rule, the language of the proposed new Rule, and the specific authority for the requested Rulemaking action; and
- 10. The Petitioner's dated signature.
- D.** The petitioner may submit additional supporting information, including:
  - 1. Statistical data; and
  - 2. A list of other persons and entities likely to be affected by the proposed Rulemaking action, with an explanation of the likely effects.
- E.** Within 60 days of the date the Department receives the petition, the Department shall send the Petitioner a written decision indicating whether the Department is denying the petition or will initiate the requested Rulemaking action, with the reasons for the decision.

**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Section heading corrected at Department Request, Office File No. M11-401, filed October 27, 2011 (Supp. 11-3). Amended by final rulemaking at 28 A.A.R. 3626 (November 25, 2022), effective January 1, 2023 (Supp. 22-4).

**ARTICLE 2. TRANSACTION OF INSURANCE****R20-6-201. Advertisements of Health**

- A.** Definitions. The following definitions apply to this Section and to R20-6-201.01, R20-6-201.02, and R20-6-203:
  - 1. "Advertisement" means materials and information used by an insurer to generate insurance business.
    - a. Advertisement includes the following information:
      - i. Printed and published material, audio visual material, or other forms of electronic communication that an insurer uses or displays in direct mail, newspapers, magazines, radio, television, billboards, Internet web sites, and similar media to inform the public about the insurer or its products;
      - ii. Descriptive literature and sales aids an insurer issues or releases for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters;

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- iii. Prepared sales talks and presentations and material for use by an insurer or prepared by an insurer for use by authorized producers; and
- iv. Material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;
- b. "Advertisement" does not include the following:
  - i. Material used solely for training and educating an insurer's employees or producers;
  - ii. Material used in-house by insurers;
  - iii. Communications within an insurer's own organization not intended for dissemination to the public;
  - iv. Individual communications with current policy holders regarding a member's personal information other than material urging the policyholders to increase or expand coverages;
  - v. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;
  - vi. Court-approved material ordered by a court to be disseminated to policyholders;
  - vii. Material in connection with promotion or sponsorship of a charitable event in which only the name of the insurer is displayed;
  - viii. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged. The announcement shall clearly indicate that it is preliminary to the issuance of a booklet and that does not describe the specific benefits under the contract or program nor the advantages as to the purchase of the contract or program;
  - ix. A general announcement by the sponsor that endorses the program;
  - x. Health and wellness material with general health and wellness information; or
  - xi. Press releases and news releases not intended to generate business.
- 2. "Disability insurance" has the same meaning prescribed in A.R.S. § 20-253.
- 3. "Elimination period" means the time between the date a loss occurs and the date that benefits begin to accrue for that loss.
- 4. "Exclusion" means a policy term stating a risk that an insurer has not assumed.
- 5. "Health insurance" means:
  - a. Disability insurance;
  - b. Insurance provided by a service corporation regulated under A.R.S. § 20-821 et seq.;
  - c. Insurance provided by a prepaid dental plan organization regulated under A.R.S. § 20-1001 et seq.; and
  - d. Insurance provided by a health care services organization regulated under A.R.S. § 20-1051 et seq.
- 6. "Insurance administrator" or "administrator" has the meaning prescribed in A.R.S. § 20-485(A)(1).
- 7. "Insurer" has the same meaning prescribed in A.R.S. § 20-104.
- 8. "Limitation" means a policy term, other than an exclusion or reduction, that decreases the risk assumed by the insurer or the insurer's obligation to provide benefits.
- 9. "Person" has the meaning in A.R.S. § 20-105.
- 10. "Policy" means any plan, certificate, contract, agreement, statement of coverage, evidence of coverage, subscription contract, membership coverage, rider, or endorsement that provides disability benefits, health insurance, medical, surgical or hospital expense benefits, long-term care benefits, or Medicare supplement benefits in the form of a cash indemnity, reimbursement, or service.
- 11. "Reduction" means a policy term that reduces the amount of an insured's benefits. A reduction means that the insurer has assumed the risk of a particular loss, but the amount or period of the insurer's coverage is less than what the insurer would have paid for the loss without the reduction.
- 12. "Spokesperson" means a person making a testimonial about or an endorsement of an insurer's product who:
  - a. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or independent contractor;
  - b. Has been formed by the insurer, is owned or controlled by the insurer or its employees, or is a person who owns or controls an insurer;
  - c. Is in a policy-making position and affiliated with the insurer in any capacity described in subsections (a) or (b); or
  - d. Is directly or indirectly compensated for making the testimonial or endorsement.
- B. Scope.**
  - 1. This Section applies to all advertisements for health insurance.
  - 2. This Section applies to the conduct of insurers, producers, and third-party administrators.
- C. General requirements.** Insurers, producers, and third-party administrators shall ensure that health insurance advertisements meet the requirements of this Section.
  - 1. Advertisements shall be truthful and not misleading. The insurer shall not use words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.
  - 2. An advertisement shall not omit information or use words, phrases, statements, references, or illustrations if the omission of information or use of words, phrases, statements, references, or illustrations may mislead or deceive purchasers or prospective purchasers.
  - 3. The words and phrases used to describe a policy shall accurately describe the benefits of the policy and not exaggerate any benefit through the use of phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills" or "this policy will replace your income," or similar words and phrases.
  - 4. If a policy covers only one disease or a list of specified diseases, any advertisement for the policy shall not imply coverage beyond the specified diseases.
  - 5. If a policy pays varying amounts for the same loss occurring under different conditions or pays benefits only when a loss occurs under certain conditions, any advertisement for the policy shall disclose the limited conditions.
  - 6. If an advertisement specifies payment of a particular dollar amount for hospital room and board expenses, the advertisement shall also include the maximum daily benefit and the maximum time limit for which those expenses are covered.

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7. An advertisement that refers to any dollar amount, period of time for which a benefit is payable, cost of policy, or specific policy benefit or the loss for which a benefit is payable shall also disclose any related exclusions, reductions, and limitations without which the advertisement would have the capacity and tendency to mislead or deceive.
  8. An advertisement covered by subsection (C)(7) shall disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy. The advertisement shall disclose the existence of an elimination period.
  9. An advertisement shall disclose any exclusion, reduction, or limitation applicable to a pre-existing condition; however, an insurer is not required to make disclosure in an advertisement that does not reference specific product information, benefit level, or dollar amounts.
  10. If a policy has an exclusion, reduction, or limitation applicable to a preexisting condition, an advertisement shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim and shall not use the phrase "no medical examination required" or other similar phrase.
  11. If an advertisement refers to renewability, cancellation, or termination of a policy, or states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, the advertisement shall disclose the provisions relating to renewability, cancellation, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that does not minimize or obscure the qualifying conditions.
  12. An advertisement shall not make any offer prohibited under A.R.S. § 20-452(4).
  13. An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised is exempt from approval or not subject to approval by order or statute.
  14. An advertisement shall not state or imply that a product being offered is an introductory, special, or initial offer that will entitle the applicant to receive advantages not described in the policy by accepting the offer.
  15. An advertisement designed to produce leads either by use of a coupon, a request to write or call the company, or subsequent advertisement before contact, shall disclose that a producer may contact the potential applicant.
- D.** Method of disclosure of required information. If an insurer is required by law to disclose particular information, the information shall be conspicuous and in close proximity to the statements to which the information relates, or under a prominent caption so that the required disclosure is not minimized, obscured, presented in an ambiguous fashion, or intermingled with the content of the advertisement.
- E.** Testimonials.
1. Testimonials used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer shall provide the Department with the full name of the author and a copy of the full testimonial if the advertisement is filed with the Department or requested by the Department. If an insurer uses a testimonial, the insurer adopts the statements in the testimonial as the insurer's own statements. If a testimonial or endorsement is used more than one year after it is given, the insurer shall obtain a written confirmation from the author that the testimonial represents the current opinion of the author.
  2. The insurer shall disclose that a spokesperson has a financial interest or the proprietary or representative capacity of a spokesperson in an advertisement in the introductory portion of a testimonial or endorsement in the same form and with equal prominence as the endorsement. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the insurer shall disclose that fact in the advertisement by language that states, "Paid Endorsement," or words of similar import in type, style, and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. For television or radio advertising, the insurer shall place the required disclosure prominently in the introductory portion of the advertisement.
- F.** Statistics. An advertisement with information on the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use facts that are irrelevant to the sale of insurance and shall accurately reflect all of the relevant facts specific to the advertised policy or insurer. An advertisement shall not state or imply that statistics are derived from the policy being advertised unless that is true. The insurer shall identify in the advertisement the source of any statistics used.
- G.** Inspection of policy. An offer in an advertisement of free inspection of a policy or offer of a premium refund does not cure misleading or deceptive statements in the advertisement.
- H.** Identification of plan or number of policies.
1. If an advertisement offers a choice in the amount of benefits the advertisement shall disclose that the amount of benefits depends on the policy selected and that the premium will vary with the amount of the benefits.
  2. If an advertisement refers to benefits contained in more than one policy, other than a group master policy, the advertisement shall disclose that the benefits are provided only if multiple policies are purchased.
- I.** Disparaging comparisons and statements. An advertisement shall not make unfair, incomplete, or unsubstantiated comparisons of other insurers' policies or benefits or falsely disparage other insurers' policies, services, or business methods. A comparison is unsubstantiated if the insurer has no empirical study, analysis, or documentation supporting the comparative statement or comparison of policies or benefits.
- J.** Jurisdictional limits. If an insurer has an advertisement that is meant to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed, the advertisement shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."
- K.** Identity of insurer. The insurer shall state the name of the actual insurer in all of its advertisements. An advertisement shall clearly identify the insurer and shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device that may mislead or deceive the public as to the insurer's identity.

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- L.** Group insurance. An advertisement shall not state or imply that prospective policyholders become group or quasi-group members and enjoy special rates or underwriting privileges, unless it is true. An advertisement to join an association, trust, or group that is also an invitation to contract for insurance coverage shall disclose that the applicant will be purchasing both membership in the association, trust, or group and insurance coverage.
- M.** Government approval. An advertisement shall not state or imply any of the following:
  1. That a governmental agency or regulator is connected with or has provided or endorsed a policy or endorsed an insurer;
  2. That a governmental agency or regulator has examined an insurer's financial condition and found it satisfactory. This subsection does not apply if an insurer is responding to a specific documented, public, false allegation about its financial condition.
- N.** Endorsements. An advertisement may state that an individual, group, society, association, or other organization has approved or endorsed the insurer or its policy if the organization or group has done so in writing and if any proprietary relationship between the organization and the insurer is disclosed.
- O.** Claims handling. An advertisement shall not contain false statements about the time within which claims are paid or statements that imply that claim settlements will be liberal or generous beyond the terms of the policy.
- P.** Statements about the insurer. An advertisement shall not contain false or misleading statements about an insurer's assets, corporate structure, financial standing, length of time in business, or relative position in the insurance business.

**Historical Note**

Former General Rule Number 2. R20-6-201 recodified from R4-14-201 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-201.01. Insurer Advertising Responsibility and Records**

- A.** An insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements. The insurer whose policies are advertised is responsible for the advertisements, regardless of who writes, creates, designs, or presents the advertisement, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement about an insurer or its products, a producer shall get written approval from the insurer for use of advertisements that were not supplied by the insurer.
- B.** An insurer shall maintain, at its home or principal office, the following:
  1. Advertisements disseminated by the insurer in Arizona or any other state, including:
    - a. Each printed, published, recorded, or prepared advertisement of individual policies; and
    - b. Typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies.
  2. A notation attached to each advertisement specifying the manner and extent of distribution and the form number of any policy advertised; and
  3. Documentation supporting any testimonials, statistical claims, or comparisons shown in the advertising.

- C.** An insurer shall maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form**

- A.** An insurer that is required to file a health insurance advertisement with the Department as specified in A.R.S. §§ 20-826(T), 20-1018, 20-1057(X), 20-1110(E), or 20-1662 shall file the advertisement with a transmittal form prescribed by the Department.
- B.** The transmittal form shall include the following information:
  1. Identifying information of the insurer, including name, address, National Association of Insurance Commissioners' identification number, and type of insurer;
  2. A contact person at the insurer with whom the Department can communicate about the advertisement;
  3. Description of the type of advertisement being filed;
  4. Planned use and dissemination of the advertisement, including date of first use, or a statement that the advertisement will not be used any earlier than a specified date;
  5. Description of product being advertised;
  6. Form number and name for the advertised product;
  7. A certification from an officer of the insurer that the advertisement complies with applicable laws; and
  8. The dated signature of the insurer's officer.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance**

- A.** The definitions in R20-6-201(A) and the following definition apply in this Section:
 

"Life insurance" means a life insurance contract, including all benefits payable under the policy.
- B.** Applicability
  1. This Section applies to:
    - a. All persons subject to regulation under A.R.S. Title 20; and
    - b. Advertising, promotion, solicitation, negotiation, and sale of life insurance policies, regardless of the form of dissemination.
  2. This Section does not apply to group insurance, franchise insurance, or to annuities without life contingencies.
- C.** General provisions. A life insurance advertisement shall not mislead the public by:
  1. Omitting information that fairly describes the subject matter as a life insurance policy and the benefits available under the policy;
  2. Placing undue emphasis on facts that, even if true, are not relevant to the sale of life insurance; or
  3. Placing undue emphasis on features of incidental or secondary importance to the life insurance aspects of the policy.
- D.** The Department deems the following acts misleading and deceptive:
  1. Using any statement, including phrases such as "investment," "investment plan," "founders plan," "charter plan," "expansion plan," "profit," "profits," or "profit sharing," in a context or under circumstances or condi-

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- tions that may mislead a purchaser or prospective purchaser to believe that the insurer is selling something other than a life insurance policy or will provide some benefit not included in the policy, or not available to other persons of the same class and equal expectation of life;
2. Using any phrase as the name or title of a life insurance policy if the phrase does not include the words "life insurance," unless other language in the same document expressly provides that the contract is a life insurance policy;
  3. Making any statement relating to the growth or earnings of the life insurance industry or to the tax status of life insurance companies in a context that would reasonably be understood as attempting to interest a prospective applicant in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy;
  4. Making any statement that reasonably tends to imply that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by purchasing the policy, unless the statement is made with reference to policies of domestic life insurers engaged in a program allowed under A.R.S. § 20-453;
  5. Providing a policyholder with a premium receipt book, policy jacket, return envelope, or other printed or electronic material referring to the insurer's "investment department," "insured investment department," or similar terminology in a manner implying that the policy is sold, issued, or serviced by the insurer's investment department;
  6. Making any statement that reasonably tends to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive the payment of dividends, special advantages, benefits, or favored treatment unless the insurance contract specifically provides for the described payment of dividend, special advantages, benefits, or favored treatment;
  7. Stating or implying that only a limited number of persons or limited class of persons may buy a particular kind of policy, unless the limitation is related to recognized underwriting practices or specifically stated in the policy or rider;
  8. Describing premium payments in language that states the payment is a "deposit," unless:
    - a. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder; or
    - b. The term is used with the word "premium" in a manner as to clearly indicate the true character of the payment;
  9. Providing any illustration or projection of future dividends that:
    - a. Is not based on the company's actual scale for payment of current dividends, and
    - b. Does not clearly indicate that the dividends are not guarantees;
  10. Using the words "dividends," "cash dividends," "surplus," or similar phrases in a manner that states or implies that the payment of dividends is guaranteed or certain to occur;
  11. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the insurer's earnings;
  12. Making any statement that projected dividends under a participating policy will be or can be sufficient at any future time to assure the receipt of benefits such as a paid-up policy without further payment of premiums unless the statement also explains:
    - a. The benefits or coverage that would be provided at the future time, and
    - b. The conditions under which the receipt of benefits without further payment of premiums would occur;
  13. Describing a life insurance policy or premium payments in terms of "units of participation," unless accompanied by other language clearly indicating that the references are to a life insurance policy or to premium payments, as applicable.
  14. Advising producers to avoid disclosing that life insurance is the subject of the solicitation or sale;
  15. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without explaining the non-forfeiture benefits;
  16. Using a dollar amount in printed material to be shown to a prospective policyholder, unless the amount is accompanied by language that:
    - a. States the nature of the dollar amount,
    - b. Prohibits including the use of dollar amounts not related to guaranteed values and properly projected dividend figures, and
    - c. Prohibits the use of figures showing growth of stock values, or other values not a part of the life insurance contract.
  17. Stating that a policy provides features not found in any other insurance policy, unless the insurer can demonstrate that other policies do not have the same feature;
  18. Making any statement or implication about an insurance policy that cannot be verified by reference to the policy contract, a sample of the policy being described, or the company's officially published rate book and dividend illustrations;
  19. Stating that life insurance is "loss proof" or "depression proof," except that an insurer may make statements that life insurance benefits, other than dividends, are guaranteed by the company regardless of economic conditions;
  20. Making any statement that a company makes a profit as a result of policy lapses or surrenders;
  21. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience for the company issuing the advertising; and
  22. Conduct or statements designed to mislead a prospective applicant or purchaser.

**Historical Note**

Former General Rule Number 68-14. R20-6-202 recodified from R4-14-202 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-203. Form Filings; Translations**

- A. An insurer, rate service organization, or rating organization shall provide to the Department, at the time of filing, an English language translation of each form, advertisement, or other document or material that the insurer is required by statute or rule to file with the Department, if the filed document or material contains communication in a language other than English.
- B. The translation filed under subsection (A) shall compare the foreign language version in a side-by-side format with the

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English language translation. An insurer, rate service organization, or rating organization shall ensure that the translation is performed by a person with formal college-level or specialized training in the foreign language, including training in grammar and sentence syntax.

- C. With each translation, an insurer, rate service organization, or rating organization shall also provide to the Department a sworn statement signed by the translator who translated the document that includes the qualifications of the translator under subsection (B) and attests that the translation is identical in substance to the English document or material.
- D. If an insurer, rate service organization, or rating organization files a foreign language version of a document or material that the insurer has previously filed in English, the insurer is not required to refile the English version, but shall identify the English version, provide the side-by-side comparison under subsection (B), and file the sworn statement required under subsection (C).

**Historical Note**

Former General Rule Number 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-203 recodified from R4-14-203 (Supp. 95-1). New Section made by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-204. Expired****Historical Note**

Former General Rule Number 71-24; Former Section R4-14-204 repealed, new Section R4-14-204 adopted effective January 1, 1981 (Supp. 80-6). R20-6-204 recodified from R4-14-204 (Supp. 95-1). Amended effective July 14, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 475, effective January 5, 2000 (Supp. 00-1). Amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 136, effective December 15, 2016 (Supp. 16-4).

**R20-6-205. Local or Regional Retaliatory Tax Information****A. Definitions.**

1. "Addition to the rate of tax" means the tax rate determined under subsection (D) to be applied under A.R.S. 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state that impose local or regional taxes.
2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
4. "Department" means the Arizona Department of Insurance and Financial Institutions.
5. "Director" has the meaning prescribed in A.R.S. § 20-102.
6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.
7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities

within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.

9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their producers by any:
    - a. City, county, or other political subdivision of a foreign country or other state; or
    - b. Combination of cities, counties, or other political subdivisions of a foreign country or other state.
  10. "Other Arizona insurer" means a domestic insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
  11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
  12. "Other state" means any state in the United States, the District of Columbia, and territories or possessions of the United States, excluding Arizona.
  13. "Premium Tax and Fees Report," includes the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet," and means the form prescribed by the Director and filed annually by insurers under A.R.S. § 20-224.
- B. Scope.** This Section applies to all foreign, alien, and domestic insurers and to Premium Tax and Fees Reports filed by all insurers.
- C. Data to be reported by domestic insurers.** As a part of its Premium Tax and Fees Report, each domestic insurer shall file a Survey of Arizona Domestic Insurers that reports the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:
1. Total local or regional taxes paid; and
  2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.
- D. Computation of statewide and foreign countrywide additions to the rate of tax.** For each foreign country or other state having one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:
1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,
  2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the other state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.
- E. Publication of additions to the rate of tax.** The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding



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calendar year under subsection (C). The Department shall publish the information annually on the Department website, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.

- F.** Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes and Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:
1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
  2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.
- G.** Contesting computation. A foreign or alien insurer subject to this Section may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.

**Historical Note**

Former General Rule Number 71-25; Repealed effective March 19, 1976 (Supp. 76-2). R20-6-205 recodified from R4-14-205 (Supp. 95-1). Section R20-6-205 renumbered from R20-6-206 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Section amended by final rulemaking at 29 A.A.R. 3621 (November 24, 2023), effective January 7, 2024 (Supp. 23-4). Effective date corrected (Supp. 23-4, Ver. 2).

**R20-6-206. Expired****Historical Note**

Former General Rule Number 72-30. Repealed effective February 22, 1993 (Supp. 93-1). R20-6-206 recodified from R4-14-206 (Supp. 95-1). New Section adopted effective December 29, 1995 (Supp. 95-4). Amended effective November 5, 1998 (Supp. 98-4). Former R20-6-206 renumbered to R20-6-205; new R20-6-206 renumbered from R20-6-207 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

**R20-6-207. Gender Discrimination**

- A.** The following definitions apply to this Section:
1. "Applicant" means a person who is applying for a policy.
  2. "Policy" means an insurance policy, plan, contract, certificate, evidence of coverage, subscription contract, or binder, including a rider or endorsement offered by an insurer.
  3. "Insurer" means any company that issues a policy.
- B.** Applicability and scope. This Section applies to any policy or certificate delivered or issued for delivery in this state.
- C.** Availability requirements.

1. An insurer shall not deny availability of any insurance policy on the basis of the gender or marital status of the insured or prospective insured.
  2. An insurer shall not restrict, modify, exclude, reduce, or limit the amount of benefits payable, or any term, conditions or type of coverage on the basis of an applicant's or insured's gender or marital status, except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S. Title 20.
  3. An insurer may consider marital status to determine whether a person is eligible for dependent coverage or benefits.
- D.** Prohibited practices. The following practices and any other practice that treats similarly situated persons differently based on gender unless the different treatment is specifically allowed by law, is prohibited.
1. Denying coverage to a person of one gender who is self-employed, employed part-time, or employed by relatives, if coverage is offered to a person of the opposite gender who is similarly employed;
  2. Denying a policy rider to a person of one gender if the rider is available to a person of the opposite gender;
  3. Denying maternity benefits to an applicant or insured who buys a policy for individual coverage if the insurer offers comparable family coverage policies with maternity benefits;
  4. Denying, under group policies, dependent coverage to an employee of one gender if dependent coverage is available to an employee of the opposite gender;
  5. Denying a disability income policy to an employed person of one gender if a policy is offered to a person of the opposite gender who is similarly employed;
  6. Treating complications of pregnancy differently from any other illness or sickness covered under a policy;
  7. Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one gender;
  8. Offering lower maximum monthly benefits to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
  9. Offering more restrictive benefit periods or more restrictive definitions of disability to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
  10. Establishing different conditions for a policyholder of one gender to exercise benefit options contained in the policy than for a person of the opposite gender;
  11. Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless the limitation is for the purpose of defining persons eligible for dependent's benefits; and
  12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance contract, the amount of benefits payable, or any term, condition or type of coverage on account of gender or marital status in all lines of insurance.

**Historical Note**

Former General Rule Number 73-32. R20-6-207 recodified from R4-14-207 (Supp. 95-1). Former R20-6-207 renumbered to R20-6-206; new R20-6-207 renumbered from R20-6-209 and amended by final rulemaking at 13

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A.A.R. 2061, effective August 4, 2007  
(Supp. 07-2).

**R20-6-208. Group Coverage Discontinuance and Replacement**

**A. Definitions.** The following definitions apply in this Section:

1. "Group insurance" means an insurance benefit that meets all the following conditions:
  - a. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;
  - b. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group;
  - c. Coverage is paid for by bulk payment of premiums to the insurer; and
  - d. An employer, union, or association sponsors the plan.
2. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, but does not include the following:
  - a. Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
  - b. Coverage issued as a supplement to liability insurance;
  - c. Liability insurance, including general liability insurance and automobile liability insurance;
  - d. Workers' compensation or similar insurance;
  - e. Automobile medical payment insurance;
  - f. Credit-only insurance;
  - g. Coverage for onsite medical clinics; and
  - h. Other insurance coverage similar to the coverage specified in subsections (2)(a) through (g), of the Health Insurance Portability and Accountability Act of 1996 (Pub.L.No. 104-191) (HIPAA), under which benefits for medical care are secondary or incidental to other insurance benefits.
  - i. The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the coverage:
    - i. Limited-scope dental or vision benefits;
    - ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits;
    - iii. Other similar, limited benefits specified in federal regulations issued under HIPAA.
  - j. The following benefits if provided under a separate policy, certificate, or contract of insurance with no coordination between provision of benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and if the benefits are paid for an event regardless of whether the benefits are provided under a group health plan maintained by the same plan sponsor:
    - i. Coverage only for a specified disease or illness, or

- ii. Hospital indemnity or other fixed indemnity insurance.
  - k. The following benefits if the benefits are offered as a separate policy, certificate, or contract of insurance:
    - i. Medicare supplemental policy as defined under § 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss;
    - ii. Coverage supplemental to the coverage provided under, 10 U.S.C. Title 10, Chapter 55; or
    - iii. Similar supplemental coverage provided to coverage under a group health plan.
  3. "Health status-related factor" means any of the following:
    - a. Health status;
    - b. Medical condition, including a physical or mental illness;
    - c. Claims experience;
    - d. Receipt of health care;
    - e. Medical history;
    - f. Genetic information;
    - g. Evidence of insurability, including conditions arising out of acts of domestic violence; or
    - h. Disability.
  4. "Insurer" means an insurer that offers or provides group health insurance coverage, and includes an insurer that issues disability insurance as defined in A.R.S. § 20-253, a medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, and a health care services organization as defined in A.R.S. § 20-1051.
- B.** This Section applies to all group insurance issued by an insurer.
- C.** Effective date of discontinuance for non-payment of premium.
1. If a group insurance policy provides for automatic discontinuance of the policy after a premium remains unpaid through the grace period allowed for payment, the insurer is liable for valid claims for covered losses incurred before the end of the grace period.
  2. If the insurer's actions after the end of the grace period indicate that the insurer considers the group insurance policy as continuing in force beyond the end of the grace period the insurer is liable for valid claims for losses beginning before the effective date of written notice of discontinuance to the policyholder or other entity responsible for paying premiums.
    - a. The following actions indicate that the insurer considers the policy in force:
      - i. Continued recognition, acknowledgement, or payment of subsequently incurred claims, or
      - ii. Continued enrollment of employees or dependents.
    - b. The following actions shall not indicate that the insurer considers that policy in force:
      - i. Recognition, payment, or acknowledgement of a claim by an insurer or processing a denial based on eligibility or other denial reasons set forth in the group benefit plan booklet; or
      - ii. Recognition, payment, or acknowledgement of claims due to the group's failure to notify the insurer that the employee or member is no longer eligible for coverage or the group policy is terminated.
  3. The effective date of discontinuance shall not be before midnight at the end of the third scheduled work day after the date on which the notice of discontinuance is delivered.

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**D. Requirements for notice of discontinuance.**

1. An insurer's notice of discontinuance shall include a request to the group policyholder to notify covered employees of the date when the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the insurer is not liable for claims for losses incurred after the date of discontinuance. If the plan involves employee contributions, the notice of discontinuance shall also advise that if the policyholder continues to collect employee contributions beyond the date of discontinuance, the policyholder is solely liable for benefits for the period which contributions were collected.
2. The insurer shall also provide the policyholder with a supply of notice forms that the policyholder can distribute to the covered employees. The notice forms shall explain the discontinuance and the effective date, and advise employees to refer to their certificates or contracts to determine their rights on discontinuance.

**E. Extension of benefits.**

1. A group policy shall provide a reasonable provision for extension of benefits for an employee or dependent who is totally disabled on the date of discontinuance as follows:
  - a. For a group life plan with a disability benefit extension of any type such as a premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy shall not terminate the benefit extension.
  - b. For a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability or hospital confinement shall not effect benefits payable for that disability or hospital confinement.
  - c. A hospital or medical expense coverage, other than dental and maternity expense, shall include a reasonable extension of benefits or accrued liability provision. A provision is reasonable if:
    - i. It provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverage; or
    - ii. Under other types of hospital or medical expense coverage, it provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event that occurred while coverage was in force, such as an accident.
2. An insurer shall ensure that the policy and group insurance certificates includes a description of the extension of benefits or accrued liability provision.
3. An insurer shall ensure that benefits payable during a period of extension or accrued liability are subject to the policy's regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.
4. For hospital or medical expense coverage, an insurer may limit benefit payments to payments applicable to the disabling condition only.

**F. Continuance of coverage in situations involving replacement of one plan by another.**

1. When a group policyholder secures replacement coverage with a new insurer, self-insures, or foregoes provision of coverage, the replaced insurer is liable only to the extent of its accrued liabilities and extensions of benefits after the date of discontinuance.
2. The succeeding insurer shall cover each individual who:
  - a. Was eligible for coverage under the prior plan on the date of discontinuance, and
  - b. Is eligible for coverage according to the succeeding insurer's plan of benefits with respect to a class of individuals eligible for coverage.
3. For the purpose of successive health insurance coverage under subsection (F)(2), a succeeding insurer's plan of benefits shall:
  - a. Not have any non-confinement rules; and
  - b. Provide, as to any actively-at-work rules, that absence from work due to a health status-related factor is treated as being actively-at-work.
4. Nothing in subsection (F)(2) prohibits an insurer from performing coordination of benefits.
5. A succeeding insurer shall cover each individual not covered under the succeeding insurer's plan of benefits under subsection (F)(2) according to subsections (a) and (b) if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and is a member of a class of individuals eligible for coverage under the succeeding insurer's plan. Any reference in subsection (a) or (b) to an individual who was or was not totally disabled is a reference to the individual's status immediately before the effective date of coverage for the succeeding insurer.
  - a. The minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer's plan reduced by any benefits payable by the prior plan.
  - b. The succeeding insurer shall provide coverage until at least the earliest of the following dates:
    - i. The date the individual becomes eligible under the succeeding insurer's plan as described in subsection (F)(2);
    - ii. The date the individual's coverage would terminate according to the succeeding insurer's plan provisions applicable to individual termination of coverage such as at termination of employment or ceasing to be eligible dependent; or
    - iii. For an individual who was totally disabled, and covered by a type of coverage for which subsection (E) requires an extension of accrued liability, the end of any period of extension of benefits or accrued liability that is required of the prior insurer under subsection (E), or if the prior insurer's policy is not subject to subsection (E), would have been required of the insurer had its policy been subject to subsection (E) at the time the prior plan was discontinued and replaced by the succeeding insurer's plan;
  - c. For health insurance coverage, if an individual who was totally disabled at the time the prior insurer's plan was discontinued and replaced by the succeeding insurer's plan, and if subsection (E) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior

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- insurer's plan, reduced by any benefits paid by the prior plan.
- d. If the succeeding insurer's plan has a preexisting conditions limitation, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding insurer's plan according to subsection (F) during the period the limitation applies under the new plan shall be the lesser of:
    - i. The benefits of the new plan determined without application of the preexisting conditions limitation, or
    - ii. The benefits of the prior plan.
  - e. The succeeding insurer, in applying any deductibles, coinsurance amounts applicable to out-of-pocket maximums, or waiting periods, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. For deductibles or coinsurance amounts applicable to out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior plan during the 90 days before the effective date of the succeeding insurer's plan but only to the extent these expenses are recognized under the terms of the succeeding insurer's plan and are subject to similar deductible or coinsurance provisions.
  - f. If the succeeding insurer is required under this Section to make a determination about the benefits in the prior plan, the succeeding insurer may ask the prior plan to provide a statement of the benefits available or other pertinent information sufficient to permit the succeeding insurer to verify the benefit determination. For the purposes of this Section, all definitions, conditions, and covered-expense provisions of the prior plan shall govern the benefit determination. The benefit determination is made as if the succeeding insurer had not replaced coverage.

**Historical Note**

Former General Rule Number 73-34. R20-6-208 recodified from R4-14-208 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-208 renumbered from R20-6-210 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-209. Life Insurance Solicitation****A. Scope.**

1. This Section applies to any solicitation, negotiation, or procurement of life insurance occurring in Arizona. This Section applies to any issuer of life insurance contracts, including fraternal benefit societies.
  2. Unless otherwise specifically included, the Section does not apply to:
    - a. Annuities,
    - b. Credit life insurance,
    - c. Group life insurance,
    - d. Life insurance policies issued in connection with a pension and welfare plan as defined by and subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq.; or
- e. Variable life insurance under which the death benefits and cash values vary according to unit values of investments held in a separate account.
- B.** In this Section, the following apply:
1. "Buyer's Guide" means a document that contains the language in the Appendix to this Section or language approved by the Director.
  2. "Cash dividend" means the current illustrated dividend that can be applied toward payment of the gross premium.
  3. "Equivalent Level Annual Dividend" is calculated as follows:
    - a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the 10th and 20th policy years;
    - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
    - c. Divide the results in subsection (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the "Equivalent Level Annual Dividend."
  4. "Equivalent Level Death Benefit" means the amount of benefit of a policy or term life insurance rider calculated as follows:
    - a. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for 10 and 20 years at 5% interest compounded annually to the end of the 10th and 20th policy years, respectively.
    - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
  5. "Generic name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.
  6. "Life Insurance Surrender Cost Index" means the cost index that is calculated as follows:
    - a. Determine the guaranteed cash surrender value, if any, available at the end of the 10th and 20th policy years.
    - b. For policies participating in dividends, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at 5% interest compounded annually to the end of the period selected and add this sum to the amount determined in subsection (a).
    - c. Divide the result in subsection (b) (subsection (a) for guaranteed-cost policies) by an interest factor that converts into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (b) or subsection (a) for guaranteed cost policies, over the periods stipulated in subsection (a)). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

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- d. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5% interest compounded annually to the end of the period stipulated in subsection (a) and dividing the result by the respective factors stated in subsection (c). This amount is the annual premium payable for a level premium plan.
- e. Subtract the result of subsection (c) from subsection (d).
- f. Divide the result of subsection (e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.
- 7. The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.
- 8. "Policy Summary" means a written statement describing elements of the policy, including:
  - a. The following prominently placed title: Statement of Policy Cost and Benefit Information.
  - b. The name and address of the insurance producer, or, if no producer is involved, a statement of the procedure to be followed to receive responses to inquiries regarding the Policy Summary.
  - c. The full name and home office or administrative office address of the company by which the life insurance policy is to be or has been written.
  - d. The generic name of the basic policy and each rider.
  - e. For the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier, the following amounts, where applicable:
    - i. The annual premium for the basic policy;
    - ii. The annual premium for each optional rider;
    - iii. Guaranteed amount payable upon death at the beginning of the policy year regardless of the cause of death except for suicide, or other specifically enumerated exclusions provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;
    - iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;
    - v. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. Dividends need not be displayed beyond the twentieth policy year; and
    - vi. Guaranteed endowment amounts payable under the policy that are not included under guaranteed cash surrender values in subsection (iv).
  - f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether the rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary shall include the maximum annual percentage rate.
  - g. Life Insurance Cost Indexes for 10 and 20 years but not beyond the premium-paying period. Separate indexes shall be displayed for the basic policy and for each optional term life insurance rider. The indexes need not be included for optional riders that are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months, and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life.
  - h. The Equivalent Level Annual Dividend in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.
  - i. If the Policy Summary includes dividends, a statement that dividends are based on the insurer's current dividend scale and are not guaranteed and a statement in close proximity to the Equivalent Level Annual Dividend as follows: "An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide."
  - j. A statement in close proximity to the Life Insurance Cost Indexes as follows: "An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide."
  - k. The date on which the Policy Summary is prepared. The Policy Summary shall consist of a separate document. All information required to be disclosed shall not be minimized or obscure. Any amounts that remain level for two or more years of the policy may be represented by a single number that clearly indicates the amounts that are applicable for each policy year. Amounts in subsection (8)(e) shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.
- C. Disclosure requirements.
  - 1. The insurer shall provide to all prospective purchasers, a Buyer's Guide and a Policy Summary before accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains an unconditional refund offer, in which case the Buyer's Guide and Policy Summary shall be delivered with the policy or before delivery of the policy.
  - 2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.
  - 3. If the Equivalent Level Death Benefit of a policy does not exceed \$5,000, the requirement for providing a Policy Summary is satisfied by delivery of a written statement containing the information described in subsections (D)(8)(b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).
- D. General rules.
  - 1. Each insurer shall maintain at its home office or principal office for at least three years after its last authorized use a copy of each form the insurer authorized for use.
  - 2. A producer shall inform a prospective purchaser, before commencing a life insurance sales presentation, that the producer is acting as a life insurance producer and inform the prospective purchaser of the full name of the insurer.

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ance company that the producer is representing. If an insurance producer is not involved in the sale, the insurer shall inform the prospective purchaser of the insurance company's full name.

3. An insurer or producer shall not use terms such as financial planner, investment advisor, financial consultant, or financial counseling to imply that the insurance producer is generally engaged in an advisory business in which compensation is unrelated to sales unless that is true.
  4. If an insurer or producer refers to policy dividends, the reference shall include a statement that dividends are not guaranteed.
  5. An insurer shall not use a system or presentation that does not recognize the time value of money through the use of appropriate interest adjustments for comparing the cost of two or more life insurance policies unless the system or presentation is used to demonstrate the cash flow pattern of a policy and the presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.
  6. In a presentation of benefits, an insurer shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately and in close proximity.
  7. An insurer shall include with a statement regarding the use of the Life Insurance Cost Indexes an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.
  8. An insurer shall include with a Life Insurance Cost Index that reflects dividends or an Equivalent Level Annual Dividend a statement that it is based on the company's current dividend scale and is not guaranteed.
  9. If an insurer reserves the right to change the premium for a basic policy or rider, the annual premium shall be the maximum annual premium.
- E. An insurer's failure to provide or deliver a Buyer's Guide or a Policy Summary as provided in subsection (C) constitutes an omission that misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

**Appendix. Life Insurance Buyers Guide****Life Insurance Buyer's Guide**

The face page of the Buyer's Guide shall read as follows:

**Life Insurance Buyer's Guide**

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,
- Decide what kind of life insurance policy you need, and
- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for

the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

**Buying Life Insurance**

When you buy life insurance, you want a policy that fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes that are described in this guide. A good life insurance producer or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds that are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance producer or company or books on life insurance in your public library.

This guide does not endorse any company or policy.

The remaining text of the buyer's guide shall begin on page 3 as follows:

**Choosing the Amount**

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

**Choosing the Right Kind**

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the producer or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

**Term Insurance**

Term insurance is death protection of a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you

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are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

#### Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called “straight life” or “ordinary life” insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop “cash values” which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called “nonforfeiture benefits.” This refers to benefits you do not lose (or “forfeit”) when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money that you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

#### Endowment Insurance

An endowment insurance policy pays a sum or income to you – the policyholder – if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

#### Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the “Surrender Cost Index” and the other is the “Net Payment Cost Index.” It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. **LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.**

#### What is Cost?

“Cost” is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called “participating” policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called “guaranteed cost” or “non participating” policies. Every feature of a guaranteed

cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

#### What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance producers and companies:

1. Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

Life Insurance Net Payment Cost Index. This Index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy’s Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

#### How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

- (1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
- (2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a “Shopper’s Guide” tells you that one company’s policy is a good buy for a particular age and

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amount, you should not assume that all of that company's policies are equally good buys.

- (3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its producer. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
- (4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or producer will provide service in the future, to you as a policyholder.
- (5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company that issued the old policy before you take action.

#### Important Things To Remember – A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums must closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance producer can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the producer or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

#### Historical Note

Adopted effective June 13, 1977 (Supp. 77-3). R20-6-209 recodified from R4-14-209 (Supp. 95-1). Former R20-6-209 renumbered to R20-6-207; new R20-6-209 renumbered from R20-6-211 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

#### **R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner**

- A. Definitions. The following definitions apply in this Section:
  1. "Readable insurance policy" means a policy that can be read and reasonably understood by a person without special knowledge or training.
  2. "Policy" means a contract or agreement for insurance, or an insurance certificate regardless of the name used, and includes all clauses, endorsements, and papers attached or incorporated.
- B. Scope. This Section applies to private passenger motor vehicle policies, homeowner policies, personal line dwelling policies,

for four family units or less, and mobile homeowner policies delivered or issued for delivery in Arizona.

- C. Compliance.
  1. An insurer shall test the readability of its policy by use of the Flesch Readability Formula as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).
  2. An insurer shall not use a policy unless the policy has a total readability score of 40 or more on the Flesch scale.
  3. An insurer shall include with each policy form filing required to be filed with the Director a checklist for the line of insurance setting forth the Flesch score.
- D. Readability guidelines.
  1. General organization of text.
    - a. A policy shall be divided into logically arranged sections for ease of locating content.
    - b. Each section shall be self-contained as to provisions relating solely to that section (for example, an exclusion section shall not be mixed with other parts of a policy).
    - c. General policy provisions applying to all or several like coverages shall be located in a common area.
    - d. The policy shall not contain non-essential provisions.
    - e. Defined words and terms shall be placed in a separate section at the beginning of the policy.
  2. Visual aids to readability. The insurer shall ensure that each policy meets the following format requirements:
    - a. Type size shall be at least eight point.
    - b. The font shall be block print rather than script, and legible.
    - c. Captions and headings shall be distinguishable from the general text.
    - d. White space separating coverages, policy sections, and columns shall be sufficient to make a distinct separation.
    - e. Defined words and terms shall be distinguishable from the general text.
  3. Language usage. The insurer shall ensure that each policy:
    - a. Is written in everyday, conversational language;
    - b. Uses short, simple sentences and words in common usage;
    - c. Uses an easy-to-read style, personal pronouns, and present tense active verbs.

#### Historical Note

Adopted effective May 28, 1979 (Supp. 79-1). R20-6-210 recodified from R4-14-210 (Supp. 95-1). Former R20-6-210 renumbered to R20-6-208; new R20-6-210 renumbered from R20-6-212 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

#### **R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness**

- A. Definitions. The following definitions apply in this Section:
  1. "Policy" means a contract or agreement for or effecting insurance, or a certificate of insurance, regardless of the name used, and includes all clauses, riders, endorsements, and attached papers.
  2. "Person" has the same meaning prescribed in A.R.S. § 20-105.
- B. Scope. This Section applies to all policies delivered or issued for delivery in this state.



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- C. Prohibition. An insurer shall not engage in the following prohibited acts or practices that constitute unfair discrimination between individuals of the same class:
1. Refusal to insure or refusal to continue to insure, or limiting the amount, extent, or kind of coverage available to an individual solely because of blindness or partial blindness; or
  2. Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.
- D. In this subsection, “refusal to insure” includes denial by an insurer of disability insurance coverage on the grounds that the policy defines “disability” as being presumed if the insured loses eyesight. An insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness if the insured was blind or partially blind when the policy was issued.
- E. For all other conditions, including the underlying cause of the blindness or partial blindness, a person who is blind or partially blind is subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person.

**Historical Note**

Adopted effective August 1, 1977 (Supp. 77-4).  
Amended effective March 27, 1976 (Supp. 78-2). Correction, Historical Note for Supp. 77-4 should read adopted effective January 1, 1979 filed August 1, 1977. Historical Note for Supp. 78-2 should read Appendix amended effective January 1, 1979 filed March 27, 1978 (Supp. 79-5). Editorial correction, (D)(7)(a), title now shown in italics (Supp. 81-1). R20-6-211 recodified from R4-14-211 (Supp. 95-1). Former R20-6-211 renumbered to R20-6-209; new R20-6-211 renumbered from R20-6-213 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities**

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at the Department of Insurance and Financial Institutions, Division of Insurance, 100 N. 15th Ave., Suite 261, Phoenix, AZ 85007-2630 and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197:

1. For the purposes of meeting the requirements of A.R.S. § 20-1241.03(C): Life Insurance and Annuities Replacement Model Regulation (MDL 613), Appendix A – Important Notice: Replacement of Life Insurance or Annuities, 2015, and no future editions.
2. For the purposes of meeting the requirements of A.R.S. § 20-1241.07(A): Life Insurance and Annuities Replacement Model Regulation (MDL 613), Appendix B – Notice Regarding Replacing Your Life Insurance Policy or Annuity?, 2015, and no future editions.
3. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(B)(2): Life Insurance and Annuities Replacement Model Regulation (MDL 613), Appendix C – Important Notice: Replacement of Life Insurance or Annuities, 2015, and no future editions.

**Historical Note**

Adopted effective March 27, 1978 (Supp. 78-2). Editorial correction see subsection (A) citation to A.R.S. (Supp. 78-4). Editorial correction see subsections (B) and (F)

citation to A.R.S. (Supp. 78-6). R20-6-212 recodified from R4-14-212 (Supp. 95-1). Former R20-6-212 renumbered to R20-6-210; new R20-6-212 renumbered from R20-6-215 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Amended by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

**R20-6-212.01. Buyer’s Guide for Annuities**

An insurer shall use the following publication of the National Association of Insurance Commissioners (and no future editions), which are incorporated by reference and available at the Department of Insurance and Financial Institutions, Division of Insurance, 100 N. 15th Ave., Suite 261, Phoenix, AZ 85007-2630 and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197:

For the purpose of meeting the requirements of A.R.S. § 20-1242.02 regarding a Buyer’s Guide: Buyer’s Guide for Deferred Annuities, - Fixed, 2013, and no future editions.

**Historical Note**

Section R20-6-212.01 renumbered from R20-6-215.01 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Amended by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

**R20-6-212.02. Standards for Annuity Illustrations**

- A. Definitions. The definitions in A.R.S. § 20-1242 and this subsection apply to this Section.

“Illustration” means a personalized presentation or depiction prepared for and provided to an individual consumer that includes non-guaranteed elements of an annuity contract over a period of years.

“Indexing Method” means point-to-point, dialing averaging or monthly averaging.

“Index Term” means the period over which indexed-based interest is calculated.

“Market Value Adjustment” or “MVA” means a feature that is a positive or negative adjustment that may be applied to the account value and/or cash value of the annuity upon withdrawal, surrender, contract annuitization or death benefit payment based on either the movement of an external index or on the company’s current guaranteed interest rate being offered on new premiums or new rates for renewal periods, if that withdrawal, surrender, contract annuitization or death benefit payment occurs at a time other than on a specified guaranteed benefit date.

“Registered product” means an annuity contract or life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

- B. An insurer or producer may elect to provide a consumer an illustration at any time, provided that the illustration is in compliance with this Section and:

1. Is clearly labeled as an illustration;
2. Includes a statement referring customers to the disclosure document and buyer’s guide provided to them at time of purchase for additional information about their annuity; and
3. Is prepared by the insurer or third party using software that is authorized by the insurer prior to its use, provided that the insurer maintains a system of control over the use of the illustration.

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- C. An illustration furnished to an applicant for a group annuity contract or contracts issued to a single applicant on multiple lives may be either an individual or composite illustration representative of the coverage on the lives of members of the group or the multiple lives covered.
- D. The illustration shall not be provided unless accompanied by the disclosure document referenced in A.R.S. § 20-1242.02.
- E. When using an illustration, the illustration shall not:
  - 1. Describe non-guaranteed elements in a manner that is misleading or has the capacity or tendency to mislead;
  - 2. State or imply that the payment or amount of non-guaranteed elements is guaranteed; or
  - 3. Be incomplete.
- F. Costs and fees of any type shall be individually noted and explained.
- G. An illustration shall conform to the following requirements:
  - 1. The illustration shall be labeled with the date on which it was prepared;
  - 2. Each page, including any explanatory notes or pages, shall be numbered and show its relationship to the total number of pages in the disclosure document (e.g., the fourth page of a seven-page disclosure document shall be labeled "page 4 of 7 pages");
  - 3. The assumed dates of premium receipt and benefit payout within a contract year shall be clearly identified;
  - 4. If the age of the proposed insured is shown as a component of the tabular detail, it shall be issue-age plus the number of years the contract is assumed to have been in force;
  - 5. The assumed premium on which the illustrated benefits and values are based shall be clearly identified, including rider premium for any benefits being illustrated;
  - 6. Any charges for riders or other contract features assessed against the account value or the crediting rate shall be recognized in the illustrated values and shall be accompanied by a statement indicating the nature of the rider benefits or the contract features, and whether or not they are included in the illustration;
  - 7. Guaranteed death benefits and values available upon surrender, if any, for the illustrated contract premium shall be shown and clearly labeled guaranteed;
  - 8. Except as provided in subsection (G)(22) of this Section, the non-guaranteed elements underlying the non-guaranteed illustrated values shall be no more favorable than current non-guaranteed elements and shall not include any assumed future improvement of such elements. Additionally, non-guaranteed elements used in calculating non-guaranteed illustrated values at any future duration shall reflect any planned changes, including any planned changes that may occur after expiration of an initial guaranteed or bonus period;
  - 9. In determining the non-guaranteed illustrated values for a fixed indexed annuity, the index-based interest rate and account value shall be calculated for three different scenarios: one to reflect historical performance of the index for the most recent 10 calendar years; one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the least index value growth (the "low scenario"); one to reflect the historical performance of the index for the continuous period of 10 calendar years out of the last 20 calendar years that would result in the most index value growth (the "high scenario"). The following requirements apply:
    - a. The most recent 10 calendar years and the last 20 calendar years are defined to end on the prior December 31, except for illustrations prepared during the first three months of the year, for which the end date of the calendar year period may be the December 31 prior to the last full calendar year;
    - b. If any index utilized in determination of an account value has not been in existence for at least 10 calendar years, indexed returns for that index shall not be illustrated. If the fixed indexed annuity provides an option to allocate account value to more than one indexed or fixed declared rate account, and one or more of these indexes has not been in existence for at least 10 calendar years, the allocation to such indexed account or accounts shall be assumed to be zero;
    - c. If any index utilized in determination of an account value has been in existence for at least 10 calendar years but less than 20 calendar years, the 10 calendar year periods that define the low and high scenarios shall be chosen from the exact number of years the index has been in existence;
    - d. The non-guaranteed element or elements, such as caps, spreads, participation rates, or other interest crediting adjustments, used in calculating the non-guaranteed index-based interest rate shall be no more favorable than the corresponding current element or elements;
    - e. If a fixed indexed annuity provides an option to allocate the account value to more than one indexed or fixed declared rate account:
      - i. The allocation used in the illustration shall be the same for all three scenarios; and
      - ii. The 10 calendar year periods resulting in the least and greatest index growth periods shall be determined independently for each indexed account option.
    - f. The geometric mean annual effective rate of the account value growth over the 10 calendar year period shall be shown for each scenario;
    - g. If the most recent 10 calendar year historical period experience of the index is shorter than the number of years needed to fulfill the requirement of subsection (I) of this Section, the most recent 10 calendar year historical experience of the index shall be used for each subsequent 10 calendar year period beyond the initial period for the purpose of calculating the account value for the remaining years of the illustration;
    - h. The low and high scenarios:
      - i. Need not show surrender values (if different than account values);
      - ii. Shall not extend beyond 10 calendar years (and therefore are not subject to the requirements of subsection (I) of this Section beyond subsection (I)(1)(a) of this Section); and
      - iii. May be shown on a separate page;
    - i. For the low and high scenarios, a graphical presentation shall also be included comparing the movement of the account value over the 10 calendar year period for the low scenario, the high scenario and the most recent 10 calendar year scenario; and
    - j. The low and high scenarios should reflect the irregular nature of the index performance and should trigger

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- every type of adjustment to the index-based interest rate under the contract. The effect of the adjustments should be clear; for example, additional columns showing how the adjustment applied may be included. If an adjustment to the index-based interest rate is not triggered in the illustration (because no historical values of the index in the required illustration range would have triggered it), the illustration shall so state;
10. The guaranteed elements, if any, shall be shown before corresponding non-guaranteed elements and shall be specifically referred to on any page of an illustration that shows or describes only the non-guaranteed elements (e.g., “see page 1 for guaranteed elements”);
  11. The account or accumulation value of a contract, if shown, shall be identified by the name this value is given in the contract being illustrated and shown in close proximity to the corresponding value available upon surrender;
  12. The value available upon surrender shall be identified by the name this value is given in the contract being illustrated and shall be the amount available to the contract owner in a lump sum after deduction of surrender charges, bonus forfeitures, contract loans, contract loan interest, and application of any market value adjustment, as applicable;
  13. Illustrations may show contract benefits and values in graphic or chart form in addition to the tabular form;
  14. Any illustration of non-guaranteed elements shall be accompanied by a statement indicating that:
    - a. The benefits and values are not guaranteed;
    - b. The assumptions on which they are based are subject to change by the insurer; and
    - c. Actual results may be higher or lower;
  15. Illustrations based on non-guaranteed credited interest and non-guaranteed annuity income rates shall contain equally prominent comparisons to guaranteed credited interest and guaranteed annuity income rates, including any guaranteed and non-guaranteed participation rates, caps, or spreads for fixed indexed annuities;
  16. The annuity income rate illustrated shall not be greater than the current annuity income rate unless the contract guarantees are in fact more favorable;
  17. Illustrations shall be concise and easy to read;
  18. Key terms shall be defined and then used consistently throughout the illustration;
  19. Illustrations shall not depict values beyond the maximum annuitization age or date;
  20. Annuitization benefits shall be based on contract values that reflect surrender charges or any other adjustments, if applicable; and
  21. Illustrations shall show both annuity income rates per \$1,000.00 and the dollar amounts of the periodic income payable.
  22. For participating immediate and deferred income annuities:
    - a. Illustrations may not assume any future improvement in the applicable dividend scale (or scales, if more than one dividend scale applies, such as for a flexible premium annuity);
    - b. Illustrations must reflect the equitable apportionment of dividends, whether performance meets, exceeds, or falls short of expectations;
  - c. If the dividend scale is based on a portfolio rate method, the portfolio rate underlying the illustrated dividend scale shall not be assumed to increase;
  - d. If the dividend scale is based on an investment cohort method, the illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, subject to the following conditions:
    - i. Any assumptions as to future investment performance in the dividend formula must be consistent with assumptions that are reflected in the marketplace within the normal range of analyst forecasts and investor behavior; these assumptions may not be changed arbitrarily, notwithstanding changes in markets or economic conditions, and must be consistent with assumptions that the issuer uses with respect to other lines of business; and
    - ii. The illustrated dividend scale should assume that reinvestment rates grade to long-term interest rates, based on U.S. Treasury bonds. For the purposes of this grading, the assumed long-term rates should not exceed the rates calculated using the formula in subsection (G)(22)(d)(iii), based on the time to maturity or reinvestment (the “Tenor”) of the investments supporting the cohort of policies.
    - iii. Maximum long-term interest rates should be calculated for tenors of three months (or less), five years, 10 years, and 20 years (or more), using U.S. Treasury rates. For each tenor, the maximum long-term interest rate will vary over time, based on historical interest rates as they emerge. The formula for the maximum long-term interest rate is the average of the median bond rate over the last 600 months and the average bond rate over the last 120 months, rounded to the nearest quarter of one percent (0.25%).
    - iv. The maximum long-term interest rate for a tenor should be recalculated once per year, in January, using historical rates as of December 31 of the calendar year two years prior to the calendar year of the calculation date. The historical rate for each month is the rate reported for the last business day of the month.
    - v. Grading to the maximum long-term interest rates should take place over no less than 20 years from issue if U.S. Treasury rates as of the illustration date are below the long-term rates, or, no more than 20 years from issue if U.S. Treasury rates as of the illustration date are above the long-term rates.
    - vi. When the 10-year U.S. Treasury rate is less than the 10-year maximum long-term interest rate, an additional illustrated dividend scale should be presented. This additional illustrated dividend scale shall assume that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates and illustrate dividends no less than half of the dividends illustrated under the current dividend scales. If the assumption that reinvestment U.S. Treasury rates do not exceed the initial investment U.S. Treasury rates conflicts with the illustration, i.e.

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half of the current dividends are greater than would be permitted by the assumption, then the reinvestment U.S. Treasury rates should equal the initial investment U.S. Treasury rates.

- vii. The illustration should include a disclosure that is substantially similar to the following:

The illustrated current dividend scale is based on interest rates that are assumed to gradually [increase/decrease] from current rates to long-term interest rates, over a period of [20] years. By regulation, the long-term assumed interest rates cannot not and do not exceed the rates listed in column (c) of the table below.

- viii. If the illustration contains an additional dividend scale pursuant to subsection (G)(22)(d)(vi), then the illustration should also include a disclosure that is substantially similar to the following:

The additional illustrated dividend scale is based on interest rates that are assumed not to increase and do not exceed the interest rates in column (b) of the table below.

Column A	Column B	Column C
Tenor	Current Interest Rate	Long Term
	Treasury Rate as of 12/31/2016	Mean Reversed Treasury Rate
3 Month (or less)	0.51%	3.00%
5 Year	1.93%	4.50%
10 Year	2.45%	5.00%
20 Years (or more)	3.06%	5.50%

- H. An annuity illustration shall include a narrative summary that includes all the following unless provided at the same time in a disclosure statement:

1. A brief description of any contract features, riders or options, guaranteed and/or non-guaranteed, shown in the basic illustration and the impact they may have on the benefits and values of the contract;
2. A brief description of any other optional benefits or features that are selected, but not shown in the illustration and the impact they have on the benefits and values of the contract;
3. Identification and a brief definition of column headings and key terms used in the illustration;
4. A statement containing in substance the following:

- a. For other than fixed indexed annuities:  
This illustration assumes the annuity's current non-guaranteed elements will not change. It is likely that they will change and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information;

- b. For fixed indexed annuities:  
This illustration assumes the index will repeat historical performance and that the annuity's current

non-guaranteed elements, such as caps, spreads, participation rates or other interest crediting adjustments, will not change. It is likely that the index will not repeat historical performance, the non-guaranteed elements will change, and actual values will be higher or lower than those in this illustration but will not be less than the minimum guarantees.

The values in this illustration are not guarantees or even estimates of the amounts you can expect from your annuity. Please review the entire Disclosure Document and Buyer's Guide provided with your Annuity Contract for more detailed information;

5. Additional explanations as follows:
  - a. Minimum guarantees shall be clearly explained;
  - b. The effect on contract values of contract surrender prior to maturity shall be explained;
  - c. Any conditions on the payment of bonuses shall be explained;
  - d. For annuities sold as an IRA, qualified plan or in another arrangement subject to the required minimum distribution (RMD) requirements of the Internal Revenue Code, the effect of RMDs on the contract values shall be explained;
  - e. For annuities with recurring surrender charge schedules, a clear and concise explanation of what circumstances will cause the surrender charge to recur; and
  - f. A brief description of the types of annuity income options available shall be explained, including:
    - i. The earliest or only maturity date for annuitization (as the term is defined in the contract);
    - ii. For contracts with an optional maturity date, the periodic income amount for at least one of the annuity income options available based on the guaranteed rates in the contract, at the later of age 70 or 10 years after issue, but in no case later than the maximum annuitization age or date in the contract;
    - iii. For contracts with a fixed maturity date, the periodic income amount for at least one of the annuity income options available, based on the guaranteed rates in the contract at the fixed maturity date; and
    - iv. The periodic income amount based on the currently available periodic income rates for the annuity income option in subsection (H)(5)(f)(ii) or in subsection (H)(5)(f)(iii), if desired.

- I. Following the narrative summary, an illustration shall include a numeric summary which shall include at minimum, numeric values at the following durations:

1. The first 10 contract years or the surrender charge period if longer than 10 years, including any renewal surrender charge period or periods;
2. Every tenth contact year up to the later of 30 years or age 70; and
3. Required annuitization age or required annuitization date.

- J. If the annuity contains a market value adjustment ("MVA"), the following provisions apply to the illustration:

1. The MVA shall be referred to as such throughout the illustration;
2. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the value available upon surrender;

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3. The narrative shall include an explanation, in simple terms, of the potential effect of the MVA on the death benefit;
  4. A statement, containing in substance the following, shall be included:  
When you make a withdrawal, the amount you receive may be increased or decreased by a Market Value Adjustment (MVA). If the interest rates on which the MVA is based go up after you buy your annuity, the MVA likely will decrease the amount you receive. If interest rates go down, the MVA will likely increase the amount you receive.
  5. Illustrations shall describe both the upside and the downside aspects of the contract features relating to the MVA;
  6. The illustrative effect of the MVA shall be shown under at least one positive and one negative scenario. This demonstration shall appear on a separate page and be clearly labeled that it is information demonstrating the potential impact of a MVA;
  7. Actual MVA floors and ceilings as listed in the contract shall be illustrated; and
  8. If the MVA has significant characteristics not addressed by subsections (J)(1) through (J)(6), the effect of such characteristics shall be shown in the illustration.
- K.** A narrative summary for a fixed indexed annuity illustration also shall include the following unless provided at the same time as the disclosure statement:
1. An explanation, in simple terms, of the elements used to determine the index-based interest, including but not limited to, the following elements:
    - a. The index(es) which will be used to determine the index-based interest;
    - b. The Indexing Method;
    - c. The Index Term;
    - d. The participation rate, if applicable;
    - e. The cap, if applicable; and
    - f. The spread, if applicable;
  2. The narrative shall include an explanation, in simple terms, of how index-based interest is credited in the indexed annuity;
  3. The narrative shall include a brief description of the frequency with which the company can re-set the elements used to determine the index-based credits, including the participation rate, the cap, and the spread, if applicable; and
  4. If the product allows the contract holder to make allocations to a declared-rate segment, then the narrative shall include a brief description of:
    - a. Any options to make allocations to a declared-rate segment, both for new premiums and for transfers from the index-based segments; and
    - b. Differences in guarantees applicable to the declared-rate segment and the index-based segments.
- L.** A numeric summary for a fixed indexed annuity illustration shall include, at a minimum, the following elements:
1. The assumed growth rate of the index in accordance with subsection (G)(9);
  2. The assumed values for the participation rate, cap and spread, if applicable; and
  3. The assumed allocation between index-based segments and the declared-rate segment, if applicable, in accordance with subsection (G)(9).
- M.** If the contract is issued other than as applied for, a revised illustration conforming to the contract as issued shall be sent with the contract, except that non-substantive changes, including but not limited to, changes in the amount of expected initial or additional premiums and any changes in amounts of exchanges pursuant to Section 1053 of the Internal Revenue Code, rollovers and transfers, which do not alter the key benefits and features of the annuity as applied for will not require a revised illustration unless requested by the applicant.
- N.** Annuity Illustration Examples. Illustrations A through C are examples only and do not reflect specific characteristics of any actual product for sale by any company.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

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**Illustration A. Annuity Illustration Example****ABC Life Insurance Company***Company Product Name*

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

(Contact us at Policyownerservice@ABCLife.com or 555-555-5555)

Sex: Male	Initial Premium Payment: \$100,000.00
Age at Issue: 54	Planned Annual Premium Payments: None
Annuitant: John Doe	Tax Status: Nonqualified
Oldest Age at Which Annuity Payments Can Begin: 95	Withdrawals: None Illustrated

<b>Initial Interest Guarantee Period</b>	5 Years
<b>Initial Guaranteed Interest Crediting Rates</b>	
First Year (reflects first year only interest bonus credit of 0.75%):	4.15%
Remainder of Initial Interest Guarantee Period:	3.40%
<b>Market Value Adjustment Period:</b>	5 Years
<b>Minimum Guaranteed Interest Rate after Initial Interest Guarantee Period*:</b>	3%

\* After the Initial Interest Guarantee Period, a new interest rate will be declared annually. This rate cannot be lower than the Minimum Guaranteed Interest Rate.

**Annuity Income Options and Illustrated Monthly Income Values**

This annuity is designed to pay an income that is guaranteed to last as long as the Annuitant lives. When annuity income payments are to begin, the income payment amounts will be determined by applying an annuity income rate to the annuity Account Value.

**Annuity income options include the following:**

- Periodic payments for Annuitant's life
- Periodic payments for Annuitant's life with payments guaranteed for a certain number of years
- Periodic payments for Annuitant's life with payments continuing for the life of a survivor annuitant

**Illustrated Annuity Income Option:** Monthly payments for annuitant's life with payments guaranteed for 10-year period.

**Assumed Age When Payments Start: 70**

	Account Value	Monthly Annuity Income Rate/\$1,000 of Account Value*	Monthly Annuity Income
Based on Rates Guaranteed in the Contract	\$164,798	\$5.00	\$823.99
Based on Rates Currently Offered by the Company	\$171,976	\$6.50	\$1,117.84

\*If, at the time of annuitization, the annuity income rates currently offered by the company are higher than the annuity income rates guaranteed in the contract, the current rates will apply.

**Historical Note**

New Appendix A made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

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**Illustration B. Annuity Illustration Example****ABC Life Insurance Company***Company Product Name*

Flexible Premium Fixed Deferred Annuity with a Market Value Adjustment (MVA)

An Illustration Prepared for John Doe by John Agent on mm/dd/yyyy

Contact us at Policyownerservice@ABCLife.com or 555-555-5555

Contract Year/Age	Premium Payment	Values Based on Guaranteed Rates				Value Based on Assumption that Initial Guaranteed Rates Continue		
		Interest Crediting Rate	Account Value	Cash Surrender Value Before MVA	Minimum Cash Surrender Value After MVA	Interest Crediting Rate	Account Value	Cash Surrender Value Before and After MVA
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1 / 55	\$100,000	4.15%	\$104,150	\$95,818	\$92,000	4.15%	\$104,150	\$95,818
2 / 56	0	3.40%	107,691	100,153	93,000	3.40%	107,691	100,153
3 / 57	0	3.40%	111,353	104,671	95,614	3.40%	111,353	104,671
4 / 58	0	3.40%	115,139	109,382	98,482	3.40%	115,139	109,382
5 / 59	0	3.40%	119,053	114,291	114,291	3.40%	119,053	114,291
6 / 60	0	3.00%	122,625	118,946	118,946	3.40%	123,101	119,408
7 / 61	0	3.00%	126,304	123,778	123,778	3.40%	127,287	124,741
8 / 62	0	3.00%	130,093	130,093	130,093	3.40%	131,614	131,614
9 / 63	0	3.00%	133,996	133,996	133,996	3.40%	136,089	136,089
10 / 64	0	3.00%	138,015	138,015	138,015	3.40%	140,716	140,716
11 / 65	0	3.00%	142,156	142,156	142,156	3.40%	145,501	145,501
16 / 70	0	3.00%	164,798	164,798	164,798	3.40%	171,976	171,976
21 / 75	0	3.00%	191,046	191,046	191,046	3.40%	203,268	203,268
26 / 80	0	3.00%	221,474	221,474	221,474	3.40%	240,255	240,255
31 / 85	0	3.00%	256,749	256,749	256,749	3.40%	283,972	283,972
36 / 90	0	3.00%	297,643	297,643	297,643	3.40%	335,643	335,643
41 / 95	0	3.00%	345,050	345,050	345,050	3.40%	396,717	396,717

**Column Descriptions**

- (1) **Ages** shown are measured from the Annuitant's age at issue.
- (2) **Premium Payments** are assumed to be made at the beginning of the Contract Year shown.

**Values Based on Guaranteed Rates**

- (3) **Interest Crediting Rates** shown are annual rates; however, interest is credited daily. During the Initial Interest Guarantee Period, values developed from the Initial Premium Payment are illustrated using the Initial Guaranteed Interest Rate(s) declared by the insurance company, which include an additional first year only interest bonus credit of 0.75%. The interest rates will be guaranteed for the Initial Interest Guarantee Period, subject to an MVA. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually, but can never be less than the Minimum Guaranteed Interest Rate shown.
- (4) **Account Value** is the amount you have at the end of each year if you leave your money in the contract until you start receiving annuity payments. It is also the amount available upon the Annuitant's death if it occurs before annuity payments begin. The death benefit is not affected by surrender charges or the MVA.
- (5) **Cash Surrender Value Before MVA** is the amount available at the end of each year if you surrender the contract (after deduction of any Surrender Charge) but before the application of any MVA. Surrender charges are applied to the Account Value according to the schedule below until the surrender charge period ends, which may be after the Initial Interest Guarantee Period has ended.

**Years Measured from Premium Payment:**    1    2    3    4    5    6    7    8+  
**Surrender Charges:**                                8%   7%   6%   5%   4%   3%   2%   0%

- (6) **Minimum Cash Surrender Value After MVA** is the minimum amount available at the end of each year if you surrender your contract before the end of five years, no matter what the MVA is. The minimum is set by law. The amount you receive may be higher or lower than the cash surrender value due to the application of the MVA, but never lower than this minimum. Otherwise the MVA works as follows: If the interest rate available on new contracts offered by the company is LOWER than your Initial Guaranteed Interest Rate, the MVA will INCREASE the amount you receive. If the interest rate available on new contracts offered by the company is HIGHER than your initial guaranteed interest rate, the MVA will DECREASE the amount you receive. The charts below provide additional information concerning the MVA.

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**Values Based on Assumption that Initial Guaranteed Rates Continue**

- (7) **Interest Crediting Rates** are the same as in Column (3) for the Initial Interest Guarantee Period. After the Initial Interest Guarantee Period, a new renewal interest rate will be declared annually. For the purposes of calculating the values in this column, it is assumed that the Initial Guaranteed Interest Rate (without the bonus) will continue as the new renewal interest rate in all years. The actual renewal interest rates are not subject to an MVA and will very likely NOT be the same as the illustrated renewal interest rates.
- (8) **Account Value** is calculated the same way as Column (4).
- (9) **Cash Surrender Value Before and after MVA** is the Cash Surrender Value at the end of each year assuming that Initial Guaranteed Interest Rates continue, and that the continuing rates are the rates offered by the company on new contracts. In this case the MVA would be zero, and Cash Surrender Values before and after the MVA would be the same.

**Important Note:** This illustration assumes you will take no withdrawals from your annuity before you begin to receive periodic income payments. **Withdrawals will reduce both the annuity Account Value and the Cash Surrender Value.** You may make partial withdrawals of up to 10% of your account value each contract year without paying surrender charges. Excess withdrawals (above 10%) and full withdrawals will be subject to surrender charges.

**This illustration assumes the annuity's current interest crediting rates will not change. It is likely that they will change and actual values may be higher or lower than those in the illustrations.**

**The values in this illustration are not guaranteed or even estimates of the amounts you can expect from your annuity. For more information, read the annuity disclosure and annuity buyer's guide.**

**Historical Note**

New Appendix B made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).



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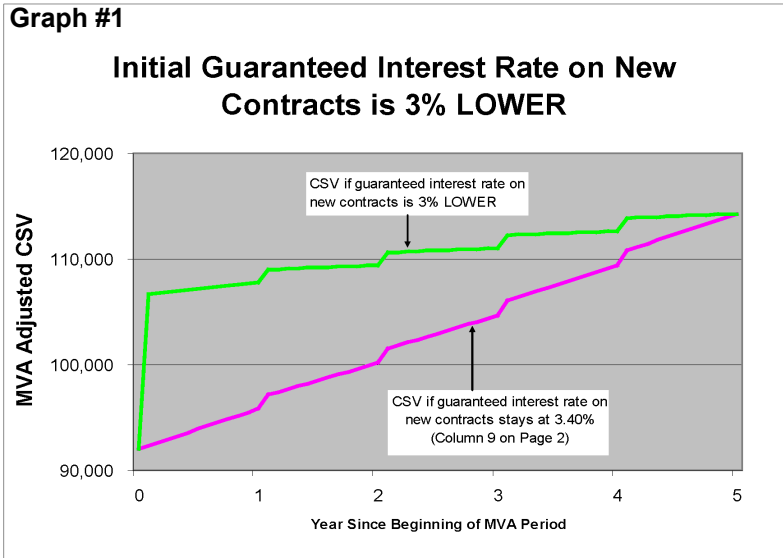
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**Illustration C. MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios**

**MVA-adjusted Cash Surrender Values (CSVs) Under Sample Scenarios**

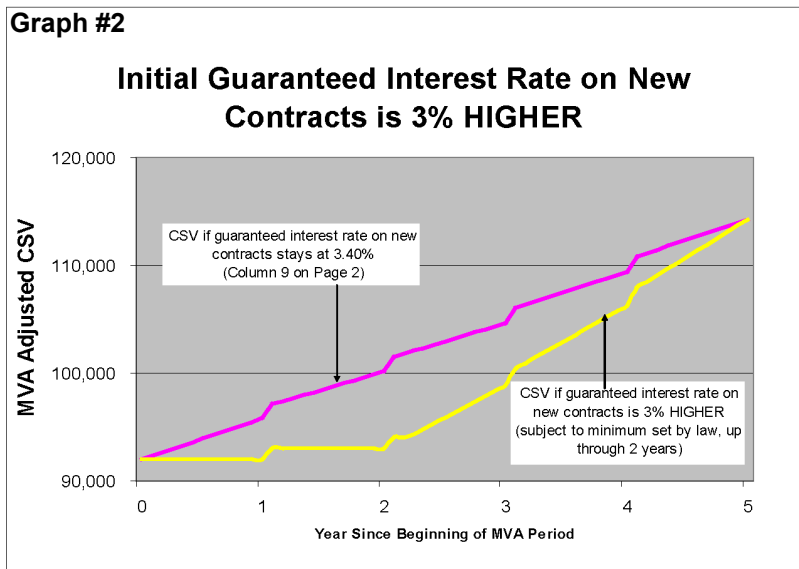
The graphs below show MVA-adjusted Cash Surrender Values (CSVs) during the first five years of the contract, as illustrated on the illustration spreadsheet above (\$100,000 single premium, a 5-year MVA Period) under two sample scenarios, as described below.

**Graph #1** shows if the interest rate on new contracts is 3% LOWER than your Initial Guaranteed Interest Rate, the MVA will increase the amount you receive (upper line). The lower line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on the illustration spreadsheet above (referenced as Page 2 in the graph)).



**Graph #2** shows if the interest rate on new contracts is 3% HIGHER than your Initial Guaranteed Interest Rate, the MVA will decrease the amount you receive, but not below the minimum set by law (Column (6) on the illustration spreadsheet above (referenced as Page 2 in the graph)), which in this scenario's limits the decrease for the first 2 years (lower line). The upper line shows the Cash Surrender Values if the Initial Guaranteed Interest Rates continue (from Column (9) on the illustration spreadsheet above).

These graphs and the sample guaranteed interest rates on new contracts used are for demonstration purposes only and are not intended to be a projection of how guaranteed interest rates on new contracts are likely to behave.



**Historical Note**

Appendix C made by final rulemaking at 28 A.A.R. 454 (February 25, 2022), effective April 5, 2022 (Supp. 22-1).

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**R20-6-213. Life and Disability Insurance Policy Language Simplification****A. Definitions.** The following definitions apply in this Section:

1. "Company" or "insurer" means any life or disability insurance company, benefit insurer, benefit stock insurer, prepaid dental plan organizations, health care service organizations, and all similar type organizations.
2. "Director" means the Director of Insurance of Arizona.
3. "Policy" or "policy form" means any policy, contract, plan or agreement of life or disability insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in the state by any company subject to this rule; and any certificate issued under a group insurance policy delivered or issued for delivery in this state.

**B. Applicability.**

1. This Section and R20-6-212 apply to all life and disability insurance policies delivered or issued for delivery in this state by any company but do not apply to:
  - a. Any policy that is a security subject to federal jurisdiction;
  - b. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy however, this shall not exempt any certificate issued under a group policy delivered or issued for delivery in this state; or
  - c. Any group annuity contract that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
2. Except as provided in R20-6-210, no other rule of this state setting language simplification standards shall apply to any policy forms.

**C. Minimum policy language simplification standards.**

1. Except as stated in subsection (B), an insurer shall not deliver or issue for delivery a policy form that has not been approved by the Director unless:
  - a. The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection (3);
  - b. It is printed, except for specification pages, schedules, and tables, in no less than 10 point type, one point leaded;
  - c. The style, arrangement and overall appearance of the policy do not give undue prominence to any portion of the text of the policy or to any endorsements or riders; and
  - d. The policy, if the policy has more than 3,000 words printed on three or fewer pages of text or if the policy has more than three pages regardless of the number of words, contains a table of contents or an index of the principal sections of the policy.
2. An insurer shall measure a Flesch reading ease test score as follows:
  - a. For policy forms containing 10,000 words or less of text, an insurer shall analyze the entire form. For policy forms containing more than 10,000 words, an insurer may analyze the readability of two, 200-word samples per page instead of the entire form. The insurer shall separate the samples by at least 20 printed lines.
  - b. The insurer shall count the number of words and sentences in the text, then divide the total number of

words by the total number of sentences, then multiply that figure by a factor of 1.015.

- c. The insurer shall count and divide the total number of syllables by the total number of words, then multiply that figure by a factor of 84.6.
  - d. The sum of the figures computed under subsections (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
  - e. For subsections (b), (c), and (d), the insurer shall use the following procedures:
    - i. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;
    - ii. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and
    - iii. A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
  - f. The term "text" as used in this subsection shall include all printed matter except the following:
    - i. The name and address of the insurer, the name, number or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules or tables; and
    - ii. Policy language that is drafted to conform to the requirements of a federal law, regulation, or agency interpretation, policy language required by a collectively bargained agreement, medical terminology, words defined in the policy, and policy language required by law or regulation, if the insurer identifies the language or terminology excepted by this subsection and certifies, in writing, that the language or terminology is entitled to be excepted by this subsection.
  3. Any other reading test may be approved by the Director for use as an alternative to the Flesch reading test if it is comparable in result to the Flesch reading ease test.
  4. Filings subject to this subsection shall be accompanied by a certificate signed by an officer of the insurer stating that the filing meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved under subsection (G) of this Section. To confirm the accuracy of any certification, the Director may require the submission of further information to verify the certification in question.
  5. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.
- D.** The Director may authorize a lower score than the Flesch reading ease score required in subsection (C)(1)(a) if a lower score:
1. Provides a more accurate reflection of readability of a policy form;
  2. Is warranted by the nature of a particular policy form or type or class of policy forms; or
  3. Is caused by certain policy language drafted to conform to the requirements of any state statute, rule, or agency interpretation of law.

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**Historical Note**

Adopted effective November 21, 1977 (Supp. 77-6).

Amended effective March 27, 1978 (Supp. 78-2).

Amended subsection (E), deleted subsection (F) and added new subsections (F) and (G) effective December 3, 1986 (Supp. 86-6). R20-6-213 recodified from R4-14-213 (Supp. 95-1). Former R20-6-213 renumbered to R20-6-211; new R20-6-213 renumbered from R20-6-216 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2). Corrected error in R20-6-213(D) that referenced subsection (E)(1)(a), which was relabeled as (C)(1)(a) in Supp. 07-2 (Supp. 08-1).

**R20-6-214. Coordination of Benefits****A. Applicability.**

1. This Section applies to all:
  - a. Group disability insurance policies;
  - b. Group subscriber contracts of hospital and medical service corporations and health care services organizations;
  - c. Group disability policies of benefit insurers; and
  - d. Group-type contracts that contain a coordination of benefits provision, are not available to the general public, and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization. Group-type contracts that meet this description are included regardless of whether denominated as "franchise," "blanket," or some other designation.
2. This Section does not apply to:
  - a. Individual or family policies or individual or family subscriber contracts except as provided for in subsection (A)(1);
  - b. Group or group-type hospital indemnity benefits, written on a non-expense incurred basis, of \$30 per day or less unless characterized as reimbursement-type benefits and designed or administered to give the insured the right to elect indemnity-type benefits, instead of the reimbursement type benefits at the time of claim; or
  - c. School accident type coverages, written on a blanket, group, or franchise basis.

**B. Definitions. In this Section, the following definitions apply:**

1. "Allowable expense" means any necessary, reasonable, and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.
  - a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is deemed to be both an allowable expense and a benefit paid.
  - b. A plan that takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.
2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.
3. "Plan," within the coordination of benefits provisions of a group policy or subscriber contract, means the types of coverage that the insurer may consider in determining whether overinsurance exists with respect to a specific claim.

4. "School accident-type coverage" means coverage of grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to-and-from school," for which the parent pays the entire premium.

**C. Order-of-benefit determination.**

1. When a claim under a plan with a coordination of benefit provision involves another plan that also has a coordination of benefit provision, the insurer shall make the order-of-benefit determination as follows:
  - a. The plan that covers the person claiming benefits other than as a dependent shall determine benefits before those of the plan that covers the person as a dependent.
  - b. The plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year. The word "birthday" as used in this subsection refers only to month and day in a calendar year, not the year in which the person was born.
  - c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
    - i. First, the plan of the parent with custody of the child;
    - ii. Then, the plan of the spouse of the parent with custody of the child; and
    - iii. Finally, the plan of the parent not having custody of the child.
  - d. Notwithstanding subsection (c), if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
2. The benefits of a plan that covers a person as an employee (or as that employee's dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this subsection does apply.
3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan that covered a claimant longer are determined before those of the plan that covered that person for the shorter time.
4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

**D. Excess and other nonconforming provisions. A plan with an order of benefit determination provision that complies with this Section, a complying plan, may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses an order-of-benefit determination provision that is inconsistent with this Section, a noncomplying plan, on the following basis:**

1. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
2. If the complying plan is the secondary plan, it shall pay or provide its benefits first, as the secondary plan. The pay-

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ment shall be the limit of the complying plan's liability, except as provided in subsection (4).

3. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay benefits accordingly. The complying plan shall adjust any payments it makes based on the assumption whether information becomes available as the actual benefits of the noncomplying plan.
4. If the noncomplying plan pays benefits so that the claimant receives less in benefits than the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, the complying plan shall advance to or on behalf of the claimant an amount equal to the difference. The complying plan shall not have a right to reimbursement from the claimant.

**Historical Note**

Adopted effective October 26, 1979 (Supp. 79-5). R20-6-214 recodified from R4-14-214 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-214 renumbered from R20-6-217 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-215. Renumbered****Historical Note**

Adopted effective September 7, 1981 (Supp. 81-3). Amended subsections (D) through (H), deleted Agent's Statement and Exhibit D effective March 30, 1983 (Supp. 83-2). R20-6-215 recodified from R4-14-215 (Supp. 95-1). Amended by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215 renumbered to R20-6-212 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-215.01. Renumbered****Historical Note**

New Section made by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215.01 renumbered to R20-6-212.01 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-216. Renumbered****Historical Note**

Adopted effective as set forth in subsection (H) (Supp. 80-6). R20-6-216 recodified from R4-14-216 (Supp. 95-1). Former R20-6-216 renumbered to R20-6-213 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

**R20-6-217. Renumbered****Historical Note**

Adopted effective September 14, 1982 (Supp. 82-3). Amended subsections (C) and (D), deleted (F) effective January 1, 1987, filed December 16, 1986 (Supp. 86-6). R20-6-217 recodified from R4-14-217 (Supp. 95-1). Former R20-6-217 renumbered to R20-6-214 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

*Editor's Note: The following Section expired under A.R.S. § 41-1056(E) on September 30, 2001 at 8 A.A.R. 491. The Notice of Rule Expiration was not received until January 9, 2002. Therefore, the repeal of the rule noted in the Historical Note is moot (Supp. 02-1).*

**R20-6-218. Repealed****Historical Note**

Adopted effective November 9, 1984 (Supp. 84-6). R20-6-218 recodified from R4-14-218 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5443, effective November 16, 2001 (Supp. 01-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1); refer to the Editor's Note before the Section.

**ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES****R20-6-301. Expired****Historical Note**

Former General Rule Number 3. R20-6-301 recodified from R4-14-301 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

**R20-6-302. Expired****Historical Note**

Former General Rule 62-11. R20-6-302 recodified from R4-14-302 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

**R20-6-303. Termination of Certificate of Authority and Release of Deposit**

**A.** Domestic Insurers. To request termination of a certificate of authority and, if applicable, release of statutory deposit, a domestic insurer shall file all of the following with the director:

1. A written request for termination of certificate of authority and release of deposit;
2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
4. A plan of extinguishment for its outstanding liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no outstanding liabilities to policyholders or claimants under subsection (C);
5. A certified copy of the insurer's Board of Directors resolution or other documentation of the insurer's official action taken according to the insurer's statutorily required organizational documents approving the insurer's:
  - a. Withdrawal from the insurance business,
  - b. Dissolution of the insurer,
  - c. Merger with an insurer authorized in Arizona to transact the insurer's previously written and active lines of business of the insurer requesting termination, or

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- d. Transfer of domicile to another state or country.
6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication, or other documentation that the insurer intends to file with the Arizona Corporation Commission after issuance of the Director's order as provided in subsection (D)(2);
  7. If requested by the director, a written agreement that guarantees payment of substantially all liabilities of the domestic insurer, other than obligations extinguished under subsection (C).
- B. Foreign and Alien Insurers.** To request termination of its certificate of authority and, if applicable, release of its deposit, a foreign or alien insurer shall file all of the following with the director:
1. A written request for termination of certificate of authority and release of deposit;
  2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
  3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
  4. A plan of extinguishment for its Arizona liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no Arizona liabilities under subsection (C);
  5. A copy of an order issued by the insurance director or other appropriate regulatory authority in the insurer's state or country of domicile that approves or authorizes either the insurer's:
    - a. Withdrawal from the insurance business,
    - b. Dissolution of the insurer,
    - c. Merger (approval of the merger from the states of domicile of the insurers), or
    - d. Transfer of domicile, if applicable.
  6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication or other required documentation that the insurer filed in its state of domicile; and
  7. If requested by the director, a written agreement that guarantees payment of substantially all Arizona liabilities of the insurer, other than obligations extinguished under subsection (C).
- C. Insurer's Plan for Extinguishment of Liabilities.**
1. To extinguish substantially all liabilities under subsection (A)(4) or subsection (B)(4) as applicable, an insurer may:
    - a. Reinsure the insurer's business in force with another insurer by entering into an agreement of bulk reinsurance that shall be effective when filed with and approved in writing by the director.
      - i. The agreement shall provide for assumption of all policyholder claims by the reinsurer including claims incurred but unreported as of the effective date of the agreement.
      - ii. The agreement may include recapture provisions exercisable by the insurer in the event the termination of its certificate of authority is not completed.
      - iii. Unless the director otherwise approves, the agreement shall provide that the reinsurer be licensed in Arizona for the particular lines of business reinsured.
    - b. Merge with another insurer that:
      - i. Assumes the liabilities of the non-surviving insurer; and
      - ii. Is authorized in Arizona for the previously written and active lines of business assumed, unless otherwise approved by the director.
    - c. Use its deposit, any additional security deposit or both to secure payment of former policyholder, policyholder, or claimant liabilities that are not reinsured or otherwise secured.
2. For purposes of this Section, "substantially all liabilities" under Title 20 means all policyholder and claimant obligations reported by the insurer in the statement of financial condition, whether or not liquidated in amount, and shall include former policyholder claims and rights to refunds.
- D. Consideration of the Request for Termination of Certificate of Authority and Release of Deposit under subsections (A) and (B).**
1. If the director determines that the insurer has extinguished substantially all liabilities as required under this Section and has otherwise demonstrated compliance with this Section and A.R.S. Title 20, the director shall grant the request to terminate the certificate of authority and, if appropriate, release the insurer's deposit, provided:
    - a. The insurer has no fees, taxes, assessments or filings outstanding to the Department; and
    - b. The insurer is not subject of any pending investigation or examination under Title 20 by the Department.
  2. The director's order shall condition the release of a domestic insurer's deposit upon receipt by the director of evidence of the official filing with the Arizona Corporation Commission of the documentation described in subsection (A)(6).
  3. If the director determines that the insurer is unable to extinguish substantially all liabilities as required under this Section, or otherwise has not complied with this Section or with A.R.S. Title 20, the director shall notify the insured in writing that the request has been denied and the reasons for the denial.
- E. Exclusions.** This Section does not apply to:
1. An insurer's exchange and substitution of cash or eligible securities under A.R.S. § 20-586;
  2. An insurer's withdrawal of excess deposits, either cash or eligible securities, under A.R.S. §§ 20-587 and 20-588(A)(2); or
  3. Releases of deposits made under A.R.S. § 20-588(A)(3).
- Historical Note**
- Former General Rule 72-29. R20-6-303 recodified from R4-14-303 (Supp. 95-1). Section R20-6-303 repealed; new Section R20-6-303 made by final rulemaking at 14 A.A.R. 3432, effective October 4, 2008 (Supp 08-3).
- R20-6-304. Reserved**
- R20-6-305. Expired**
- Historical Note**
- Adopted effective September 13, 1978, except that it shall apply to the accounting treatment for unearned premium reserves and reinsurance premium receivables for credit life disability insurance on January 1, 1979, and all

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annual statements filed for periods on or after that date (Supp. 78-5). R20-6-305 recodified from R4-14-305 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

**R20-6-306. Reserved****R20-6-307. Life and Disability Reinsurance Agreements**

**A.** Scope. This rule applies to all domestic life and disability insurers and reinsurers, and to all other licensed life and disability insurers and accredited reinsurers that are not subject to a substantially similar rule in their jurisdictions of domicile. This rule applies to the disability business of licensed property and casualty insurers. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance, or nonproportional stop loss or catastrophe reinsurance, or similar forms of nonproportional reinsurance.

**B. Definitions**

1. "Agreement" means a reinsurance agreement and any amendment to a reinsurance agreement.
2. "Credit Quality" means the risk that invested assets supporting the reinsured business will decrease in value but excludes decreases to changes in interest rate.
3. "Department" means the Arizona Department of Insurance and Financial Institutions – Insurance Division.
4. "Director" has the same meaning as A.R.S. § 20-102.
5. "Disintermediation" means the risk that interest rates will rise and policy loans and surrenders will increase or maturing contracts will not renew at anticipated rates of renewal.
6. "Lapse" means the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issuance of the policy.
7. "Reinvestment" means the risk that interest rates will fall and funds reinvested will therefore earn less than expected.

**C. Accounting Requirements**

1. Unless authorized by the Director, an insurer shall not, for reinsurance ceded, reduce any liability, or establish any asset in any statutory financial statement filed with the Department if, by the terms of the agreement, or in effect, any of the following conditions exist:
  - a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover the ceding insurer's allocable renewal expenses anticipated at the time the business is reinsured on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured.
  - b. The ceding insurer is required to reimburse the reinsurer for negative experience under the agreement. Neither the offset of the ceding insurer's experience refunds against current and prior years' losses, nor payment by the ceding insurer of an amount equal to the reinsurer's current and prior years' losses upon voluntary termination of in-force reinsurance by the ceding insurer, shall be considered a reimbursement to the reinsurer for negative experience.
  - c. The ceding insurer may be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of a specified event, including the insolvency of the ceding insurer. Termination of the

agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due shall not be considered a deprivation of surplus or assets within the meaning of this subsection.

- d. The ceding insurer is required, at scheduled times, to terminate the agreement or recapture automatically all or part of the reinsurance ceded.
  - e. The ceding insurer may be required to pay the reinsurer amounts other than from income reasonably expected from the reinsured policies.
  - f. Significant risks inherent in the business reinsured are not transferred to the reinsurer. Table A identifies the risks deemed significant for representative types of business.
  - g. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not transfer the underlying assets to the reinsurer, segregate the underlying assets in a trust or escrow account, or otherwise segregate the underlying assets. The assets that support the reserves for classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk, or for long-term care or long-term disability insurance, traditional non-par permanent, traditional par permanent, adjustable premium permanent, indeterminate premium permanent, or universal life fixed premium with no dump-in premiums allowed, may be held by the ceding company without segregation. To determine the reserves for classes of business, the supporting assets of which may be held without being segregated, the reserve interest rate adjustment formula shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reported in the ceding insurer's statutory financial statement.
  - h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.
  - i. The ceding insurer is required to make representations or warranties unrelated to the business reinsured.
  - j. The ceding insurer is required to make representations or warranties related to future performance of the business reinsured.
2. An agreement entered into after the effective date of this rule to reinsure business issued before the effective date of the agreement shall be filed by the ceding insurer with the Director within 30 days after execution of the agreement. Each filing shall be accompanied by a description of the corresponding reduction in liabilities or other credit for reinsurance, and any other financial impact of the agreement, reported in the ceding insurer's statutory financial statements. When an increase in surplus net of federal income tax results from an agreement falling under this subsection, the ceding insurer shall separately identify the increase as a surplus item in the aggregate write-ins for gains and losses in surplus in the Capital and Surplus account of the ceding insurer's statutory financial statement. As earnings emerge from the business reinsured, the ceding insurer shall report in its statutory financial statement recognition of surplus increase as income on a net of tax basis as reinsurance ceded.

**D. Written Agreements**

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1. A ceding insurer shall not reduce any liability or establish any asset in any statutory financial statement filed with the Department, unless the ceding insurer and the reinsurer have executed an agreement or a binding letter of intent by the “as of” date of the statutory financial statement.
2. A ceding insurer shall not be allowed a credit for the reinsurance ceded based on a letter of intent unless the ceding insurer and the reinsurer execute an agreement within 90 days from the execution date of the letter of intent.
3. The agreement shall provide that:
  - a. The agreement constitutes the entire contract between the parties with respect to the business reinsured, and there are no understandings between the parties other than as expressed in the agreement; and
  - b. Any change or modification to the agreement shall be void unless made by written amendment signed by all parties.

**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-307 recodified from R4-14-307 (Supp. 95-1). Amended effective December 7, 1995 (Supp. 95-4). Amended by final rulemaking at 29 A.A.R. 739 (March 17, 2023), effective May 8, 2023 (Supp. 23-1).

**Table A. Risk Categories**

Risk Categories:

- |                |                        |
|----------------|------------------------|
| (a). Morbidity | (d). Credit Quality    |
| (b). Mortality | (e). Reinvestment      |
| (c). Lapse     | (f). Disintermediation |

	a	b	c	d	e	f
Disability Insurance, other than long-term care or long-term disability insurance	+	0	+	0	0	0
Long-term care or long-term disability insurance	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-par Permanent Life	0	+	+	+	+	+
Traditional Non-par Term Life	0	+	+	0	0	0
Traditional Par Permanent Life	0	+	+	+	+	+
Traditional Par Term Life	0	+	+	0	0	0
Adjustable Premium Permanent Life	0	+	+	+	+	+
Indeterminate Premium Permanent Life	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium, with dump-in premiums allowed	0	+	+	+	+	+

+ - Significant

0 - Insignificant

**Historical Note**

Adopted effective December 7, 1995 (Supp. 95-4). Corrected misspelled word “adjustable” as submitted in final rule (Supp. 98-3).

**R20-6-308. Expired**

expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

**Historical Note**

Adopted effective March 22, 1993 (Supp. 93-1). R20-6-308 recodified from R4-14-308 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 22 A.A.R. 3374, effective May 31, 2016 (Supp. 16-4).

**R20-6-309. Expired**

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section

**R20-6-309.01. Expired**

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

**R20-6-309.02. Expired**

**Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section

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expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

**R20-6-309.03. Expired****Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

**R20-6-309.04. Expired****Historical Note**

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

**R20-6-310. Corporate Governance**

The purpose of Sections R20-6-310.01 through R20-6-310.03 is to set forth procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD) deemed necessary by the Director to carry out the provisions of Title 20, Chapter 2, Article 16 on Corporate Governance.

**Historical Note**

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

**R20-6-310.01. Definitions**

The definitions in A.R.S. § 20-492 and this Section apply to Sections R20-6-310.02 through R20-6-310.04.

“CGAD” means Corporate Governance Annual Disclosure.

“NAIC” means National Association of Insurance Commissioners.

“Senior Management” means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer (“CEO”), Chief Financial Officer (“CFO”), Chief Operations Officer (“COO”), Chief Procurement Officer (“CPO”), Chief Legal Officer (“CLO”), Chief Information Officer (“CIO”), Chief Technology Officer (“CTO”), Chief Revenue Officer (“CRO”), Chief Visionary Officer (“CVO”), or any other “C” level executive.

**Historical Note**

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

**R20-6-310.02. Filing Procedures**

- A. Deadline to file. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by A.A.C. Title 20, Chapter 2, Article 16 shall, no later than June 1 of each calendar year, submit to the Director a CGAD that contains the information described in Section R20-6-310.03.
- B. Attestation. The CGAD must include a signature of the insurer’s or insurance group’s CEO or corporate secretary attesting to the best of that person’s belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that the copy of the CGAD has been provided to the insurer’s or insurance group’s Board of Directors or appropriate committee of the Board of Directors.

- C. Format of the CGAD. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Director to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.
- D. Insurer or insurance group to determine level of reporting.
  1. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending on how the insurer or insurance group has structured its system of corporate governance.
  2. The insurer or insurance group is encouraged to make the CGAD disclosures at:
    - a. The level at which the insurer’s or insurance group’s risk appetite is determined,
    - b. The level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or
    - c. The level at which legal liability for failure of general corporate governance duties would be placed.
  3. If the insurer or insurance group determines the level of reporting based on the criteria in subsection (D)(2), it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.
- E. CGAD completed at the insurance group level. Notwithstanding subsection (A) and as outlined in A.R.S. § 20-492.01, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the NAIC’s Financial Analysis Handbook 2018 Annual/2019 Quarterly, pp. 771 through 774, and no future editions. In these instances, a copy of the CGAD must also be provided, upon request, to the chief regulatory official of any state in which the insurance group has a domestic insurer.
- F. Reference to other existing documents. An insurer or insurance group may comply with this Section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in R20-6-310.03. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the Director.
- G. Subsequent filings of the CGAD. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made to the previously filed CGAD. The filing shall also state if no changes are made to the information or activities previously reported by the insurer or insurance group.

**Historical Note**

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

**R20-6-310.03. Contents of CGAD**



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- A. Inclusion of attachments. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.
- B. Board. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:
  1. The Board and its various committees ultimately responsible for overseeing the insurer or insurance group and the level or levels at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and
  2. The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of the Chief Executive Officer (CEO) and Chairman of the Board within the organization.
- C. Senior Governing Entity. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and its significant committees, including a discussion of the following factors:
  1. How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.
  2. How an appropriate amount of independence is maintained on the Board and its significant committees.
  3. The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.
  4. How the insurer or insurance group identifies, nominates and elects members of the Board and its committees. The discussion should include, for example:
    - a. Whether a nomination committee is in place to identify and select individuals for consideration.
    - b. Whether term limits are placed on directors.
    - c. How the election and re-election processes function.
    - d. Whether a Board diversity policy is in place and if so, how it functions.
  5. The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).
- D. Senior Management. The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:
  1. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:
    - a. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.
    - b. Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.
  2. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:
    - a. Compliance with laws, rules, and regulations; and
    - b. Proactive reporting of any illegal or unethical behavior.
  3. The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Director to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk-taking. Elements to be discussed may include, for example:
    - a. The Board's role in overseeing management compensation programs and practices.
    - b. The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;
    - c. How compensation programs are related to both company and individual performance over time;
    - d. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;
    - e. Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;
    - f. Any other factors relevant to understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.
  4. The insurer's or insurance group's plans for CEO and Senior Management succession.
- E. Oversight. The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:
  1. How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;
  2. How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps the Senior Management is taking to monitor and manage those risks;
  3. How reporting responsibilities are organized for each critical risk area. The description should allow the Director to understand the frequency at which information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer:
    - a. Risk management processes (an ORSA Summary Report filer may refer to its ORSA Summary Report submitted pursuant to A.R.S. § 20-491.03);
    - b. Actuarial function;
    - c. Investment decision-making processes;

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- d. Reinsurance decision-making processes;
- e. Business strategy/finance decision-making processes;
- f. Compliance function;
- g. Financial reporting/internal auditing; and
- h. Market conduct decision-making processes.

**Historical Note**

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

**R20-6-310.04. Severability Clause**

If any provision of this Section, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of this Section which can be given effect without the invalid provision or application, and to that end the provisions of this Section are severable.

**Historical Note**

New Section made by final exempt rulemaking at 25 A.A.R. 3715, with an immediate effective date of December 4, 2019 (Supp. 19-4).

**Appendix A. Expired****Table 1. Expired****Table 2. Expired****Table 3. Expired****Table 4. Expired****Table 5. Expired****Table 6. Expired****Historical Note**

Appendix A adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Appendix A (including Tables 1 through 6) expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

**ARTICLE 4. TYPES OF INSURANCE COMPANIES****R20-6-401. Proxies, Consents, and Authorizations of Domestic Stock Insurers**

- A. The Department incorporates by reference National Association of Insurance Commissioners Model Laws, Regulations and Guidelines, Volume III, pp. 490-1 through 490-33, Regulation Regarding Proxies, Consents, and Authorization of Domestic Stock Insurers, April 1995 (and no future editions or amendments), which is on file with and available from the Department of Insurance, 100 N. 15th Ave., Suite 261, Phoenix, AZ 85007-2630, the Department's website: <https://difi.az.gov/insurance-division-rulemaking>, and the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197, modified as follows:

Section 1 A is modified to read: "No domestic stock insurer that has any class of equity securities held of record by 100 or more persons, or any director, officer or employee of that insurer, or any other person, shall solicit, or permit the use of the person's name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect to any class of equity securities in contravention of this regulation and Schedules A and B, hereby made a part of this regulation.

- B. Domestic stock insurance companies shall comply with this Section as required under A.R.S. § 20-143(B).

**Historical Note**

Former General Rule 57-3. R20-6-401 recodified from R4-14-401 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3). New Section made by final rulemaking at 9 A.A.R. 1086, effective March 6, 2003 (Supp. 03-1). Section amended by final expedited rulemaking with an immediate effective date of September 16, 2019 (Supp. 19-3). Section amended by final rulemaking at 29 A.A.R. 3615 (November 24, 2023), effective January 7, 2024 (Supp. 23-4).

**R20-6-402. Expired****Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**Exhibit A. Expired****Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**Exhibit B. Expired****Historical Note**

Former General Rule 69-19. R20-6-402 recodified from R4-14-402 (Supp. 95-1). Exhibit expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**R20-6-403. Expired****Historical Note**

Former General Rule 69-21. R20-6-403 recodified from R4-14-403 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**Appendix A. Expired****Historical Note**

R20-6-403, Appendix A recodified from R4-14-403, Appendix A (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**Appendix B. Expired****Historical Note**

R20-6-403, Appendix B recodified from R4-14-403, Appendix B (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**Appendix C. Expired****Historical Note**

R20-6-403, Appendix C recodified from R4-14-403, Appendix C (Supp. 95-1). Appendix expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**R20-6-404. Repealed**

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**Historical Note**

Former General Rule 73-31; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-404 recodified from R4-14-404 (Supp. 95-1).

**R20-6-405. Health Care Services Organization****A. Scope**

1. The scope of this Section is the scope of A.R.S. Title 20 as it relates to Insurers or Hospital or Medical Service Corporations. As it relates to Health Care Services Organizations, the scope of this Section is the scope of Title 20, Chapter 1 and Title 20, Chapter 4, Article 9, as provided in A.R.S. § 20-1068. This Section is applicable to agents of persons, and persons operating or proposing to operate Health Care Services Organizations in the State of Arizona.
2. The statutory authority for this Section, A.R.S. Title 20, Chapter 4, Article 9, does not provide for exemptions for persons or agents of persons subject to A.R.S. Title 20, Chapter 4, Article 9, and no such exemption is intended or should be presumed by this Section or any provision of this Section.

**B.** Repeal. This Section does not repeal any known prior Section, memorandum, bulletin, directive or opinion on this subject matter. If such prior Section or directive exists and is in conflict with this Section, it is repealed by this Section.

**C.** Definitions. In addition to the definitions provided in A.R.S. § 20-1051, the following definitions apply to this Section unless the context otherwise requires:

1. "Agent" has the same meaning as "insurance producer" found at A.R.S. § 20-281(5).
2. "Certificate of Authority" has the meaning found at A.R.S. § 20-217.
3. "Director" has the meaning found at A.R.S. § 20-102.
4. "Hospital Service Corporation" has the meaning found at A.R.S. § 20-822.
5. "Insurer" has the meaning found at A.R.S. § 20-104.
6. "License" means the authority to act as an agent of a Health Care Services Organization.
7. "Medical Service Corporation" has the meaning found at A.R.S. § 20-822.
8. "Net charges" means the total of all sums prepaid by or for all enrollees, less approved refunds, adjustments and deductions, as consideration for Health Care Services of a Health Care Plan under an Evidence of Coverage.
9. "Physician and patient relationship" has the meaning found at A.R.S. § 20-833.
10. "Prepaid Group Practice Plan" means a person authorized and approved under A.R.S. Title 20.
11. "Prepaid Health Plan" means any Health Care Plan to pay or make reimbursement for Health Care Services on a prepaid basis other than insured plans otherwise authorized and approved under A.R.S. Title 20.
12. "Transact" has the meaning found at A.R.S. § 20-106(A) and (B).
13. "Unqualified agent" means a person directly or indirectly representing or acting for a Health Care Services Organization and not qualified as an agent thereof.

**D. Certificate of Authority – Application**

1. Pursuant to the authority of A.R.S. § 20-1053(A)(13), the Director finds that biographical information disclosing the past activities, employment and financial transactions of principals, principal officers, controlling persons, and agents of applicant Health Care Services Organizations is necessary for the protection of residents of this State.

2. Pursuant to the authority of A.R.S. § 20-1053(A)(13), the Director finds that records of fingerprints of principal officers and agents of applicant Health Care Services Organizations may be necessary for the protection of citizens of this state and may be required prior to licensing or approval of a Certificate of Authority.

**E. Certificate of Authority – Grounds for denial**

1. Policy. A Certificate of Authority to operate a Health Care Services Organization shall not be granted until the Director is satisfied by the affirmative showing, verified by the applicant, that all of the requirements of A.R.S. §§ 20-1051, 20-1052, 20-1052.01, 20-1053 and 20-1054 are met and will continue to be met.
2. Guidelines. The guidelines and standards for determination of appropriate mechanisms to achieve an effective Health Care Plan include, but are not limited to the following:
  - a. Ability to provide basic Health Care Services without undue restrictions, limitations, discrimination, unreasonable fee schedules, or unreasonable administrative costs; an affirmative showing that the form of organization does not evidence any coercion, duress or other compulsion over members;
  - b. The form of organization does not lend itself to practices prohibited by A.R.S. §§ 20-441 through 20-459, and
  - c. The evidence of coverage does not contain provisions or statements which are unjust, inequitable, misleading, deceptive or untrue or encourage misrepresentation.
3. Failure to pay obligations. Applications for a Certificate of Authority to operate a Health Care Services Organization may be denied or rejected if the applicant has failed after 30 days from the entry of final judgment, to pay obligations within the provisions of an evidence of coverage issued by such applicant. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an action or appealing a judgment at law or equity in a court of this state, or is required to obtain a Certificate of Authority so as to maintain such action.

**F. Solicitation requirements**

1. Forms for evidences of coverage, advertising matter, sales material and amendments thereto will not be approved until the Director is satisfied all applicable statutory requirements have been met and will continue to be met, and the necessary fees have been paid.
2. Each Health Care Services Organization shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement brochure, form letter of solicitation, evidence of coverage, certificate, agreement or contract, and a copy of all radio and television forms of the above hereafter disseminated in this or any other state with a notation attached to each such solicitation or inducement to indicate the manner and extent of distribution and the date of approval by the Department of such solicitation. Such advertising file shall be maintained for a period of not less than three years.

**G. Taxes**

1. All Health Care Services Organizations operating and transacting business in the State of Arizona shall on or before March 1 and with the filing of the Annual Report,

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file a tax return and pay the tax due on the filed return pursuant to A.R.S. § 20-1060.

2. Annual tax returns required to be filed coincident with the annual report shall be for the full calendar year next preceding the date of filing the annual report.
3. Net charges, as in this Section defined, shall represent the net charges received during the calendar year next preceding the date of filing the annual report and tax return.

**H. Deposit requirements**

1. In the event a Health Care Services Organization determines to maintain statutory deposits by a surety bond, such surety bond shall be on a form as approved by the Director guaranteeing the payment of Health Care Services furnished to enrollees, and shall be deposited with the State Treasurer.
2. Provider sponsored Health Care Services Organizations claiming to be exempt from the deposit requirement, pursuant to A.R.S. § 20-1055(F), shall submit to the Director an affirmative showing or certification executed by an authorized federal, state or municipal government or political subdivision thereof, demonstrating operational commitments equivalent to the statutory deposit requirements.
3. Statutory deposits shall not be withdrawn or a surety bond cancelled until all contingent and perfected liens, including judgments, debts, and other liabilities for payment of Health Care Services to which the enrollee is entitled under the evidence of coverage, shall have been paid and the Director authorizes, in writing, to withdraw such deposits or cancel such bonds. Equal par value statutory deposit exchanges may be completed without the Director's prior approval.

**I. Insurers and hospital and medical service corporations – Certificate of Authority**

1. Insurers, Hospital Service Corporation, Medical Service Corporations, and Hospital and Medical Service Corporations, holding current Certificates of Authority to do business in this state may organize and operate Health Care Services Organizations jointly or severally without compliance with the deposit and reserve requirements of the statute if the application contains an affirmative showing that the applicant organization has complied with comparable provisions of Title 20, and is an appropriate mechanism to achieve an effective Health Care Plan.
2. The provisions of statute and this Section applying to Certificates of Authority and Application therefor, shall apply to all insurers, Hospital Service Corporations, Medical Service Corporations, and Hospital and Medical Service Corporations doing business in this state.
3. Organizations claiming exemption or partial exemption pursuant to A.R.S. § 20-1063(C) shall file with the Director simultaneously with the application for Certificate of Authority, a statement affirmatively showing that the applicant has complied with provisions of Title 20 A.R.S. comparable to or more restrictive than the provisions of Title 20, Chapter 4, Article 9, and shall have received the written approval of the Director for such exemption or partial exemption.

**J. Application, examination and licensing of agents. No agent of a Health Care Services Organization shall be eligible for transactions of a Health Care Services Organization unless, prior to making any solicitation or transaction, the agent has been appointed by a Health Care Services Organization holding a current valid Certificate of Authority and is licensed as an**

insurance producer. The Health Care Services Organization is not required to report its appointments to the Department. An agent directly or indirectly representing or acting for a Health Care Services Organization and not licensed or otherwise qualified under A.R.S. Title 20, shall be an unqualified agent.

**K. Forms**

1. The forms prescribed by this Section and their instructions are adopted as requirements of the Director and necessary for the protection of citizens of this state. Such forms, instructions, manuals or examinations are those currently in use, but the same may be amended and approved without reference to this Section. The form of manual or examination of agents, or any form adopted by the Director may be reproduced for the purpose of reporting or for other purposes.
2. For good cause shown, the Director may authorize the filing of forms and reports on dates other than required by this Section, if applied for in writing not less than 10 days prior to the due date of the report and statement, exhibit, return or accounting.

**L. Severability. In any provision of this Section or the forms, statements, returns or reports made part of this Section, or the application to any person or circumstance is held invalid, such invalidity shall not affect the provisions of applications of this Section, which can be given effect without the invalid provision or application, and to this end the provisions of this Section are declared to be severable.****Historical Note**

Former General Rule 73-33; Amended subsections (E), (P), (R), (S), and (T) effective August 12, 1981 (Supp. 81-4). R20-6-405 recodified from R4-14-405 (Supp. 95-1). Section amended by final rulemaking at 29 A.A.R. 3615 (November 24, 2023), effective January 7, 2024 (Supp. 23-4).

**R20-6-406. Expired****Historical Note**

Adopted effective May 18, 1978 (Supp. 78-3). R20-6-406 recodified from R4-14-406 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E), filed in the Office of the Secretary of State August 24, 2000 (Supp. 00-3).

**R20-6-407. Service Companies**

- A. Scope.** This rule shall apply to all service companies except those that are exempt under A.R.S. § 20-1095.02.
- B. Definitions.** The definitions in A.R.S. § 20-1095 apply to this rule.
  1. "Contract Holder" has the same meaning as "consumer" as defined in A.R.S. § 20-1095(1).
  2. "Department" means the Arizona Department of Insurance and Financial Institutions, Insurance Division.
  3. "Director" means the Director of the Department.
  4. "Insolvent" as used in A.R.S. § 20-1095.08(3) means total liabilities are equal to or exceed total assets.
  5. "Provider" means a person who is contractually obligated to the service contract holder under the terms of a service contract. "Provider" is synonymous with "service company" and "obligor" as defined in A.R.S. § 20-1095(6).
  6. "Reasonable time" or "Reasonable period of time:"
    - a. As used in A.R.S. § 20-1095.06(C)(2), means at the time of purchase or mailed or electronically delivered but not more than 10 business days after the purchase date of the contract. The service company

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must be able to provide proof of delivery if requested by the Department.

- b. As used in A.R.S. § 20-1095.09(A)(4), is what an ordinary person would consider “reasonable” under the totality of the circumstances.

7. “Solvent” as used in A.R.S. § 20-1095.03(A)(1) means total assets exceed total liabilities.

8. “Subcontractor” means a person or business having a contractual relationship with a service company to provide work or services which a service company has agreed to perform under a service contract. If required by the type of work being performed, all subcontractors must be licensed.

C. Application for a service company permit.

1. Application form. The application for a service company permit shall be on a form designated by the Department and shall be transmitted through an electronic online system if such a system is designated on the Department’s web site. An application must be complete and have all attachments to be considered by the Department.

2. Application. The application shall contain the following information:

- a. Applicant’s full legal name;
- b. Applicant’s federal employer identification number (EIN);
- c. Applicant’s trade name or names, if applicable;
- d. Applicant’s state of domicile;
- e. Applicant’s form of business entity (corporation, limited liability company, etc.);
- f. Applicant’s addresses, phone numbers, e-mail address or addresses and website or addresses;
- g. Name, address, and phone number or e-mail address for each contact person of the applicant;
- h. A list of the applicant’s officers, directors, LLC managers, and persons owning 25% or more of the service company, and for each officer, director, manager, or person owning 25% or more of an entity that owns the service company;
- i. If the applicant intends to use a service contract administrator, the name and contact information for the applicant’s service contract administrator;
- j. The applicant’s fiscal year end date;
- k. A summary of the applicant’s financial position including current assets, current liabilities, equity and income;
- l. The name and signature of an officer of the applicant; and
- m. Any other information the Department deems necessary to aid in the approval of the application.

3. Application attachments. The applicant shall include the following as part of the application:

- a. A copy of the service company’s most recent financial statement sworn to and certified by the owner, duly elected officer or a certified public accountant.
- b. Evidence of compliance with the financial security requirements of A.R.S. § 20-1095.03(A)(3).
- c. A biographical affidavit, on a form approved by the Department, for each officer, director, LLC manager, or person owning 25% or more of the service company, and for each officer, director, manager, or person owning 25% or more of an entity that owns the service company.

- d. A list of any actions taken against the applicant in any jurisdiction by a regulatory agency or state attorney general.

4. Application fee. At the time of filing the application, the applicant shall pay the nonrefundable application fee prescribed by A.R.S. § 20-167 and fixed by the Department.

D. Term of the service company permit.

1. Term of permit. A service company permit shall have a term that begins on the date that the Department either grants or renews a service company permit and expires at midnight on the last day of the month, three months after the service company’s fiscal year-end date.

2. The Department is not required to issue a paper copy of the service company permit. However, the Department will make a copy of the service company permit available by electronic or other means.

3. Expiration of a service company permit.

- a. Unless the Department receives an application and full payment of fees for renewal prior to the end of the service company permit term, the service company permit expires.
- b. A service company whose permit term has expired shall not offer, extend, or renew a service contract.
- c. A service company whose permit has expired shall continue to fulfill the obligations of its in-force contracts and shall maintain the security required under A.R.S. § 20-1095.03(3) until such time that all of the service company’s contractual obligations to contract holders are fulfilled.

E. Service company permit renewal and late-renewal.

1. Timely renewal. A service company seeking to renew its permit shall file with the Department a renewal application, consisting of the renewal application form, all required attachments and the renewal fee after the end of its fiscal year but before the expiration of its permit term. A service company shall transmit the renewal application through an electronic online system if such a system is designated on the Department’s website. A renewal application must be complete, have all required attachments and the renewal fee to be considered as having been received by the Department.

2. Renewal form. A service company shall use the renewal form designated by the Department. The renewal shall contain the following information:

- a. Service company name appearing on the permit, and the service company’s Arizona license number and EIN;
- b. Any additions or deletions to the service company’s trade name or trade names, addresses, phone numbers and website addresses;
- c. Any changes to the service company’s contact person or persons or service contract administrator, or their contact information;
- d. A summary of the applicant’s financial position including current assets, current liabilities, equity and income; and
- e. Any other information the Department deems necessary to aid in the renewal of the permit.

3. Renewal attachments. The service company shall attach the following to the renewal:

- a. A copy of the service company’s financial statement as of the end of the service company’s most recently completed fiscal year, sworn to and certified by the

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- owner, duly elected officer or a certified public accountant.
- b. Evidence of continuing compliance with the financial security requirements of A.R.S. § 20-1095.03(A)(3).
  - c. Any additions or deletions to the officers, directors, LLC managers, or persons owning 25% or more of the service company, or to an entity that owns the service company since the last report to the Department.
  - d. A biographical affidavit, on a form approved by the Department, for each new person identified in subsection (3)(c).
  - e. Any actions taken against the service company in any jurisdiction by a regulatory agency or state attorney general not previously reported to the Department.
4. Renewal fee. At the time of filing the renewal, the service company shall pay a nonrefundable renewal fee as prescribed by A.R.S. § 20-167 and fixed by the Department.
  5. Late-renewed application and fee.
    - a. Late-renewal period. A service company whose permit term has expired may file a renewal application up to ninety days after the expiration of the permit term. After the ninety-day period, a renewal application will not be accepted by the Department and the service company must file a service company permit application with the Department pursuant to subsection (C) of this Section.
    - b. A service company whose permit term has expired shall not offer, extend, or renew a service contract until the permit is renewed or a new permit is issued by the Department.
    - c. Fee. In addition to the nonrefundable renewal fee required under subsection (E)(4) of this Section, the service company shall pay a nonrefundable additional fee of \$25 per day starting the calendar day after the permit term expiration and ending on the date the service company files a complete renewal application.
    - d. Term of a late-renewed permit. The term of a late-renewed permit shall begin on the date the Department renews the permit and shall end on the last day of the permit term.
- F. Deposits of cash or alternatives to cash.**
1. Contracts issued, renewed, or extended on or after August 3, 2018. For any contract that a service company issues, extends, or renews from and after August 3, 2018, a service company may not satisfy the financial responsibility requirements of A.R.S. § 20-1095.04 by means of providing a deposit of cash or alternatives to cash.
  2. Contracts issued, renewed, or extended before August 3, 2018. If a service company provided a deposit of cash or alternatives to cash covering service contracts that were issued, last extended, or last renewed prior to August 3, 2018, the service company shall maintain the deposit in the amount required to cover those contracts and the deposit shall not be encumbered.
  3. Release of deposits of cash or alternatives to cash. As it relates to financial responsibility requirements fulfilled by a deposit of cash or alternatives to cash, the Director shall only release the deposit upon one of the following:
    - a. The service company provides a surety bond or mechanical reimbursement policy that covers the outstanding service contract liabilities secured by the cash or alternatives to cash.
- b. The Department has approved the assumption of outstanding service contracts and liabilities by another service company that has acknowledged the assumption of the outstanding contracts and that shall provide each affected contract holder an endorsement issued by the mechanical reimbursement insurer or surety.
  - c. The service company provides evidence satisfactory to the Department that:
    - i. The outstanding service contracts and liabilities have expired or have been cancelled in accordance with the service contract terms;
    - ii. All claims under the service contracts have been settled; and
    - iii. The service company is financially able and agrees to be financially responsible for any valid unreported claims.
- G. Filing of forms.**
1. Contracts to be submitted for approval. A service company shall submit contracts for the Department's approval pursuant to A.R.S. § 20-1095.06. A service company is not required to submit advertisements or marketing materials for approval by the Department but shall abide by the provisions of Title 20, Chapter 2 - Article 6, Chapter 4 - Article 11, and this Section regarding misrepresentations in the sales of service contracts.
  2. Requirements for approval. No service contract form shall be approved unless it:
    - a. Complies with A.R.S. § 20-1095.06;
    - b. Identifies the covered products under the contract and, in bold-faced type, preferably in a larger font, the specific items or components of those products which are excluded;
    - c. States the service fee or deductible charge, if any, to be charged, or applied, for service calls and/or each covered repair;
    - d. Specifies in clear and easily understood language the specific circumstances under which a contract holder may engage a subcontractor who is not recommended by the service company without becoming financially responsible under the contract and whether pre-authorization is required prior to engaging a subcontractor who is not recommended by the service company;
    - e. Specifies in clear and easily understood language the service company's financial responsibilities to the contract holder when any of the systems, products or appliances covered by the contract cannot be replaced or repaired;
    - f. If applicable, states the conditions under which the service contract or coverage may be reinstated;
    - g. States the dates of coverage under the service contract including any delay in coverage that differs from the purchase date of the contract which would extend the coverage term of the contract and any terms that govern renewal of the service contract; and
    - h. If providing a pro rata refund upon cancellation of the service contract before the end of the coverage period of the service contract, the service contract shall contain language in conformance with A.R.S. § 20-1095.06(D)(9).

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3. Disapproval of contracts. The Department may disapprove any service contract that is in violation of Title 20, Chapter 4 - Article 11, or this subsection (G). The service company may request a hearing to appeal the disapproval pursuant to A.R.S. § 20-161.

**Historical Note**

Adopted effective April 30, 1981 (Supp. 81-2). Former Section R4-14-407 repealed and a new Section R4-14-407 adopted effective July 2, 1987 (Supp. 87-3). R20-6-407 recodified from R4-14-407 (Supp. 95-1). Section amended by final rulemaking at 28 A.A.R. 3968 (December 30, 2022), effective February 6, 2023 (Supp. 22-4).

**R20-6-408. Expired****Historical Note**

Former Section R4-14-408 renumbered as Section R4-14-409; a new Section R4-14-408 adopted effective July 15, 1987 (Supp. 87-3). R20-6-408 recodified from R4-14-408 (Supp. 95-1). Section expired under A.R.S. § 41-1056(J) at 24 A.A.R. 3106, effective October 9, 2018 (Supp. 18-4).

**R20-6-409. Hospital, Medical, Dental, and Optometric Service Corporations**

- A.** Applicability. This rule applies to all subscription contracts issued by hospital, medical, dental and optometric service corporations.
- B.** Subscription contract provision. Subscription contracts of hospital, medical, dental and optometric service corporations subject to the provisions of Article 3, Chapter 4 of Title 20, A.R.S., shall meet the requirements of the following Sections:
1. R20-6-201. Advertisements of Health,
  2. R20-6-207. Gender Discrimination,
  3. R20-6-208. Group Coverage Discontinuance and Replacement,
  4. R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness,
  5. R20-6-213. Life and Disability Insurance Policy Language Simplification, and
  6. R20-6-607. Reasonableness of Benefits in Relation to Premium Charged.

**Historical Note**

Adopted effective July 9, 1982 (Supp. 82-4). Former Section R4-14-408 renumbered without change as Section R4-14-409 effective July 15, 1987 (Supp. 87-3). R20-6-409 recodified from R4-14-409 (Supp. 95-1). Section amended by final rulemaking at 29 A.A.R. 3615 (November 24, 2023), effective January 7, 2024 (Supp. 23-4).

**ARTICLE 5. THE INSURANCE CONTRACT****R20-6-501. Ten-day Period to Examine Disability Insurance Policy**

For the purpose of implementing A.R.S. §§ 20-442, 20-443, 20-826, 20-1111 and 20-1113 and to make more specific the regulation therein provided relative to policies of individual disability insurance (accident and sickness, hospitalization, medical, surgical and loss of time) issued in the State of Arizona and further to provide satisfactory public remedy against the hazards of misunderstanding by an applicant, of deception and coercion by an agent and of certain policy exclusions and limitations that cheapen the value of coverage, the Insurance Department of Arizona adopts the following rule:

1. Each policy of individual disability insurance, except one for which no provision for renewal is made, issued for delivery in the State of Arizona on or after October 1, 1961, by an insurance company or by a hospital or medical service corporation shall have printed on the first page thereof or attached thereto or endorsed thereupon in prominent style a notice declaring that, during a period of 10 days (or, at the insurer's option, a longer period) from the date of delivery to the policyholder, such policy may be returned for cancellation to the insurer at its home office (or, at the insurer's option, to its branch office or to the agent through whom it was purchased) and declaring further that in the event of such return the insurer will refund the entirety of any premium paid therefor, including any policy fees or other charges, and that the policy shall be deemed void from the beginning and that the parties shall be returned to their original position as if no policy had been issued.
2. The Insurance Department does not specify the particular language the notice shall contain but prefers usage of a phraseology approximately along the lines of either the longer (Form A) or shorter (Form B) sample below:

**Sample Form A****NOTICE OF TEN-DAY RIGHT TO EXAMINE POLICY**

The \_\_\_\_\_ Insurance Company urges you to read this policy carefully and trusts that upon doing so you will fully understand, and will be pleased with, its coverage. If, however, questions arise or information is desired, do not hesitate to consult the selling agent. In addition, should the policy for any reason be unsatisfactory, by surrendering it within ten days following receipt to our office at \_\_\_\_\_ or to the selling agent, immediately full premium will be refunded and the policy will be cancelled and deemed void and as never in force and effect.

**Sample Form B****IMPORTANT NOTICE**

If for any reason this policy is unsatisfactory, it may be returned for cancellation within ten days following receipt – in which case the entire premium will be refunded.

(Insurer's name and address)

**Historical Note**

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Former General Rule 61-7. R20-6-501 recodified from R4-14-501 (Supp. 95-1).

**ARTICLE 6. TYPES OF INSURANCE CONTRACTS****R20-6-601. Regulations Governing Bail Transactions****A. General provisions**

1. Effective date
  - a. These regulations are effective November 1, 1960. On and after date, no bail transaction or severable portion thereof shall be conducted, directly or indirectly except in full conformity herewith.
  - b. No surety insurer shall furnish for use and no bail bond agent shall use any forms or documents which contain any provisions contrary to these regulations on or after the effective date hereof.
2. Authority. Authority for these regulations is A.R.S. §§ 20-142, 20-143 and 20-257 and A.R.S. Chapter 2, Article 3.
3. Public interest served. These regulations serve the public interest by prohibiting inequities in bail transactions and by establishing standards of licensing and conduct for bail bond agents.
4. Regulations as severable. These regulations shall be construed as severable, such that, where one or more Sections are held invalid, such remaining Sections will not be adversely affected.
5. Penalty. Violation of these regulations will subject the guilty party to the penalties of A.R.S. §§ 20-114, 20-220 and 20-316 and to the enforcement procedures of A.R.S. §§ 20-152 and 20-160 through 20-166.

**B. Definitions**

1. "Bail transaction" defined. As used in these regulations, the term "bail transaction" includes solicitation and inducement, preliminary negotiation and effectuation of a contract of surety insurance and the transaction of matters subsequent thereto and arising therefrom – all in connection with the release of persons arrested or confined.
2. "Bail bond agent" defined. As used in these regulations, the term "bail bond agent" means any person who engages in a bail transaction on behalf of a surety insurer or representative thereof.
3. "Arrestee" defined. As used in these regulations, the term "arrestee" means any person arrested or detained whose release on bail is solicited or procured or concerning whose release negotiations are commenced.
4. "Director" defined. As used in these regulations, the term "Director" means the Director of Insurance of the state.

**C. Licensing**

1. Application for license. Each application for original or renewal license as a bail bond agent shall be on a form furnished by the Director, and each applicant for such license shall furnish such supplementary information and supporting statements as the Director may require.
2. Prohibited associations. A bail bond license shall not be issued to, renewed for or maintained by any person who associates regularly with criminals, gamblers or persons of poor repute – except to the extent such association is required by business or professional duty and responsibility.
3. Transactions by unlicensed persons prohibited. No bail bond agent shall directly or indirectly permit any person on his behalf to solicit or negotiate bail transactions unless such person is duly licensed by the Director.

4. Employees. Employees of bail bond agents performing only clerical duties need not be licensed hereunder and shall be deemed not engaged in bail transactions.

**D. Conduct of bail bond agents**

1. Disclosure of business. Every bail bond agent shall conduct his business in such a manner that the public and those dealing with him shall be aware of the capacity in which he is acting.
2. Control of employees. A bail bond agent shall exercise direct supervision over his employees and keep informed of their actions as his employees.
3. Prohibited employees. No bail bond agent shall have in his employ at any time any criminal, gambler or person of poor repute.
4. Acting for attorney. No bail bond agent shall receive, or collect for an attorney any money or other item of value for attorney's fee, costs or any other purpose on behalf of an arrestee, unless a receipt is given therefor.
5. Informants prohibited. No bail bond agent shall for any purpose, directly or indirectly, enter into an arrangement of any kind or have an understanding with a law enforcement officer, with a newspaper employee, with a messenger service or employee thereof, with a trusty in a jail, with other person incarcerated in a jail, or with any person whatever, to inform or notify any bail bond agent directly or indirectly of:
  - a. The existence of a criminal complaint;
  - b. The fact of an arrest; or
  - c. The fact that an arrest of any person is pending or contemplated; or
  - d. Any information pertaining to matters set forth in (a), (b), and (c) hereof or to the persons involved therewith.
6. Compliance with rules of public authority. No bail bond agent shall solicit any person in a bail transaction in a prison or jail or other place of detention, court or public institution connected with the administration of justice unless said bail bond agent has fully complied with every rule, regulation and ordinance issued by each public authority governing the conduct of persons in or about said premises.
7. Representations to public authority
  - a. No bail bond agent shall make any misleading or untrue representation to a court or to a public official with respect to a bail transaction, nor for the purpose of avoiding or preventing a forfeiture of bail or of having set aside a forfeiture which has occurred.
  - b. Every bail bond agent shall truthfully and fully answer every question asked him by the Director or his representative respecting his bail transactions and matters relating to the conduct of his bail business. Any bail bond agent may have his attorney present when he answers any such question.
8. Maintenance of records. Every bail bond agent shall keep complete records of all business done under authority of his license. Such records shall be open to inspection or examination by the Director or his representatives at all reasonable times at the principal place of business of the bail bond agent as designated in his license.

**E. Charges, collateral, refunds and rebates**

1. Rates
  - a. No bail bond agent shall issue or deliver a bail bond except at the premium rates most recently filed and



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- approved by the Director in accordance with A.R.S. § 20-357.
- b. Every bail bond agent shall post the premium rates of the surety insurer he represents in a conspicuous manner at his place of business.
  2. Charges permitted. No bail bond agent shall, in any bail transaction or in connection therewith, directly or indirectly, charge or collect money or other valuable consideration from any person except for the following purposes:
    - a. To pay the premium at the rates established by the surety insurer and approved by the Director.
    - b. To provide collateral.
    - c. To reimburse himself for actual and reasonable expenses incurred in connection with the individual bail transaction, including:
      - i. Guard fees after the first 12 hours following release of an arrestee on bail;
      - ii. Notary fees, recording fees, necessary long distance telephone expenses, telegram charges, and travel expenses for other than local community travel.
      - iii. Any other actual expenditure necessary to the bail transaction which is not usually and customarily incurred in connection with the ordinary operation and conduct of bail transactions.
  3. Delivery of documents to arrestee
    - a. Every bail bond agent shall, at the time of obtaining the release of an arrestee on bail or immediately thereafter, deliver to such arrestee or to the principal person with whom negotiations were made, if other than the arrestee, a copy of the bail bond premium agreement, which shall include:
      - i. The name of the surety insurer and the name and business address of the bail bond agent.
      - ii. The amount of bail and the premium thereof.
    - b. The bail bond agent shall also deliver at such time a statement detailing all charges in addition to the premium, the amount received on account, the unpaid balance if any, and a description of and a receipt for any collateral received.
  4. Collateral
    - a. Any bail bond agent who receives collateral in connection with a bail transaction shall do so in a fiduciary capacity and, prior to any forfeiture of bail, shall keep such collateral separate and apart from any other funds, assets or property of such bail bond agent.
    - b. Any collateral received shall be returned to the person who deposited it with the bail bond agent or any assignee as soon as the obligation, the satisfaction of which was secured by the collateral, is discharged. Where such collateral has been deposited to secure the obligation of a bond, it shall be returned immediately upon the entry of any order by an authorized official by virtue of which liability under the bond is terminated, or, if any bail bond agent fails to cooperate fully with any authorized official to secure the termination of such liability, immediately upon the accrual of any right to secure an order of termination of liability.
    - c. When such collateral has been deposited as security for unpaid premium or charges and, if such premium or charges remained unpaid at the time of exoneration and after demand therefor has thereafter been made by the bail bond agent, collateral other than cash may be levied upon in the manner provided by law and cash collateral up to the amount of such unpaid premium or charges may be applied in payment thereof.
    - d. If collateral received by a bail bond agent is in excess of the bail forfeited, such excess shall be returned to the depositor immediately upon application of the collateral to the forfeiture subject, however, to any claim of the bail bond agent for unpaid premium or charges as provided in subparagraph (c) of paragraph (4) of subsection (E), or as agreed to in writing by the bail bond agent and arrestee or his indemnitor.
    5. Premium refund upon surrender of arrestee. No bail bond agent shall surrender an arrestee to custody prior to the time specified in the bail bond for the appearance of the arrestee, or prior to any other occasion when the presence of the arrestee in court is lawfully required, without returning all premium paid therefor, unless as a result of judicial action, or material misrepresentation by the arrestee or his indemnitor with respect to the execution of the bail bond agreement, or a material and substantial increase in the hazard assumed. Failure of the arrestee to pay the premium, or charges permitted under these regulations or any part thereof, and failure to furnish collateral required by the bail bond agent, shall not be considered a material and substantial increase in the hazard assumed.
    6. Rebating prohibited. No bail bond agent shall pay or allow in any manner, directly or indirectly, to any person who is not also a bail bond agent any commission or valuable consideration on or in connection with a bail transaction. This Section shall not prohibit payments by a bail bond agent to an unlicensed person of charges by such persons for services of the kind specified in paragraph (2) subsection (E) of this Section.

**Historical Note**

Former General Rule 60-5. R20-6-601 recodified from R4-14-601 (Supp. 95-1).

**R20-6-602. Nationwide Inland Marine Definition**

- A. Applicability. This rule applies to risks and coverages which may be classified or identified as Marine, Inland Marine or Transportation insurance but shall not be construed to mean that the kinds of risks and coverages are solely Marine, Inland Marine or Transportation insurance in all instances. This rule shall not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and license whether used separately, in combination or otherwise.
- B. Marine and/or transportation policies may cover under the following conditions:
  1. Imports.
    - a. Imports may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.
    - b. An import, as a proper subject of marine or transportation insurance, shall be deemed to maintain its character as such so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and

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- shall be deemed to have been completed when such property has been:
- i. Sold and delivered by the importer, factor or consignee; or
  - ii. Removed from place of storage and placed on sale as part of the importer's stock in trade at a point of sale or distribution; or
  - iii. Delivered for manufacture, processing or change in form to premises of the importer or of another for any such purposes.
2. Exports.
    - a. Exports may be covered wherever the property may be located without restriction as to time, provided the coverage of each issuing company includes hazards of transportation.
    - b. An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this rule respecting domestic shipments shall apply, provided, however, that this provision shall not apply to long established methods of insuring certain commodities, e.g., cotton.
  3. Domestic shipments.
    - a. Domestic shipments on consignment, for sale or distribution, exhibit, or trial, or approval or auction, while in transit, while in the custody of others and while being returned, provided the coverage of each issuing company includes hazards of transportation, and further provided that in no event shall the policy cover domestic shipments on consignment on premises owned, leased or operated by the consignor.
    - b. Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, and further provided that such shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by assured or purchaser.
  4. Bridges, tunnels and other instrumentalities of transportation and communication excluding buildings, their improvements and betterments, their furniture and furnishings, fixed contents and supplies held in storage. The foregoing includes:
    - a. Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto.
    - b. Piers, wharves, docks, slips, dry docks and marine railways.
    - c. Pipelines, including on-line propulsion, regulating and other equipment appurtenant to such pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants.
    - d. Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges.
    - e. Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus.
    - f. Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.
  5. Personal Property Floater Risks covering individuals and/or generally
    - a. Personal Effects Floater Policies
    - b. The Personal Property Floater
    - c. Government Service Floater
    - d. Personal Fur Floaters
    - e. Personal Jewelry Floaters
    - f. Wedding Present Floaters for not exceeding 90 days after the date of the wedding.
    - g. Silverware Floaters.
    - h. Fine Arts Floaters, covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit.
    - i. Stamp and Coin Floaters.
    - j. Musical Instrument Floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments.
    - k. Mobile Articles, Machinery and Equipment Floaters, excluding vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use, covering identified property of a mobile or floating nature pertaining to or usual to a household. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.
    - l. Installment Sales and Leased Property Policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract or installment sales contract or leased, but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest.
    - m. Live Animal Floaters.
  6. Commercial Property Floater Risks covering property pertaining to a business, profession or occupation.
    - a. Radium Floaters.
    - b. Physicians' and Surgeons Instrument Floaters. Such policies may include coverage of such furniture, fixtures and tenant assured's interest in such improvements and betterments of buildings as are located in that portion of the premises occupied by the assured in the practice of his profession.
    - c. Pattern and Die Floaters.
    - d. Theatrical Floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes.
    - e. Film Floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records.
    - f. Salesmen's Samples Floaters.
    - g. Exhibition Policies on property while on exhibition and in transit to or from such exhibitions.
    - h. Live Animal Floaters.
    - i. Builders Risks and/or Installation Risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating or repair-

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ing. Such policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.

- i. Such coverage shall be limited to Builders Risks or Installation Risks where Perils in addition to Fire and Extended Coverage are to be insured.
- ii. If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverage shall terminate when the interest of the seller or contractor ceases.
- j. Mobile Articles, Machinery and Equipment Floaters, excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into the custody or control of parties who intend to use such property for the purpose for which it was manufactured or created. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.
- k. Property in transit to and from and in custody of bailees not owned, controlled or operated by the bailor. Such policies shall not cover bailee's property at his premises.
- l. Installment sales and leased property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This Section is not intended to include machinery and equipment under certain "lease-back" contracts.
- m. Garment Contractors Floaters.
- n. Furriers or Fur Storer's Customer's Policies, i.e., policies under which certificates or receipt are issued by furriers or fur storers covering specified articles the property of customers.
- o. Accounts Receivable Policies, Valuable Papers and Records Policies.
- p. Floor Plan Policies, covering property for sale while in possession of dealers under a Floor Plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:
  - i. Such merchandise is specifically identifiable as encumbered to the bank or lending institution.
  - ii. The dealer's right to sell or otherwise dispose of such merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.
  - iii. That such policies cover in transit and do not extend beyond the termination of the dealer's interest.
  - iv. That such policies shall not cover automobiles or motor vehicles; merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.
- q. Sign and Street Clock Policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.
- r. Fine Arts Policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.
- s. Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically, by the owner, under Inland Marine Policies including:
  - i. Musical Instrument Dealers Policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.
  - ii. Camera Dealers Policies, covering property consisting principally of cameras and their accessories.
  - iii. Furrier's Dealers Policies, covering property consisting principally of furs and fur garments.
  - iv. Equipment Dealers Policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural equipment and accessories therefor; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools, and similar equipment and accessories therefor; but excluding motor vehicles designed for highway use.
  - v. Stamp and Coin Dealers covering property of philatelic and numismatic nature.
  - vi. Jewelers' Block Policies.
  - vii. Fine Arts Dealers. Such policies may include coverage of money in locked safes or vaults on the Assured's premises. Such policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insureds interest in improvements of buildings.
  - t. Wool Growers Floaters.
  - u. Domestic Bulk Liquids Policies, covering tanks and domestic bulk liquids stored therein.
  - v. Difference in Conditions Coverage excluding fire and extended coverage perils.
  - w. Electronic Data Processing Policies.
- C. Unless otherwise permitted, nothing in the foregoing shall be construed to permit MARINE OR TRANSPORTATION POLICIES TO COVER:
  - 1. Storage of assured's merchandise, except as hereinbefore provided.
  - 2. Merchandise in course of manufacture, the property of and on the premises of the manufacturer.
  - 3. Furniture and fixtures and improvements and betterments to buildings.
  - 4. Monies and/or securities in safes, vaults, safety deposit vaults, bank or assured's premises, except while in course of transportation.

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**Historical Note**

Former General Rule 59-4; Amended effective August 30, 1985 (Supp. 85-4). R20-6-602 recodified from R4-14-602 (Supp. 95-1).

**R20-6-603. Repealed****Historical Note**

Former General Rule 69-18; Repealed effective July 27, 1981 (Supp. 81-4). R20-6-603 recodified from R4-14-603 (Supp. 95-1).

**R20-6-604. Consumer Credit Insurance; Definitions**

The definitions in A.R.S. § 20-1603 and this Section apply to R20-6-604 through R20-6-604.10.

1. "Actual loss ratio" means incurred claims divided by earned premiums at rates in use.
2. "Actuarially equivalent" means of equal actuarial present value determined as of a given date with each value based on the same set of actuarial assumptions. When used in this Article in reference to rates and coverage, "actuarially equivalent" means a rate or coverage that is actuarially determined to yield loss ratios of 50% for credit life insurance and 60% for credit disability insurance.
3. "Credit insurance" means credit life insurance, credit disability insurance, or both, but does not include any insurance for which there is no identifiable charge.
4. "Earned premiums" means earned premiums at prima facie rates and earned premiums at rates in use.
5. "Earned premiums at prima facie rates" means an insurer's actual earned premiums, adjusted to the amount that the insurer would have earned if the insurer's premium rates had equaled the prima facie rates in effect during the experience period.
6. "Earned premiums at rates in use" means the premiums that an insurer actually earns on the premium rates the insurer charges during an experience period.
7. "Evidence of individual insurability" means information about a debtor's health status or medical history that a debtor provides as a condition of credit insurance becoming effective.
8. "Experience" means an insurer's earned premiums and incurred claims during an experience period.
9. "Experience period" means a period of time for which an insurer reports income and expense information on the insurer's credit insurance business.
10. "Final adjusted rates" means the prima facie rates referred to in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08.
11. "Incurred claims" means the total claims an insurer pays during an experience period, adjusted for the change in the claim reserves.
12. "Plan of credit insurance" means an insurance plan based on one of the following rate and coverage categories:
  - a. Credit life insurance, other than on revolving accounts, including joint and single life coverage, decreasing and level insurance, and outstanding balance and single premium;
  - b. Credit life insurance on revolving accounts;
  - c. Credit life insurance on an age-graded basis;
  - d. Credit disability insurance, other than on revolving accounts, including outstanding balance and single premium, and each combination of waiting period and retroactive or non-retroactive benefits;

- e. Credit disability insurance on revolving accounts, including each combination of waiting period and retroactive or non-retroactive benefits.
13. "Preexisting condition" means a condition:
  - a. For which a debtor received medical advice, consultation, or treatment within six months before the effective date of credit insurance coverage; and
  - b. From which the debtor dies, in the case of life insurance, or becomes disabled, in the case of disability insurance, within six months after the effective date of coverage.
14. "Prima facie adjusted loss ratio" means incurred claims divided by earned premiums at prima facie rates.
15. "Prima facie rates" means the rates established by the Director as prescribed in R20-6-604.03.
16. "Reasonableness standard" means the requirement in A.R.S. § 20-1610(B) that an insurer's premiums for credit insurance shall not be excessive in relation to the benefits provided under the policy.
17. "Rule of Anticipation" means the product of the gross single premium per \$100 of indebtedness for a debtor's remaining term of indebtedness, times the number of hundreds of dollars of remaining indebtedness.

**Historical Note**

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2). Section amended by final rulemaking at 29 A.A.R. 3621 (November 24, 2023), effective January 7, 2024 (Supp. 23-4). Effective date corrected (Supp. 23-4, Ver. 2).

**Exhibit A. Repealed****Historical Note**

Former General Rule 70-22; Correction, original publication did not include Exhibit C (Supp. 76-1). Amended effective January 8, 1980 (Supp. 80-1). Former Section R4-14-604 repealed, new Section R4-14-604 adopted effective April 1, 1982. See subsection (N) for further detail (Supp. 82-2). Amended subsection (N) and Exhibit A effective March 30, 1983 (Supp. 83-2). R20-6-604 recodified from R4-14-604 (Supp. 95-1). Section repealed by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.01. Rights and Treatment of Debtors****A. Creditor Obligations.**

1. Multiple plans of insurance. If a creditor makes more than one plan of credit insurance available to debtors, the creditor shall inform each debtor of each plan for which the debtor is eligible and of the premium and charges for each plan.
2. Substitution. If a creditor requires a debtor to have credit insurance as additional security for a debt, the creditor shall inform the debtor in writing of the debtor's right to obtain alternative coverage as prescribed in A.R.S. § 20-1614 before the loan transaction is completed.

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3. Remittance of premiums. If a creditor adds an insurance charge or premium to a debt, the creditor shall remit the insurance charge or premium to the insurer within 60 days after it is added to the debt.
- B. Creditor and insurer obligations regarding insurance on refinanced debt.**
  1. If a debt is discharged because the debtor refinances the debt before the scheduled maturity date, the creditor shall notify the insurer that issued the credit insurance on the discharged debt.
  2. An insurer shall not issue any credit insurance that covers the refinanced debt with an effective date preceding the termination date of the insurance on the original debt.
  3. The insurer issuing the coverage on the discharged debt shall refund to or credit the debtor with all unearned insurance charges or premium according to R20-6-604.06.
  4. If a debt is refinanced, the effective date of the policy provisions in any new insurance covering the refinanced debt shall be the first date on which the debtor became insured under the previous policy. An insurer may apply any new exclusion period or preexisting condition limitation only to the portion of the new loan that exceeds the previous loan.
- C. Required policy provisions.**
  1. Termination provisions for group policies. A group credit insurance policy shall provide for continued coverage of debtors covered under the policy if the policy terminates, as follows:
    - a. For a policy with a single premium payment, or any other payment method that prepays coverage for more than one month, a provision requiring continued insurance coverage for the entire period for which the premium has been paid; and
    - b. For a policy with a monthly premium payment, a provision requiring the insurer to send the debtor a termination notice at least 30 days before the effective date of termination, unless an insurer is issuing replacement coverage in at least the same amount, without lapse of coverage.
  2. Maximum aggregate provisions. A provision in an individual policy or group certificate that sets a maximum limit on total claim payments shall apply only to that individual policy or group certificate.
- D. Creditor and insurer obligations when debtor prepays debt.**
  1. Except as provided in subsection (D)(2), if a debtor prepays a debt in full, any credit insurance covering the debt shall terminate on the date of prepayment. The creditor and insurer shall refund to or credit the debtor with any unearned premium according to R20-6-604.06.
  2. If a debt is fully prepaid because of the debtor's death or any other lump-sum credit insurance payment, a creditor or insurer is not required to refund premium for the coverage under which the lump sum was paid.
  3. If a claim under credit disability coverage is in progress at the time of prepayment, the insurer:
    - a. May calculate the refund as if the prepayment did not occur until the end of the period for payment of benefits, and
    - b. Is not required to refund premiums for any period for which credit disability benefits are payable.
- E. Benefits payable on revolving account.** If a debtor is paying for credit insurance coverage on a revolving account and dies, the insurer shall pay a benefit amount equal to the amount of

indebtedness outstanding on the date of death. The insurer may exclude preexisting conditions occurring within six months of any advance on the revolving account, running separately for each advance or charge.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.02. Satisfying the Reasonableness Standard**

- A.** An insurer shall comply with all requirements of A.R.S. § 20-1610 regarding premium and insurance charges.
- B.** An insurer may satisfy the reasonableness standard in A.R.S. § 20-1610(B) if the insurer's premium rate develops a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.
- C.** While in effect, the rates described in R20-6-604.04 and R20-6-604.05, subject to any deviations approved under R20-6-604.08 are conclusively presumed to develop the loss ratios described in subsection (B). For purposes of prospective effect, the Department may rebut this presumption by disapproving or withdrawing approval for the rates as prescribed in A.R.S. § 20-1610.
- D.** An insurer may provide coverage other than the standard coverage described in R20-6-604.04 and R20-6-604.05. An insurer that wishes to provide nonstandard coverage shall:
  1. File the nonstandard coverage policy information as prescribed in A.R.S. § 20-1609, and
  2. Demonstrate that the rates for the coverage are reasonably expected to develop a loss ratio of not less than 50% for credit life insurance and not less than 60% for credit disability insurance.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.03. Determination of Prima Facie Rates**

- A.** The Director shall, by order, establish prima facie rates as prescribed in this Section.
- B.** At least once every three years, the Director shall:
  1. Determine the rate of expected claims on a statewide basis;
  2. Compare the rate of expected claims with the rate of actual claims for the past three years determined from the incurred claims and earned premiums at prima facie rates; and
  3. If the Director determines that the prima facie rates require adjustment, issue a notice of hearing and proposed order adjusting the actual statewide prima facie rates. The hearing date on the proposed order shall be no earlier than 45 days from the date of the notice.
- C.** The Director shall mail a copy of the notice and proposed order to:
  1. Each insurer that reported transaction of credit insurance on its annual statement immediately preceding the date of the notice, and
  2. Any other person who sends the Director a written request for notice of proceedings to adjust the prima facie rates.
- D.** Any person may submit written comments to the Director or appear at the hearing and provide oral comments on the record. Written comments shall be received no later than the close of record date specified in the notice of hearing.
- E.** The Director shall:
  1. Consider written and oral comments; and

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2. Issue a final order setting prima facie rates no later than 30 days after the close of record date specified in the notice of hearing.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.04. Credit Life Insurance Rates and Provisions**

- A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit life insurance.
- B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.
- C. A credit life insurance policy shall meet the requirements listed in this Section. The policy shall:
  1. Provide coverage for death, by whatever means caused, to all eligible debtors, with or without evidence of individual insurability for debtors that purchase coverage within 30 days of being eligible;
  2. Have no exclusions other than for:
    - a. Suicide within six months after the effective date of coverage, or
    - b. A preexisting condition;
  3. Have no age restrictions, except the following permissible exclusions:
    - a. An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 70 and that all insurance shall terminate on a debtor attaining age 70; and
    - b. An age restriction for a revolving credit life insurance policy that:
      - i. Excludes a class of debtors determined by age, or
      - ii. Provides for termination of insurance or reduction in the amount of insurance when a debtor reaches age 70; and
  4. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.05. Credit Disability Insurance Rates and Provisions**

- A. Under the process prescribed in R20-6-604.03, the Director shall issue an order establishing prima facie rates for credit disability insurance.
- B. The Department shall presume that an insurer meets the loss ratios prescribed in R20-6-604.02(B) if the insurer uses the prima facie rates, subject to the requirements in this Section and R20-6-604.08. An insurer may use the prima facie rates without filing additional actuarial support.
- C. A credit disability insurance policy shall meet the requirements listed in this Section. The policy shall:
  1. Provide coverage for disability, by whatever means caused, to all eligible debtors, with or without evidence of

individual insurability for debtors that purchase coverage within 30 days of becoming eligible;

2. Include a definition of disability that is no more restrictive than the following:
  - a. For the first 12 months of disability, the inability of the insured to perform the essential functions of the insured's occupation; and
  - b. After the first 12 months of disability, the inability of the insured to perform the essential functions of any occupation for which the insured is reasonably suited by virtue of education, training, or experience;
3. Not include any employment requirement that a debtor be employed more than full-time on the effective date of coverage, with a definition of "full-time" as a regular work week of at least 30 hours;
4. Have no exclusions other than for disabilities resulting from:
  - a. Normal pregnancy,
  - b. Intentionally self-inflicted injury, or
  - c. A preexisting condition;
5. For insurance on revolving accounts, have the date on which an advance or charge occurs as the effective date of coverage for each part of the insurance attributable to a different advance or a charge to the plan account. Any exclusion period or preexisting condition limitation shall run separately for each advance or charge;
6. Have no age restrictions, except the following permissible exclusion:
 

An age restriction providing that no insurance will become effective on a debtor on or after the attainment of age 65 and that all insurance shall terminate on a debtor attaining age 66; and
7. Include a provision for a daily benefit of not less than one-thirtieth of the monthly benefit payable under the policy.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.06. Refund Methods**

- A. When refunding premiums as prescribed in A.R.S. § 20-1611, an insurer shall use the following methods:
  1. For insurance paid by a single premium, the Rule of Anticipation method; and
  2. For insurance paid by other than a single premium, a method that refunds at least the pro rata gross unearned amount charged to the debtor.
- B. The Director may approve other refund methods similar to those described in subsection (A), that are actuarially equivalent to the type of coverage the debtor purchased.
- C. An insurer's refund method may recognize adjustments to a daily basis for interest or payments if the adjustments are consistent with the underlying credit transaction.
- D. An insurer is not required to refund any amount less than \$5.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.07. Experience Reports**

- A. By April 1 of each year, an insurer that transacts credit insurance in this state shall file with the Director an experience report, on a form specified by the Director, for each class of business that the insurer transacts as provided in this Section.

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1. In this Section, a "class of business" means:
  - a. Credit unions;
  - b. Banks, savings and loan institutions, and mortgage companies;
  - c. Finance companies, small loan companies, and consumer lenders defined in A.R.S. § 6-601(5);
  - d. Dealers, including auto, truck, and boat dealers, retail stores, and other persons selling financed goods; and
  - e. All other persons selling credit insurance not specifically listed in subsection (A)(1)(a) through (d).
2. The report shall include the following information:
  - a. Mode of premium payment,
  - b. Plan of benefits description,
  - c. Earned premiums,
  - d. Incurred claims,
  - e. Loss ratios, and
  - f. For credit life insurance, mean insurance in force.
- B. For each day a report is late, the Director may assess a penalty as prescribed in A.R.S. § 20-223.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.08. Use of Prima Facie Rates; Rate Deviations**

- A. Use of rates greater than prima facie rates. An insurer may file for approval and use of any deviated rates that are higher than the prima facie rates referred to in R20-6-604.04 and R20-6-604.05 as prescribed in A.R.S. § 20-1610.
  1. The deviated rates shall meet the minimum loss ratio standards and other requirements prescribed by R20-6-604.02.
  2. The filing shall specify the accounts to which the rates apply.
  3. The rates may be:
    - a. Applied uniformly to all accounts of the insurer; or
    - b. Applied on an equitable basis approved by the Director to accounts of the insurer for which the insurer's experience has been less favorable than expected.
- B. Approval period of deviated rates. An insurer may use a deviated rate for the same period of time as the experience period used to establish the rate, not to exceed a period of three years from the date of approval. An insurer may file for a new deviated rate before the end of the approval period, but not more often than once in any 12 month period.
- C. Approval is non-transferable. The Director's approval of a deviated rate is not transferable to another insurer. If an insurer acquires an account for which another insurer obtained a deviated rate, the successor insurer may not charge the deviated rate without obtaining approval for the deviated rate as prescribed in subsection (B).
- D. Use of rates lower than filed rates. An insurer may use a rate that is less than its filed rate without notice to the Director.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.09. Supervision of Consumer Credit Insurance Operations**

- A. At least once every three years, an insurer transacting credit insurance in Arizona shall review the credit insurance operations of each creditor with whom the insurer does business to

ensure that each creditor is complying with applicable credit insurance laws. The insurer shall review the following:

1. The creditor does not charge rates in excess of the prima facie rates or any deviated rates for which the insurer obtains approval;
  2. The creditor makes benefit payments as prescribed in the policy; and
  3. The creditor refunds unearned premiums as prescribed in R20-6-604.06.
- B. The insurer shall maintain for the Director's inspection a written record of each review and action the insurer takes to address any creditor noncompliance found by the insurer, for at least three years following the end of the review.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-604.10. Prohibited Transactions**

- A. The practices listed in this Section are deemed unfair trade practices under A.R.S. § 20-442. An insurer that commits any of the following practices is subject to penalties as prescribed in A.R.S. § 20-456:
  1. Offering or providing a creditor with any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than payment of commissions;
  2. Agreeing to deposit with a bank or financial institution, the insurer's money or securities as a substitute for a deposit of money or securities that the financial institution would otherwise require from the creditor as a compensating balance or deposit offset for a loan or other advancement; or
  3. Depositing money or securities without interest or at a lesser rate of interest than the creditor, bank, or financial institution is currently paying on other similar deposits.
- B. This Section does not prohibit an insurer from maintaining demand deposits or premium deposit accounts that are reasonably necessary for use in the ordinary course of the insurer's business.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2725, effective June 7, 2002 (Supp. 02-2).

**R20-6-605. Emergency Expired****Historical Note**

Former General Rule 72-26. Repealed effective December 4, 1986 (Supp. 86-6). Adopted as an emergency effective January 9, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days; re-adopted as an emergency with changes effective March 26, 1990, pursuant to A.R.S. § 41-1026 valid for only 90 days (Supp. 90-1). Re-adopted as an emergency without change effective June 20, 1990, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 90-2). Emergency expired. R20-6-605 recodified from R4-14-605 (Supp. 95-1).

**R20-6-606. Repealed****Historical Note**

Adopted effective July 1, 1980 (Supp. 80-3). Amended effective June 1, 1981. See also subsection (G) (Supp. 81-1). Amended subsections (D), (E)(3)(a), (F)(2)(b), (3)(a), (4)(e), (G), and (H) effective January 11, 1982 (Supp. 82-1). Amended subsections (G) and (H) as an emergency effective August 1, 1988, pursuant to A.R.S. § 41-1026,

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valid for only 90 days (Supp. 88-3). Emergency expired.

Amended and readopted as an emergency effective November 18, 1988, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 88-4). Emergency expired. Corrected and readopted as an emergency effective February 10, 1989, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 89-1). Emergency expired. Amended effective August 4, 1989 (Supp. 89-3). Amended and adopted as an emergency effective September 13, 1989 (Supp. 89-3). Emergency expired (Supp. 89-4). Amended effective November 19, 1990 (Supp. 90-4). Repealed by emergency action effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Repealed again by emergency action effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Repealed effective May 28, 1992 (Supp. 92-2). R20-6-606 recodified from R4-14-606 (Supp. 95-1).

#### **R20-6-607. Reasonableness of Benefits in Relation to Premium Charged**

- A.** Applicability. This rule shall apply to individual disability insurance (as defined in A.R.S. § 20-253) policy forms and rates.
- B.** When rate filing is required. Every individual policy form, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement form shall also be filed.
- C.** General contents of all rate filings. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment, the rate filing is in compliance with applicable laws and regulations of this state and that the benefits are reasonable in relation to the premiums.
- D.** Previously approved forms. Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:
  1. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums including the anticipated loss ratio for the form.
  2. A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons.
  3. A history of the experience under existing rates, including at least the data indicated in subsection (E). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. All additional data must be reconciled, as appropriate, to the required data. Additional data might include:
    - a. Substitution of actual claim run-offs for claim reserves and liabilities,
    - b. Determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums,

- c. Substitution of net level policy reserves for preliminary term policy reserves,
  - d. Adjustment of premiums to an annual mode basis, or
  - e. Other adjustments or schedules suited to the form and to the records of the company.
4. The date and magnitude of each previous rate change, if any.
- E.** Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit to the NAIC annual statement convention blank. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except the data for calendar years prior to the most recent five years may be combined.
  - F.** Evaluation experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:
    1. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.
    2. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.
    3. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.
    4. The mix of business by risk classification.
  - G.** Anticipated loss ratio standard. With respect to a new form or a currently approved form, except currently approved non-cancelable policy forms, under which the average annual premium (as defined below) is expected to be at least \$700, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical expense	60%	55%	55%	50%
Loss of income and other	60%	55%	50%	45%

For a policy form including riders and endorsements, under which the expected average annual premium per policy is \$200 or more but less than \$700, subtract 5 percentage points from the numbers in the table above, or if less than \$200, subtract 10 percentage points.

The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation.)

The above anticipated loss ratio standards do not apply to a class of business which is regulated by specific statutes or regulations mandating loss ratios for such business, e.g., Medicare Supplement and Credit Life and Disability.

#### **Definitions of Renewal Clause**

OR – Optionally Renewable: renewal is at the option of the insurance company.



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CR – Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR – Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC – Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

**H.** Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in subsection (G) above.

1. The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;
2. The anticipated loss ratio derived by dividing (a) by (b) where:
  - a. Is the sum of the accumulated benefits, from the original effective date of the form or the effective date of this regulation, whichever is later, to the effective date of the revision, and the present value of future benefits; and
  - b. Is the sum of the accumulated premiums from the original effective date of the form or the effective date of the regulation, whichever is later, to the effective date of the revision, and the present value of future premiums. Such present values shall be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

**I.** Anticipated loss ratios lower than those indicated in subsections (H)(1) and (H)(2) will require justification based on the special circumstances that may be applicable.

1. Examples of coverages requiring special consideration are as follows:
  - a. Accident only;
  - b. Short term nonrenewable, e.g., airline trip, student accident;
  - c. Specified peril, e.g., common carrier; and
  - d. Other special risks.
2. Examples of other factors requiring special consideration are as follows:
  - a. Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
  - b. Extraordinary expenses;
  - c. High risk of claim fluctuation because of the low loss frequency of the catastrophic, or experimental nature of the coverage;
  - d. Product features such as long elimination periods, high deductibles and high maximum limits;
  - e. The industrial or debit method of distribution; and
  - f. Forms issued prior to the effective date of this rule. Companies are urged to review their experience periodically and to file rate revisions, as appropriate,

in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

3. Notwithstanding the foregoing paragraphs to the contrary, hospital indemnity and cancer and other dread diseases policies shall develop the loss ratios pursuant to subsection (G).

**J.** Severability provision. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

**K.** Effective date. This rule shall become effective upon filing with the Secretary of State and shall apply to all individual disability policy form and rate filings submitted on and after said date.

**Historical Note**

Adopted effective July 14, 1981 (Supp. 81-1). R20-6-607 recodified from R4-14-607 (Supp. 95-1). Amended by final rulemaking at 24 A.A.R. 103, effective February 17, 2018 (Supp. 17-4).

**ARTICLE 7. LICENSING PROVISIONS AND PROCEDURES**

**R20-6-701. Repealed**

**Historical Note**

Former General Rule 56-1; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-701 recodified from R4-14-701 (Supp. 95-1).

**R20-6-702. Expired**

**Historical Note**

Former General Rule 56-2. R20-6-702 recodified from R4-14-702 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

**R20-6-703. Expired**

**Historical Note**

Former General Rule 61-6. R20-6-703 recodified from R4-14-703 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

**R20-6-704. Expired**

**Historical Note**

Former General Rule 6-19. R20-6-704 recodified from R4-14-704 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

**R20-6-705. Expired**

**Historical Note**

Former General Rule 66-13. R20-6-705 recodified from R4-14-705 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

**R20-6-706. Expired**

**Historical Note**

Former General Rule 69-15; Repealed effective February 22, 1977 (Supp. 77-1). New Section R4-14-706 adopted effective November 5, 1980 (Supp. 80-5). R20-6-706 recodified from R4-14-706 (Supp. 95-1). Section expired

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under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

**R20-6-707. Expired****Historical Note**

Former General Rule 69-18; Amended effective March 17, 1981 (Supp. 81-2). R20-6-707 recodified from R4-14-707 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 9 A.A.R. 2115, effective April 30, 2003 (Supp. 03-2).

**R20-6-708. Licensing Time-frames**

- A.** Definitions. The definitions in A.R.S. § 41-1072 and the following definitions apply to this Article.
1. "Department" means the Insurance Division of the Department of Insurance and Financial Institutions.
  2. "License" has the meaning prescribed in A.R.S. § 41-1001(13).
- B.** The time-frames listed in Table A apply to licenses issued by the Department. The licensing time-frames consist of an administrative completeness review, a substantive review, and an overall review.
- C.** Within the time-frame for the administrative completeness review set forth in Table A, the Department shall notify the applicant in writing whether the application is complete or deficient.
1. If the application is deficient, the Department shall issue a notice of deficiency to the applicant which shall include a comprehensive list of the specific deficiencies. If the Department issues a written notice of deficiency within the administrative completeness review time-frame, the administrative completeness review time-frame and the overall review time-frame are suspended from the date the notice is issued until the date that the Department receives an adequate response from the applicant.
  2. The Department is not precluded from issuing additional notices of deficiency during an administrative completeness review.
  3. If an applicant does not adequately respond to each specified deficiency in a notice of deficiency issued under subsection (C)(1) within 60 days after the date of a notice of deficiency, the application is deemed withdrawn, and the Department is not required to take further action with respect to the application.
- D.** Within the time-frame for the substantive review set forth in Table A, the Department may issue one comprehensive written request for additional information to the applicant specifying each component or item of information required.
1. If the Department issues a comprehensive written request for additional information within the substantive review time-frame, the substantive review time-frame and the overall time-frame are suspended from the date the written request is issued until the date that the Department receives an adequate response from the applicant.
  2. The Department is not precluded from issuing supplemental requests by mutual agreement for additional information, during the substantive review.
  3. If an applicant does not adequately respond to each component or item of information required in a comprehensive written request or a supplemental request for additional information within 60 days after the date of a comprehensive written request, or within 60 days after the date of the supplemental request for additional information, the application is deemed withdrawn, and the

Department is not required to take further action with respect to the application.

- E.** Within the overall time-frames set forth in Table A, unless extended by mutual agreement under A.R.S. § 41-1075, the Department shall notify the applicant in writing that the application is granted or denied. If the application is denied, the Department shall provide to the applicant a written notice that complies with the provisions of A.R.S. § 41-1076.
- F.** In computing the time periods prescribed in these time-frame rules, the last day of a notice period is included in the computation, unless it is a Saturday, Sunday, or legal holiday.

**Historical Note**

Former General Rule 70-22; Correction, original publication did not include Exhibit C. (Supp. 76-1). Repealed effective January 8, 1980 (Supp. 80-1). R20-6-708 recodified from R4-14-708 (Supp. 95-1). Amended effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4). Amended by final rulemaking at 29 A.A.R. 612 (February 24, 2023), effective April 10, 2023 (Supp. 23-1).

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**Table A. Licensing Time-frames**

License	Relevant A.R.S.	Administrative Completeness	Substantive Review	Overall Time-frame
<b>Insurance</b>				
Captive Insurer	§ 20-1098.01	150	30*	180
Certificate of Authority	§ 20-216	210	90*	300
Certificate of Exemption	§ 20-401.05	92	30	122
Health Care Services Organization	§ 20-1052	210	90	300
Hospital, Medical, Dental, and Optometric Service Corporation	§ 20-825	210	90	300
Life Care Provider Permit	§ 20-1803	60*	30*	90
Life Settlement Provider	§ 20-3202	60	60	120
Mechanical Reimbursement Reinsurer	§ 20-1096.04	210	90	300
Prepaid Dental Plan Organization	§ 20-1004	210	90	300
Prepaid Legal Insurer*	§ 20-1097.02	45	15	60*
Qualifying Surplus Lines Insurer	§ 20-413	45	30	75
Reinsurance Intermediary	§ 20-486.01	120	60	180
<b>Insurance Professional</b>				
Adjuster	§ 20-321.01	60	60	120
Bail Bond Agent	§ 20-340.01	60	60	120
Certified Application Counselor	§ 20-336.04	60	60	120
Life Settlement Broker	§ 20-3202	60	60	120
Limited Travel Agent	§ 20-3553	60	60	120
Navigator	§ 20-336.03	60	60	120
Nonresident Insurance Producer (Agent/Broker)	§ 20-287	60	60	120
Portable Electronics Insurance Adjuster	§ 20-321.01	60	60	120
Portable Electronics Insurance Vendor	§ 20-1693.01	60	60	120
Rental Car Agent	§ 20-331	60	60	120
Resident Insurance Producer (Agent/Broker)	§ 20-285	60	60	120
Risk Management Consultant	§ 20-331.01	60	60	120
Self-service Storage Agents	§ 20-332	60	60	120
Surplus Lines Broker	§ 20-411	60	60	120
Temporary License	§ 20-294	60	60	120
Title Insurance Agent	§ 20-1580	60	60	120
Variable Contract Agent	§ 20-2662	60	60	120
<b>Other</b>				
Rating Organization*	§ 20-361	30	30	60*
Rate Service Organization	§ 20-389	60	60	120
Third Party Administrator	§ 20-485.12	45	45	90
Senior Residential Entrance Fee Contracts: Provider Registration	§ 44-6952	60	60	120
Service Company	§ 20-1095.01	30	30	60
Utilization Review Agent	§ 20-2505	30	90	120
<b>Risk Retention Groups</b>				
Risk Retention Group (Foreign)	§ 20-2403	60	0	60
Risk Purchasing Groups	§ 20-2407	30	30	60

\* Statutory time-frames

**Historical Note**

Table A adopted effective January 1, 1999; filed in the Office of the Secretary of State December 4, 1998 (Supp. 98-4). Table A amended by final rulemaking at 29 A.A.R. 612 (February 24, 2023), effective April 10, 2023 (Supp. 23-1).

**R20-6-709. Repealed****Historical Note**

Former General Rule 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-709 recodified from R4-14-709 (Supp. 95-1).

**ARTICLE 8. PROHIBITED PRACTICES, PENALTIES****R20-6-801. Unfair Claims Settlement Practices**

**A.** Applicability. This rule applies to all persons and to all insurance policies, insurance contracts and subscription contracts

except policies of Worker's Compensation and title insurance. This rule is not exclusive, and other acts not herein specified, may also be deemed to be a violation of A.R.S. § 20-461, The Unfair Claims Settlement Practices Act.

**B. Definitions**

1. "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim. "Agent" has the same meaning as "Insurance producer" as defined at A.R.S. § 20-281(5).

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2. "Claimant" means either a first party claimant, a third party claimant, or both and includes the claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.
  3. "Department" means the Arizona Department of Insurance and Financial Institutions – Insurance Division.
  4. "Director" has the meaning of A.R.S. § 20-102.
  5. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency of loss covered by the policy or contract.
  6. "Insurance policy or insurance contract" has the meaning of A.R.S. § 20-103.
  7. "Insurer" has the meaning of A.R.S. § 20-106(C).
  8. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.
  9. "Notification of claim" means any notification, whether in writing or other means, acceptable under the terms of any insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.
  10. "Person" has the meaning of A.R.S. § 20-105.
  11. "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.
  12. "Worker's compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.
- C.** File and record documentation. The insurer's claim files shall be subject to examination by the Director or by his duly appointed designees. The files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of the events can be reconstructed.
- D.** Misrepresentation of policy provisions
1. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.
  2. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim.
  3. No insurer shall deny a claim on the basis that the claimant has failed to exhibit the damaged property to the insurer, unless the insurer has requested the claimant to exhibit the property and the claimant has refused without a sound basis.
  4. No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if the time limit is not complied with unless the failure to comply with the time limit prejudices the insurer's rights.
  5. No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.
  6. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language that releases the insurer or its insured from its total liability.
- E.** Failure to acknowledge pertinent communications
1. Every insurer, upon receiving notification of a claim shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the 10 working days. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.
  2. Every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.
  3. An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.
  4. Every insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (E)(1).
- F.** Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within 30 days.
- G.** Standards for prompt, fair and equitable settlements applicable to all insurers
1. Notice of acceptance or denial of claim.
    - a. Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.
    - b. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall also notify the first party claimant within 15 working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.
    - c. Where there is a reasonable basis supported by specific information available for review by the Director for suspecting that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of subsections (G)(1)(a) and (b). Provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.
  2. If a claim is denied for reasons other than those described in subsection (G)(1)(a), and is made by any other means

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than writing, an appropriate notation shall be made in the claim file of the insurer.

3. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.
4. Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's right. The notice shall be given to first party claimants 30 days, and to third party claimants 60 days, before the date on which the time limit may expire.
5. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

**H. Standards for prompt, fair and equitable settlements applicable to automobile insurance**

1. When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:
  - a. The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection of the offer must be documented in the claim file.
  - b. The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. The cost may be determined by:
    - i. The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area.
    - ii. One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.
  - c. When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections (H)(1)(a) and (b), the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from the cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for the settlement shall be fully explained to the first party claimant.
2. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make

claim under their own policies solely to avoid paying claims under the insurer's policy or insurance contract.

3. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate, or to have the automobile repaired at a specific repair shop.
4. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect the deductible recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.
5. If an insurer prepares an estimate of the cost of automobile repairs, the estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.
6. When the amount claimed is reduced because of betterment or depreciation, all information for the reduction shall be contained in the claim file. The reductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of reductions.
7. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.
8. The insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which the insurer would pay if the repairs were made, other than in total loss situations, unless the amount is agreed to by the insured.
- I. Severability. If any provision of this Section or its application to any person or circumstances is held invalid, the remainder of the Section and the application of the provision to other persons and circumstances shall not be affected.

**Historical Note**

Adopted effective January 12, 1982 (Supp. 81-5). R20-6-801 recodified from R4-14-801 (Supp. 95-1). The reference to subsections as "subparagraphs" in this Section has been updated to current Chapter style (Supp. 22-1). Section amended by final rulemaking at 29 A.A.R. 3621 (November 24, 2023), effective January 7, 2024 (Supp. 23-4). Effective date corrected (Supp. 23-4, Ver. 2).

**R20-6-802. Emergency Expired**

**Historical Note**

Emergency rule adopted effective May 31, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-2). Emergency expired. Emergency rule readopted without change effective September 5, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-3). Emergency expired. R20-6-802 recodified from R4-14-802 (Supp. 95-1).

**ARTICLE 9. TERMINATION OR DISSOLUTION**

**R20-6-901. Reserved**

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**ARTICLE 10. LONG-TERM CARE INSURANCE****R20-6-1001. Applicability and Scope**

Except as otherwise specifically provided, this Article applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care, delivered or issued for delivery in this state by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health care service organizations and all similar organizations.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1001 recodified from R4-14-1001 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1002. Definitions**

The definitions in A.R.S. § 20-1691 and the following definitions apply in this Article.

- A. “Benefit trigger,” for purposes of a tax-qualified long-term care insurance contract, as defined in Section 7702B(b) of the Internal Revenue Code of 1968, as amended, “benefit trigger” shall include a determination by a licensed health care practitioner that an insured is a chronically ill individual.
- B. “Exceptional increase” means only those rate increases that an insurer has filed as exceptional and that the Director determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state; or due to increased and unexpected utilization that affects the majority of insurers of similar products.
  - 1. Except as provided in Sections R20-6-1014 and R20-6-1015, exceptional increases are subject to the same requirements as other premium rate schedule increases.
  - 2. The Director may request independent actuarial review on the issue of whether an increase should be deemed an exceptional increase.
  - 3. The Director may also determine whether there are any potential offsets to higher claims costs.
- C. “Incidental,” as used in R20-6-1014(L) and R20-6-1015(L), means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy, with value measured as of the date of issue.
- D. “Licensed health care professional” means an individual qualified by education and experience in an appropriate field, to determine, by record review, an insured’s actual functional or cognitive impairment.
- E. “Long-term care benefit classification” means one of the following:
  - 1. Institutional long-term care – benefits only;
  - 2. Non-institutional long-term care – benefits only; or
  - 3. Comprehensive long-term care benefits.
- F. “Managed care plan” means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, use of specific provider networks, or a combination of these methods.
- G. “Personal information” has the same meaning prescribed in A.R.S. § 20-2102(19).
- H. “Privileged information” has the same meaning prescribed in A.R.S. § 20-2102(22).
- I. “Qualified actuary” means a member in good standing of the American Academy of Actuaries.

- J. “Similar policy forms” means all long-term care insurance policies and certificates that are issued by a particular insurer and that have the same long-term care benefit classification as a policy form being reviewed.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1002 recodified from R4-14-1002 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1003. Policy Terms**

- A. A long-term care insurance policy delivered or issued for delivery in this state shall not use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:
  - 1. “Activities of daily living” means eating, toileting, transferring, bathing, dressing, or continence.
  - 2. “Acute condition” means that an individual is medically unstable and requires frequent monitoring by medical professionals, such as physicians and registered nurses, to maintain the individual’s health status.
  - 3. “Adult day care” means a program of social and health-related services for six or more individuals, that is provided during the day in a community group setting, for the purpose of supporting frail, impaired, elderly, or other disabled adults who can benefit from the services and care in a setting outside the home.
  - 4. “Agent” means an insurance producer as defined in A.R.S. § 20-281(5).
  - 5. “Bathing” means washing oneself by sponge bath, or in a tub or shower, and includes the act of getting in and out of the tub or shower.
  - 6. “Chronically ill individual” has the meaning prescribed for this term by A.R.S. § 20-1691(3) and Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended.
    - a. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:
      - i. Being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to loss of functional capacity; or
      - ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.
    - b. The term “chronically ill individual” does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.
  - 7. “Cognitive impairment” means a deficiency in a person’s:
    - a. Short or long-term memory;
    - b. Orientation as to person, place, or time;
    - c. Deductive or abstract reasoning; or
    - d. Judgment as it relates to safety awareness.
  - 8. “Continence” means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.

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9. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
  10. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, or by a feeding tube or intravenously.
  11. "Guaranteed renewable" means the insured has the right to continue a long-term-care insurance policy in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that the insurer may revise rates on a class basis.
  12. "Hands-on assistance" means physical help to an individual who could not perform an activity of daily living without help from another individual, and includes minimal, moderate, or maximal help.
  13. "Home health services" means the services described at A.R.S. § 36-151.
  14. "Level premium" means that an insurer does not have any right to change the premium, even at renewal.
  15. "Licensed health care practitioner" has the same meaning as A.R.S. § 20-1691(6).
  16. "Maintenance or personal care services" has the same meaning as A.R.S. § 20-1691(10).
  17. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
  18. "Noncancellable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally cancel or make any change in any provision of the insurance or in the premium rate.
  19. "Personal care" means the provision of hands-on assistance to help an individual with activities of daily living in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
  20. "Qualified long-term care services" has the meaning prescribed for this term under A.R.S. § 20-1691(13) and means services that meet the requirements of Section 7702B(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.
  21. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.
  22. "Transferring" means moving into or out of a bed, chair, or wheelchair.
- B.** Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:
1. "Home care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
  2. "Intermediate care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
  3. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
  4. "Skilled nursing care," "specialized care," "assisted living care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.
  5. Service providers, including "skilled nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility" and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1003 recodified from R4-14-1003 (Supp. 95-1). Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2). Section amended by final rulemaking at 29 A.A.R. 3621 (November 24, 2023), effective January 7, 2024 (Supp. 23-4). Effective date corrected (Supp. 23-4, Ver. 2).

**R20-6-1004. Required Policy Provisions****A. Renewability**

1. An individual long-term care insurance policy shall contain a renewability provision which shall be either "guaranteed renewable" or "noncancellable." The renewability provision shall be appropriately captioned, shall appear on the first page of the policy, and shall state that the coverage is guaranteed renewable or noncancellable. This requirement does not apply to a long-term care insurance policy that is part of or combined with a life insurance policy that does not contain a renewability provision and that reserves the right not to renew solely to the policyholder.
2. An insurer shall not use the terms "guaranteed renewable" and "noncancellable" in any individual long-term care insurance policy without further explanatory language according to the disclosure requirements of this Article.
3. A qualified long-term care insurance policy shall have the guaranteed renewability provisions specified in Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended, in the policy.
4. A long-term care insurance policy or certificate shall include a statement that premium rates are subject to change, unless the policy does not afford the insurer the right to raise premiums.

**B. Limitations and Exclusions**

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1. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
  2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility not prohibited by A.R.S. §§ 20-1691.03 and 20-1691.05 shall describe the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label the paragraph "Limitations or Conditions on Eligibility for Benefits."
  3. A policy shall not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
    - a. Preexisting conditions or disease;
    - b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of the benefits on the basis of Alzheimer's Disease;
    - c. Alcoholism and drug addiction;
    - d. Illness, treatment or medical condition arising out of:
      - i. War, declared or undeclared, or act of war;
      - ii. Participation in a felony, riot or insurrection;
      - iii. Service in the armed forces or auxiliary units;
      - iv. Suicide, attempted suicide, or intentionally self-inflicted injury; or
      - v. Aviation, if non-fare-paying passenger;
    - e. Treatment provided in a government facility, unless otherwise required by law;
    - f. Services for which benefits are available under Medicare or other governmental program, except Medicaid;
    - g. Any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
    - h. Services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;
    - i. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or
    - j. In the case of a qualified long-term care insurance policy, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be reimbursable but for the application of a deductible or coinsurance amount;
  4. Subsection (B) does not prohibit exclusions and limitations by type of provider or territorial limitations. No long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:
    - a. When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
    - b. When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
  5. "State of policy issue" means the state in which the insurer issued the individual policy or certificate.
- C. Extension of benefits. A long-term care insurance policy shall provide that termination of long-term care insurance is without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. An insurer may limit this extension of benefits period to the duration of the benefit period, if any, or to payment of the maximum benefits and the insurer may still apply any policy waiting period and all other applicable provisions of the policy.
- D. Reinstatement. A long-term care insurance policy shall include a provision for reinstatement of coverage if a lapse occurs if the insurer receives proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the grace period in the policy. The option to reinstate shall be available to the insured for at least five months after the date of termination and shall allow for the collection of past due premiums, as appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for these conditions set forth in the original long-term care policy.
- E. Continuation or conversion.
1. A group long-term care insurance policy shall provide covered individuals with a basis for continuation or conversion of coverage as specified in this subsection.
  2. The policy shall include a provision that maintains coverage under the existing group policy when the coverage would otherwise terminate, subject only to the continued timely payment of premiums when due. A group policy that restricts provision of benefits and services to, or has incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels and administrative complexity.
  3. The policy shall include a provision that an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuation of the group policy in its entirety or with respect to an insured class, who has been continuously insured under the group policy (and any group policy which it replaced) for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.
  4. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or benefits that the Director determines to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements.



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ments, service availability, benefit levels and administrative complexity, and other plan elements.

5. An insurer may require an individual seeking a conversion policy to make a written application for the converted policy and pay the first premium due, if any, as directed by the insurer not later than 31 days after termination of coverage under the group policy. The insurer shall issue the converted policy effective on the day following the termination of coverage under the group policy. The converted policy shall be renewable annually.
  6. Unless the group policy from which conversion is made replaced previous group coverage, the insurer shall calculate the premium for the converted policy on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.
  7. An insurer is required to provide continuation of coverage or issuance of a converted policy as provided in this subsection, unless:
    - a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
    - b. The terminating coverage is replaced not later than 31 days after termination, by group coverage that:
      - i. Is effective on the day following the termination of coverage;
      - ii. Provides benefits identical to or benefits the Director determines to be substantially equivalent to or in excess of those provided by the terminating coverage; and
      - iii. Has a premium calculated in a manner consistent with the requirements of subsection (E)(6).
  8. Notwithstanding any other provision of this Section, a converted policy that an insurer issues to an individual who at the time of conversion is covered by another long-term care insurance policy providing benefits on the basis of incurred expenses, may contain a provision that reduces benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100% of incurred expenses. An insurer may include this provision in the converted policy only if the converted policy also provides for a premium decrease or refund that reflects the reduction in payable benefits.
  9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
  10. Notwithstanding any other provision of this Section, an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person, is entitled to continuation of coverage under the group policy if the qualifying relationship terminates by death or dissolution of marriage.
- F. Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:
1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
  2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.
- G. Premium Increases.**
1. An insurer shall not increase the premium charged to an insured because of:
    - a. The increasing age of the insured at ages beyond 65, or
    - b. The duration of coverage under the policy.
  2. Purchase of additional coverage is not considered a premium rate increase, however, for the calculation required under R20-6-1019, an insurer shall add to and consider the portion of the premium attributable to the additional coverage as part of the initial annual premium.
  3. A reduction in benefits is not considered a premium change, however, for the calculation required under R20-6-1019, an insurer shall base the initial annual premium on the reduced benefits.
- H. Electronic enrollment for group policies.**
1. For coverage offered to a group defined in A.R.S. § 20-1691(5)(a), any requirement that an insurer or insurance producer obtain an insured's signature is satisfied if:
    - a. The group policyholder or insurer obtains the insured's consent by telephonic or electronic enrollment, and provides the enrollee with verification of enrollment information within five business days of enrollment; and
    - b. The telephonic or electronic enrollment process has necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records, and the confidentiality of individually identifiable and privileged information.
  2. If the Director requests, the insurer shall make available records showing the insurer's ability to confirm enrollment and coverage amounts.
- I. Minimum standards for home health and community care benefits.**
1. If an insurer issues a long-term care insurance policy or certificate that provides benefits for home-health or community care, the policy or certificate shall not limit or exclude benefits by any of the following:
    - a. Requiring that the insured would need skilled care in a skilled nursing facility if home health services are not provided;
    - b. Requiring that the insured first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health services are covered;
    - c. Requiring that eligible services be provided by a registered nurse or licensed practical nurse;
    - d. Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of licensure or certification;
    - e. Requiring that the insured or claimant have an acute condition before home health services are covered;

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- f. Limiting benefits to services provided by Medicare-certified agencies or providers;
  - g. Excluding coverage for personal care services provided by a home health aide;
  - h. Requiring that home health care services be provided at a level of certification or licensure greater than that required by the eligible service; or
  - i. Excluding coverage for adult day care services.
2. If a long-term care insurance policy provides benefits for home health or community care services, it shall provide home health or community care coverage that equals a dollar amount equivalent to at least one-half of one year's missing home benefit coverage available at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.
3. An insurer may apply home health care coverage to non-home health care benefits in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.
- J. Appeals. Policy shall include a clear description of the process for appealing and resolving benefit determinations.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1004 recodified from R4-14-1004 (Supp. 95-1).

Amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1005. Unintentional Lapse**

- A. An insured may designate in writing at least one person to receive notice of lapse or termination of a long-term care insurance policy for nonpayment of premium, in addition to the insured. Designation shall not constitute acceptance of any liability by the third-party notice recipient for services provided to the insured.
- B. An insurer shall not issue an individual long-term care insurance policy or certificate until the applicant has provided either a written designation of at least one person, in addition to the applicant, who shall receive notice of lapse or termination of the policy or certificate for nonpayment of premium, with the person's full name and home address, or the applicant's written waiver, dated and signed, indicating that the applicant chooses not to designate a notice recipient.
- C. The insurer shall use a form for written designation or waiver that provides space clearly delineated for the designation. The insurer shall include the following language on the form for waiver of the right to name a designated recipient: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."
- D. At least once every two years, an insurer shall notify the insured of the right to change the person designated to receive notice in subsection (A). An insured may add, delete, or change a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and home address for the new designated recipient or the designated recipient to be deleted.

- E. If the insured pays premiums for the long-term care insurance policy or certificate through a payroll or pension deduction plan, the insurer is not required to comply with the requirements in subsections (A) through (D) until 60 days after the insured is no longer on the payment plan.
- F. An individual long-term care insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer gives the insured and any recipient designated under subsections (A) through (D) written notice at least 30 days before the effective date of termination or lapse, by first class mail, postage prepaid, at the address provided by the insured for purposes of receiving notice of lapse or termination. An insurer shall not give notice until 30 days after the date on which a premium is due and unpaid. Notice is deemed given five days after the date of mailing.
- G. Reinstatement. In addition to the requirement in subsections (A) through (D), a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage in the event of a lapse if the insurer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy or certificate. Reinstatement after termination for other than unintentional lapse shall be governed by A.R.S. § 20-1348.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1005 recodified from R4-14-1005 (Supp. 95-1). Section

R20-6-1005 renumbered to R20-6-1006; new Section R20-6-1005 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1006. Inflation Protection**

- A. An insurer shall not offer a long-term care insurance policy unless the insurer offers to the policyholder, at the time of purchase, in addition to any other inflation protection, the option to purchase a policy with an inflation protection provision that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. The terms of the required provision shall be no less favorable than one of the following:
  1. A provision that provides for annual increases in benefit levels compounding annually at a rate of not less than 5%;
  2. A provision that guarantees an insured the right to periodically increase benefit levels without providing evidence of insurability or health status, if the insured did not decline the option for the previous period. The increased benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning from the purchase of the existing benefit and extending until the year in which the offer is made; or

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3. A provision for coverage of a specified percentage of actual or reasonable charges that is not subject to a maximum specified indemnity amount or limit.
  - B. If the policy is issued to a group, the insurer shall extend the offer required by subsection (A) to the group policyholder; except, if the policy is issued under A.R.S. § 20-1691.04(C) to a group, other than to a continuing care retirement community, the insurer shall make the offer to each proposed certificate-holder.
  - C. An insurer is not required to make the offer in subsection (A) for life insurance policies or riders with accelerated long-term care benefits.
  - D. An insurer shall include the information listed in this subsection in or with the outline of coverage.
    1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
    2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall provide a revised schedule of attained-age premiums. An insurer may use a reasonable hypothetical or a graphic demonstration for this disclosure.
  - E. Inflation-protection benefit increases shall continue without regard to an insured's age, claim status, claim history, or length of time the person has been insured under the policy.
  - F. An insurer's offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The insurer shall disclose in the offer in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.
  - G. An insurer shall include in a long-term care insurance policy inflation protection as provided in subsection (A)(1) unless the insurer obtains a rejection of inflation protection signed by the insured as required in subsection (H). The rejection may be either on the application form or on a separate form.
  - H. A rejection of inflation protection is deemed part of an application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I reviewed Plans [insert description of plans], and I reject inflation protection."
- tance by the individual insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall require the signed written agreement of the insured unless the increased benefits or coverage are required by law. If the insurer charges a separate additional premium for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.
- B. Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall define the terms and explain them in its accompanying outline of coverage.
  - C. Disclosure of tax consequences. For life insurance policies that provide an accelerated benefit for long-term care, an insurer shall provide a disclosure statement at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.
  - D. Benefit triggers. A long-term care insurance policy shall use activities of daily living and cognitive impairment to measure an insured's need for long-term care. The long-term care insurance policy shall describe these terms and provisions in a separate paragraph in the policy labeled "Eligibility for the Payment of Benefits" that includes and explains:
    1. Any additional benefit triggers,
    2. Benefit triggers that result in payment of different benefit levels, and
    3. Any requirement that an attending physician or other specified person certify a certain level of functional dependency for the insured to be eligible for benefits.
  - E. A long-term care insurance contract shall contain a disclosure statement in the policy and in the outline of coverage indicating whether it is intended to be a qualified long-term care insurance contract as specified in the outline of coverage in Appendix J, paragraph 3. The contract shall also include a Specification Page which shall include the benefits, amounts, durations, the premium rate including all optional benefits selected by the insured, and any other benefit data applicable to the insured.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1006 recodified from R4-14-1006 (Supp. 95-1). R20-6-1006 renumbered to R20-6-1007; new Section R20-5-1006 renumbered from R20-6-1005 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1007. Required Disclosure Provisions**

- A. Riders and endorsements. Except for riders or endorsements by which an insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, if an insurer adds a rider or endorsement to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy, the insurer shall require signed accep-

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1007 recodified from R4-14-1007 (Supp. 95-1). Former Section R20-6-1007 renumbered to R20-6-1010; new Section R20-6-1007 renumbered from R20-6-1006 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1008. Required Disclosure of Rating Practices to Consumers**

- A. This Section applies as follows:
  1. Except as provided in subsection (A)(2), this Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005.
  2. For certificates issued under an in-force, long-term care insurance policy issued to a group as defined in A.R.S. §

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20-1691(5)(a), the provisions of this Section apply on the first policy anniversary that occurs on or after November 10, 2005.

- B.** Unless a policy is one for which an insurer cannot increase the applicable premium rate or rate schedule, the insurer shall provide the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the insurer shall provide the information to the applicant no later than at the time of delivery of the policy or certificate.
1. A statement that the policy may be subject to rate increases in the future.
  2. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option if a premium rate revision occurs.
  3. The premium rate or rate schedules applicable to the applicant that will be in effect until the insurer makes a request for an increase.
  4. A general explanation for applying premium rate or rate schedule adjustments that includes:
    - a. A description of when premium rate or rate-schedule adjustments will be effective (e.g., next anniversary date, next billing date); and
    - b. The insurer's right to a revised premium rate or rate schedule as provided in subsection (B)(3) if the premium rate or rate schedule is changed.
  5. Information regarding each premium rate increase on this policy form or similar policy form over the past 10 years for this state or any other state that, at a minimum, identifies:
    - a. The policy forms for which premium rates have been increased;
    - b. The calendar years when the form was available for purchase; and
    - c. The amount or percent of each increase, which may be expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.
  6. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required under subsection (B)(5).
- C.** An insurer may exclude from the disclosure required under subsection (B)(5), premium rate increases applicable to:
1. Blocks of business acquired from other nonaffiliated insurers, and
  2. Policies acquired from other nonaffiliated insurers if the increases occurred before the acquisition.
- D.** If an acquiring insurer files for a rate increase on a long-term care insurance policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the January 10, 2005, or the end of a 24-month period following the acquisition of the policies or block of policies, the acquiring insurer may exclude that rate increase from the disclosure required under subsection (B)(5). However, the nonaffiliated insurer that sells the policy form or a block of policy forms shall include that rate increase in the disclosure required under subsection (B)(5). If the acquiring insurer files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection (B)(5), including disclosure of the earlier rate increase.

- E.** Unless the method of application does not allow an insured to sign an acknowledgement that the insurer made the disclosures required under subsection (B) at the time of application, the applicant shall sign an acknowledgement of disclosure at that time. Otherwise, the applicant shall sign a disclosure acknowledgement no later than at the time of delivery of the policy or certificate.
- F.** An insurer shall use the forms in Appendix A and Appendix B to comply with the requirements of subsections (B) through (E). The text and format of an insurer's forms shall be substantially similar to the text and format of Appendices A and B.
- G.** An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days before the effective date of the increase. The notice shall include the information required by subsection (B).

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1008 recodified from R4-14-1008 (Supp. 95-1). Former Section R20-6-1008 renumbered to R20-6-1011; new Section R20-6-1008 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1009. Initial Filing Requirements**

- A.** This Section applies to any long-term care policy issued in this state on or after May 10, 2005.
- B.** At the time of making a filing under A.R.S. § 20-1691.08, an insurer shall provide to the Director a copy of the disclosure documents required under R20-6-1008 and an actuarial certification that includes the following:
1. The initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
  2. The policy design and coverage provided have been reviewed and taken into consideration;
  3. The underwriting and claims adjudication processes have been reviewed and taken into consideration;
  4. The premiums contain at least the minimum margin for moderately adverse experience as defined in subsection (4)(a) or the specification of and justification for a lower margin as required by subsection (4)(b).
    - a. A composite margin shall not be less than 10% of lifetime claims.
    - b. A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.
    - c. A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.
    - d. A greater margin may be appropriate in circumstances where the company has less credible experi-

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ence to support its assumptions used to determine the premium rates.

5. A statement that the premium rate schedule:
  - a. Is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits, or
  - b. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences; and
6. A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
  - a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
  - b. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.
- C. An actuarial memorandum shall be included that is signed by a member of the Academy of Actuaries and that addresses and supports each specific item required as part of the actuarial certification and provides at least the following:
  1. An explanation of the review performed by the actuary prior to making the statements in subsections (B)(2) and (B)(3);
  2. A complete description of pricing assumptions;
  3. Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in subsection (B)(1) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. The actuary shall clearly describe deviations in margins between ages, sexes, plans or states. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales; and
  4. A demonstration that the gross premiums include the minimum composite margin specified in subsection (B)(4).
- D. In any review of the actuarial certification and actuarial memorandum, the Director may request review by an actuary with experience in long-term care pricing who is independent of the insurer. In the event the Director asks for additional information as a result of any review, the period in A.R.S. § 20-1691.08 does not include the period during which the insurer is preparing the requested information.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1009 recodified from R4-14-1009 (Supp. 95-1). Section R20-6-1009 renumbered to R20-6-1012; new Section R20-6-1009 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1010. Requirements for Application Forms and Replacement Coverage; Prohibition Against Preexisting Condi-****tions and Probationary Periods in Replacement Policies or Certificates; Reporting Requirements**

- A. An insurer's application form for a long-term care insurance policy shall include the questions listed in this Section to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other health or long-term care policy or certificate presently in force. An insurer may include the questions in a supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer. For a replacement policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the insurer may modify the questions only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced if the certificateholder has been notified of the replacement.
  1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
  2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?
    - a. If so, with which company?
    - b. If that policy lapsed, when did it lapse?
  3. Are you covered by Medicaid?
  4. Do you intend to replace any of your medical or health insurance coverage with this policy or certificate?
- B. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan the applicant selects.
- C. An insurance producer shall list any other health insurance policies the insurance producer has sold to the applicant, including:
  1. Policies that are still in force, and
  2. Policies sold in the past five years that are no longer in force.
- D. Solicitations Other than Direct Response. On determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer; shall furnish the applicant, before issuing or delivering the individual long-term care insurance policy, a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage. The insurer shall:
  1. Give one copy of the notice to the applicant, and
  2. Keep an additional copy signed by the applicant.
- E. Direct Response Solicitations. Insurers using direct response solicitation methods as defined in A.R.S. § 20-1661 shall deliver a notice that substantially conforms to the form prescribed in Appendix C or D regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy.
- F. If replacement is intended, the replacing insurer shall send the existing insurer written notice of the proposed replacement within five working days from the date the replacing insurer receives the application or issues the policy, whichever is sooner. The notice shall identify the existing policy by name of the insurer and the insured, and policy number or insured's address including zip code.
- G. A life insurance policy that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply

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with the replacement requirements of Title 20, Chapter 6, Article 1.1. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with the requirements of this Section and with A.R.S. Title 20, Chapter 6, Article 1.1.

- H.** Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits if similar exclusions are satisfied under the original policy.
- I.** Reporting requirements.
  - 1. An insurer shall maintain the following records for each insurance producer:
    - a. The amount of the insurance producer's replacement sales as a percent of the insurance producer's total annual sales, and
    - b. The amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.
  - 2. No later than June 30 of each year, on the forms specified in Appendix E and Appendix F, an insurer shall report the following information for the preceding calendar year to the Department:
    - a. The 10% of its insurance producers licensed in Arizona with the greatest percentages of lapses and replacements as measured by subsection (I)(1);
    - b. The number of lapsed policies as a percent of the total annual sales and as a percent of the insurer's total number of policies in force as of the end of the preceding calendar year;
    - c. The number of replacement policies sold as a percent of the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year; and
    - d. For qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.
- J.** In subsection (I):
  - 1. "Claim" means a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.
  - 2. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.
  - 3. "Policy" means only long-term care insurance.
  - 4. "Report" means on a statewide basis.
- K.** Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance. Reports required under this Section shall be filed with the Director.
- L.** Annual rate certification requirements. This subsection applies to any long-term care policy issued in Arizona on or after November 10, 2017. The following annual submission requirements apply subsequent to initial rate filings for individual long-term care insurance policies made under this Section:

- 1. An actuarial certification prepared, dated and signed by a member of the American Academy of Actuaries which contains a statement of the sufficiency of the current premium rate schedule, including:
  - a. For the rate schedules currently marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated or a statement that margins for moderately adverse experience may no longer be sufficient. For a statement that margins for moderately adverse experience may no longer be sufficient, the insurer shall provide to the Director, within 60 days of the date the actuarial certification is submitted to the Director, a plan of action, including a time frame, for the re-establishment of adequate margins for moderately adverse experience so that the ultimate premium rate schedule would be reasonably expected to be sustainable over the future life of the form with no future premium increases anticipated. Failure to submit a plan of action to the Director within 60 days or to comply with the time frame stated in the plan of action constitutes grounds for the Director to withdraw or modify approval of the form for future sales pursuant to A.R.S. § 20-1691.08.
  - b. For the rate schedules that are no longer marketed, that the premium rate schedule continues to be sufficient to cover anticipated costs under best estimate assumptions or that the premium rate schedule may no longer be sufficient. If the premium rate schedule is no longer sufficient, the insurer shall provide to the Director, within 60 days of the date the actuarial certification is submitted to the Director, a plan of action, including time frame, for the re-establishment of adequate margins for moderately adverse experience;
- 2. A description of the review performed that led to the statement; and
- 3. An actuarial memorandum dated and signed by a member of the American Academy of Actuaries who prepares the information shall be prepared to support the actuarial certification and provide at least the following information:
  - a. A detailed explanation of the data sources and review performed by the actuary prior to making the statement in subsection (L)(1),
  - b. A complete description of experience assumptions and their relationship to the initial pricing assumptions,
  - c. A description of the credibility of the experience data, and
  - d. An explanation of the analysis and testing performed in determining the current presence of margins.
- 4. The actuarial certification required pursuant to subsection (L)(1) must be based on calendar year data and submitted annually starting in the second year following the year in which the initial rate schedules are first used. The actuarial memorandum required pursuant to subsection (L)(3) must be submitted at least once every three years with the certification.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1010 recodified from R4-14-1010 (Supp. 95-1). R20-6-

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1010 renumbered to R20-6-1013; new Section R20-6-1010 renumbered from R20-6-1007 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1011. Prohibition Against Post-claims Underwriting**

A. An application for a long-term care insurance policy or certificate that is not guaranteed issue shall meet the requirements of this Section.

1. The application shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.
  - a. If the application has a question asking whether the applicant has had medication prescribed by a physician, the application shall also ask the applicant to list the prescribed medication.
  - b. If the insurer knew or reasonably should have known that the medications listed in the application are related to a medical condition for which coverage would otherwise be denied, the insurer shall not rescind the policy or certificate for that condition.
2. The application shall include the following language which shall be set out conspicuously and in close conjunction with the applicant's signature block: **"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."**
3. The policy or certificate shall contain, at the time of delivery, the following language, or language substantially similar to the following, set out conspicuously: **"Caution: The issuance of this long-term care insurance [policy] [certificate] is based on your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]."**

B. Before issuing a long-term care insurance policy or certificate that is not guaranteed issue to an applicant age 80 or older, the insurer shall obtain one of the following:

1. A report of a physical examination,
2. An assessment of functional capacity,
3. An attending physician's statement, or
4. Copies of medical records.

C. The insurer or its insurance producer shall deliver a copy of the completed application or enrollment form, as applicable, to the insured no later than at the time of delivery of the policy or certificate unless the insurer gave a copy to the applicant it at the time of application.

D. An insurer selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and country-wide, except those which the insured voluntarily effectuated.

E. On or before March 31 of each year, an insurer shall report the following information to the Director for the preceding calendar year, using the form prescribed in Appendix G:

1. Insurer name, address, phone number;
2. As to each rescission except those voluntarily effectuated by the insured:
  - a. Policy form number,

- b. Policy and certificate number,
  - c. Name of the insured,
  - d. Date of policy issuance,
  - e. Date claim submitted,
  - f. Date of rescission, and
  - g. Detailed reason for rescission; and
3. Signature, name and title of the preparer, and date prepared.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1011 recodified from R4-14-1011 (Supp. 95-1). R20-6-1011 renumbered to R20-6-1014; new Section R20-6-1011 renumbered from R20-6-1008 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1012. Reserve Standards**

A. If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders, an insurer shall determine policy reserves for long-time care benefits under A.R.S. § 20-510. An insurer shall also establish claim reserves for a policy or rider in claim status.

B. An insurer shall base reserves for policies and riders under subsection (A) on the multiple decrement model using all relevant decrements except for voluntary termination rates. An insurer may use single decrement approximations if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The insurer, when calculating reserves, may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. The insurer shall not set the reserves for the long-term care benefit and the life insurance benefit to be less than the reserves for the life insurance benefit assuming no long-term care benefit.

C. In the development and calculation of reserves for policies and riders subject to this Section, an insurer shall give due regard to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which impact projected claim costs including the following:

1. Definition of insured events,
2. Covered long-term care facilities,
3. Existence of home convalescence care coverage,
4. Definition of facilities,
5. Existence or absence of barriers to eligibility,
6. Premium waiver provision,
7. Renewability,
8. Ability to raise premiums,
9. Marketing method,
10. Underwriting procedures,
11. Claims adjustment procedures,
12. Waiting period,
13. Maximum benefit,
14. Availability of eligible facilities,
15. Margins in claim costs,
16. Optional nature of benefit,
17. Delay in eligibility for benefit,
18. Inflation protection provisions,
19. Guaranteed insurability option, and
20. Other similar or comparable factors affecting risk.

D. A member of the American Academy of Actuaries shall certify an insurer's use of any applicable valuation morbidity table as appropriate as a statutory valuation table.

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- E. When long-term care benefits are provided other than as described in subsection (A), an insurer shall determine reserves under A.R.S. § 20-508.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1012 recodified from R4-14-1012 (Supp. 95-1). R20-6-1012 renumbered to R20-6-1016; new Section R20-6-1012 renumbered from R20-6-1009 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section repealed; new Section renumbered from R20-6-1013 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1013. Loss Ratio**

- A. This Section applies to policies and certificates issued any time prior to May 10, 2005.
- B. Benefits under an individual long-term care insurance policy are deemed reasonable in relation to premiums if the expected loss ratio is at least 60% calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, the director shall consider all relevant factors, including:
1. Statistical credibility of incurred claims experience and earned premiums;
  2. The period for which rates are computed to provide coverage;
  3. Experienced and projected trends;
  4. Concentration of experience within early policy duration;
  5. Expected claim fluctuation;
  6. Experience refunds, adjustments, or dividends;
  7. Renewability features;
  8. All appropriate expense factors;
  9. Interest;
  10. Experimental nature of the coverage;
  11. Policy reserves;
  12. Mix of business by risk classification; and
  13. Product features such as long elimination periods, high deductibles, and high maximum limits.
- C. A premium rate schedule or proposed revision to a premium rate schedule that is expected to produce, over the lifetime of the long-term care insurance policy, benefits that are less than 60% of the proposed premium rate schedule is deemed to be unreasonable.
- D. Subsections (B) and (C) do not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is deemed to provide reasonable benefits in relation to premiums paid if the policy complies with all of the following:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
  2. The portion of the policy that provides life insurance benefits complies with the nonforfeiture requirements of A.R.S. § 20-1231;
  3. The policy complies with the disclosure requirements of A.R.S. § 20-1691.06(A) through (E);
  4. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes the following information:

- a. A description of the basis on which the long-term care rates were determined;
- b. A description of the basis for the reserves;
- c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
- d. A description and a table of each actuarial assumption used; for expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;
- e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- f. The estimated average annual premium per policy and the average issue age;
- g. A statement as to whether underwriting is performed, including:
  - i. Time of underwriting;
  - ii. A description of the type of underwriting used, such as medical underwriting or functional assessment underwriting; and
  - iii. For a group policy, whether an enrollee's dependents are subject to underwriting; and
- h. A description of the effect of the long-term care policy provisions on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1013 recodified from R4-14-1013 (Supp. 95-1). Section R20-6-1013 renumbered to R20-6-1017; new Section R20-6-1013 renumbered from R20-6-1010 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1013 renumbered to R20-6-1012; new Section R20-6-1013 renumbered from R20-6-1014 and amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1014. Premium Rate Schedule Increase**

- A. This Section applies to any long-term care policy or certificate issued in this state on or after May 10, 2005 and prior to November 10, 2017.
- B. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 60 days before issuing notice to its policyholders. The notice to the Director shall include:
1. Information required by R20-6-1008;
  2. Certification by a qualified actuary that:
    - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
    - b. The premium rate filing complies with the provisions of this Section; and
    - c. The insurer may request a premium rate schedule increase less than what is required under this Section and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification



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- required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.
3. An actuarial memorandum justifying the rate schedule change request that includes:
    - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
      - i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
      - ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;
      - iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase; and
      - iv. A demonstration of compliance with subsection (C).
    - b. For exceptional increases, the actuarial memorandum shall also include:
      - i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
      - ii. If the Director determines under Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;
    - c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
    - d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
    - e. A statement that the actuary has considered policy design, underwriting, and claims adjudication practices;
    - f. Composite rates reflecting projections of new certificates in the event it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase; and
    - g. A demonstration that actual and projected costs exceed costs anticipated at the time of the initial pricing under moderately adverse experience and that the composite margin specified in R20-6-1009(B)(4) is projected to be exhausted;
  4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
  5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.
- C. All premium rate schedule increases shall be determined in accordance with the following requirements:
1. The insurer shall return 70% of the present value of projected additional premiums from an exceptional increase to policyholders in benefits;
  2. The sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, shall not be less than the sum of the following:
    - a. The accumulated value of the initial earned premium times 58%;
    - b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
    - c. The present value of future projected initial earned premiums times 58%; and
    - d. 85% of the present value of future projected premiums not in subsection (C)(2)(c) on an earned basis;
  3. If a policy form has both exceptional and other increases, the values in subsections (C)(2)(b) and (C)(2)(d) shall also include 70% for exceptional rate increase amounts; and
  4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Accounting Practices and Procedures Manual to which insurers are subject under A.R.S. § 20-223. The actuary shall disclose the use of any appropriate averages in the actuarial memorandum required under subsection (B)(3).
- D. For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (B)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder in lieu of filing with the Director.
- E. If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in subsection (D). For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.
- F. If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (B)(3)(f), if applicable.
- G. If the majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:
1. A plan, subject to Director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in

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effect; otherwise the Director may impose the conditions in subsections (H) through (J); and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (C) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsections (C)(2)(a) and (C)(2)(c).
- H.** For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
1. The rate increase is not the first rate increase requested for the specific policy form or forms,
  2. The rate increase is not an exceptional increase, and
  3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.
- I.** If the Director finds excess lapsation under subsection (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The information communicating the offer is subject to the Director's approval. The offer shall:
1. Be based on actuarially sound principles, but not on attained age;
  2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
  3. Allow the insured the option of retaining the existing coverage.
- J.** The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (I) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:
1. The maximum rate increase determined based on the combined experience; and
  2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus 10%.
- K.** If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (H) through (J), prohibit the insurer from the following:
1. Filing and marketing comparable coverage for a period of up to five years, and
  2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- L.** Subsections (A) through (K) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as defined under R20-6-1002(C), if the policy complies with all of the following provisions:
1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
  2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
  3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
  4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
    - a. A.R.S. Title 20, Chapter 6, Article 1.2; and
    - b. A.R.S. Title 20, Chapter 16, Article 2;
  5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
    - a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
    - b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
    - c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
    - d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
    - e. The estimated average annual premium per policy and the average issue age;
    - f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
      - i. Whether underwriting is used, and if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
      - ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
    - g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.
- M.** Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:
1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
  2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1014 recodified from R4-14-1014 (Supp. 95-1). Section repealed; R20-6-1014 renumbered from R20-6-1011 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1014 renumbered to R20-6-1013; new Section R20-6-1014 renumbered from R20-6-1015 and amended by final

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exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1015. Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings**

- A.** This Section applies to any long-term care policy or certificate issued in this state on or after November 10, 2017.
- B.** An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 60 days before issuing notice to its policyholders. The notice to the Director shall include:
1. Information required by R20-6-1008;
  2. Certification by a qualified actuary that:
    - a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
    - b. The premium rate filing complies with the provisions of this Section; and
    - c. The insurer may request a premium rate schedule increase less than what is required under this Section and the Director may approve the premium rate schedule increase, without submission of the certification required by subsection (B)(2)(a), if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required by subsection (B)(2)(a), the premium rate schedule increase filing satisfies all other requirements of this Section, and is, in the opinion of the Director, in the best interest of the policyholders.
  3. An actuarial memorandum justifying the rate schedule change request that includes:
    - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
      - i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
      - ii. Annual values for the five years preceding and the three years following the valuation date, provided separately;
      - iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase; and
      - iv. A demonstration of compliance with subsection (C).
    - b. For exceptional increases, the actuarial memorandum shall also include:
      - i. The projected experience that is limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
      - ii. If the Director determines under Section R20-6-1002(B)(3) that offsets may exist, the insurer shall use appropriate net projected experience;
    - c. Disclosure of how reserves have been incorporated in this rate increase when the rate increase will trigger contingent benefit upon lapse;
    - d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
- C.** All premium rate schedule increases shall be determined in accordance with the following requirements:
1. Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
  2. The insurer shall calculate premium rate increases such that the sum of the lesser of either the accumulated value of the actual incurred claims (without the inclusion of active life reserves) or the accumulated value of historic expected claims (without the inclusion of active life reserves) plus the present value of the future expected incurred claims (projected without the inclusion of active life reserves) will not be less than the sum of the following:
    - a. The accumulated value of the initial earned premium times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience;
    - b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
    - c. The present value of future projected initial earned premiums times the greater of 58% or the lifetime loss ratio consistent with the original filing including margins for moderately adverse experience; and
    - d. 85% of the present value of future projected premiums not in subsection (C)(2)(c) on an earned basis;
  3. Historic expected claims shall be calculated based on the original filing assumptions assumed until new assumptions are filed as part of a rate increase. New assumptions shall be used for all periods beyond each requested effective date of a rate increase. Historic expected claims are calculated for each calendar year based on the in-force at the beginning of the calendar year. Historic expected claims shall include margins for moderately adverse experience; either amounts included in the claims that were used to determine the lifetime loss ratio consistent with the original filing or as modified in any rate increase filing;
  4. In the event that a policy form has both exceptional and other increases, the values in subsections (C)(2)(b) and (C)(2)(d) will also include 70% for exceptional rate increase amounts; and
- D.** A statement that the actuary has considered policy design, underwriting, and claims adjudication practices;
- E.** Composite rates reflecting projections of new certificates in the event it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase; and
- F.** A demonstration that actual and projected costs exceed costs anticipated at the time of the initial pricing under moderately adverse experience and that the composite margin specified in R20-6-1009(B)(4) is projected to be exhausted.

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5. All present and accumulated values used to determine rate increases, including the lifetime loss ratio consistent with the original filing reflecting margins for moderately adverse experience, shall use the maximum valuation interest rate for contract reserves as specified in A.R.S. § 20-508. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- D. For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (B)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the reporting period beyond three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (M), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Director.
- E. If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (B)(3)(a), for the Director's approval every five years following the end of the required period in subsection (D). For group insurance policies that meet the conditions in subsection (M), the insurer shall provide the projections required by this subsection to the policyholder instead of filing with the Director.
- F. If the Director finds that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (B)(3)(f), if applicable.
- G. If the majority of policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file a plan, subject to approval by the Director, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form experience requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. Otherwise, the Director may impose the conditions in subsections (H) through (J).
- H. For a rate increase filing that meets the criteria listed in this subsection, the Director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if lapsation in excess of projected lapsation has occurred or is anticipated:
  1. The rate increase is not the first rate increase requested for the specific policy form or forms;
  2. The rate increase is not an exceptional increase; and
  3. The majority of the policies or certificates to which the increase applies are eligible for the contingent benefit upon lapse.
- I. If the Director finds excess lapsation under subsection (H) has occurred, is anticipated in the filing or is evidenced in the actual results as presenting in the updated projections provided by the insurer following the requested rate increase, the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The information communicating the offer is subject to the Director's approval. The offer shall:
  1. Be based on actuarially sound principles, but not on attained age; and
  2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
  3. Allow the insured the option of retaining the existing coverage.
- J. The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (I) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:
  1. The maximum rate increase determined based on the combined experience; and
  2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus 10%.
- K. If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of policies with inadequate rates, the Director may, in addition to remedies available under subsections (H) through (J), prohibit the insurer from the following:
  1. Filing and marketing comparable coverage for a period of up to five years; and
  2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.
- L. Subsections (A) through (K) shall not apply to a policy for which long-term care benefits provided by the policy are incidental, as defined under R20-6-1002(C), if the policy complies with all of the following provisions:
  1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
  2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231, 20-1232 and 20-2636;
  3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
  4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
    - a. A.R.S. Title 20, Chapter 6, Article 1.2; and
    - b. A.R.S. Title 20, Chapter 16, Article 2.
  5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
    - a. Description of the bases on which the actuary determined the long-term care rates and the reserves;
    - b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
    - c. A description and a table of each actuarial assumption used, with the percent of premium dollars per

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- policy and dollars per unit of benefits, if any, for expenses;
- d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- e. The estimated average annual premium per policy and the average issue age;
- f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
  - i. Whether underwriting is used, and if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
  - ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- g. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

**M.** Subsections (F) and (H) through (J) shall not apply to group insurance as defined in A.R.S. § 20-1691(6) where:

1. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
2. The policyholder, and not the certificateholder, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1015 recodified from R4-14-1015 (Supp. 95-1). Section R20-6-1015 renumbered to R20-6-1022; new Section R20-6-1015 made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1015 renumbered to R20-6-1014; new Section R20-6-1015 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1016. Filing Requirements for Group Policies**

- A.** Out-of-State Policies. Before an insurer or similar organization may offer group long-term care insurance to a resident of this state under A.R.S. § 20-1691.02(D), the insurer or organization shall file with the Director evidence that a state with statutory or regulatory long-term care insurance requirements substantially similar to those of this state has approved the group policy or certificate for use in that state.
- B.** Associations. For long-term policies marketed or issued to associations, the insurer or organization shall file with the insurance department the policy, certificate, and corresponding outline of coverage.

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). R20-6-1016 recodified from R4-14-1016 (Supp. 95-1). Section R20-6-1016 renumbered to R20-6-1023; new Section R20-6-1016 renumbered from R20-6-1012 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

**R20-6-1017. Standards for Marketing**

- A.** Every insurer marketing long-term care insurance coverage in this state, directly or through an insurance producer shall:

1. Establish marketing procedures to assure that any comparison of policies by its insurance producers is fair and accurate, and that excessive insurance is not sold or issued;
2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following language: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations;"
3. Provide the applicant with copies of the disclosure forms in Appendices A and B;
4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance;
5. Provide an explanation of contingent benefit upon lapse as provided for in R20-6-1019(D)(3);
6. Provide written notice to an applicant or prospective policyholder or certificateholder advising of this state's senior insurance counseling program (SHIP), and the name, address, and phone number for the SHIP, at the time of solicitation; and
7. Establish auditable procedures for verifying compliance with this subsection (A).

**B.** In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
3. Cold lead advertising. Making use directly or indirectly or any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.
4. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

**C.** An insurer shall not market or issue a long-term care policy or certificate to an association unless the insurer files the information required under R20-6-1016(B) and annually certifies that the association has complied with the requirements of this Section.

**Historical Note**

New Section R20-5-1017 renumbered from R20-6-1013 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1018. Suitability**

- A.** This Section does not apply to life insurance policies that accelerate benefits for long-term care.

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- B.** Every insurer or other person marketing long-term care insurance, including an insurance producer or managing general agent, (the “issuer”) shall:
1. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant,
  2. Train its insurance producers in the use of its suitability standards, and
  3. Maintain a copy of its suitability standards and make them available for inspection upon the Director’s request.
- C.** To determine whether an applicant meets an issuer’s suitability standards, the insurance producer and issuer shall develop procedures that take the following into consideration:
1. The applicant’s ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
  2. The applicant’s goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
  3. The values, benefits, and costs of the applicant’s existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.
- D.** The issuer shall make reasonable efforts to obtain the information set out in subsection (C), including giving the applicant the “Long-Term Care Insurance Personal Worksheet” prescribed in Appendix A, to complete before or at the time of application. The issuer shall use a personal worksheet that contains, at a minimum, the information contained in Appendix A, in substantially the same text and format, in not less than 12 point type. The issuer may ask the applicant to provide additional information to comply with its suitability standards. An issuer shall file a copy of its personal worksheet with the Director.
- E.** An issuer shall not consider an applicant for coverage until the issuer has received the applicant’s completed personal worksheet, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.
- F.** No one shall sell or disseminate information obtained through the personal worksheet outside the issuer that obtains the worksheet.
- G.** The issuer shall use its suitability standards to determine whether issuance of long-term care insurance coverage to a particular applicant is appropriate.
- H.** An insurance producer shall use the suitability standards developed by the issuer in marketing long-term care insurance.
- I.** When giving an applicant a personal worksheet, the issuer shall also provide the applicant with a disclosure form entitled “Things You Should Know Before You Buy Long-Term Care Insurance.” The form shall be in substantially the same format and text contained in Appendix H, in not less than 12 point type.
- J.** If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter that is substantially similar to Appendix I. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant’s intent to purchase the long-term care policy. The issuer shall have either the applicant’s returned Appendix I letter or a record of the alternative method of verification as part of the applicant’s file.
- K.** The issuer shall report annually to the Director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter as prescribed in subsection (J).

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1019. Nonforfeiture Benefit Requirement**

- A.** This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B.** To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of A.R.S. § 20-1691.11, an insurer shall meet the following requirements:
1. A policy or certificate offered with nonforfeiture benefits shall have the same coverage elements, eligibility, benefit triggers and benefit length as a policy or certificate issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (E); and
  2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.
- C.** If the offer required to be made under A.R.S. § 20-1691.11 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if the non-forfeiture benefit offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subsection (D)(4) shall still apply.
- D.** Contingent Benefit Upon Lapse.
1. If a prospective policyholder rejects the offer of a nonforfeiture benefit, the insurer shall provide the contingent benefit upon lapse described in this Section for individual and group policies without the nonforfeiture benefit, issued after January 10, 2005.
  2. If a group policyholder elects to make the nonforfeiture benefit an option to a certificateholder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.
  3. The contingent benefit on lapse is triggered when:
    - a. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured’s initial annual premium set forth in the chart below, based on the insured’s issue age; and
    - b. The policy or certificate lapses within 120 days of the due date of the increased premium.
    - c. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%

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45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

4. A contingent benefit on lapse is also triggered for policies with a fixed or limited premium paying period when:
- An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
  - The policy or certificate lapses within 120 days of the due date of the increased premium; and
  - The ratio in subsection (D)(6)(b) is 40% or more.
  - Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase on policies with a fixed or limited premium paying period	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%

65-80	30%
Over 80	10%

- This provision shall be in addition to the contingent benefit provided by subsection (D)(3) and where both are triggered, the benefit provided shall be at the option of the insured.
5. On or before the effective date of a substantial premium increase as defined in subsection (D)(3), an insurer shall:
- Offer the insured the option of reducing policy benefits under the current coverage consistent with the requirements of R20-6-1025 so that required premium payments are not increased;
  - Offer to convert the coverage to a paid-up status with a shortened benefit period according to the terms of subsection (E), which the insured may elect at any time during the 120-day period referenced in subsection (D)(3); and
  - Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (D)(3) is deemed to be the election of the offer to convert under subsection (5)(b) unless the automatic option in subsection (D)(6)(c) applies.
6. On or before the effective date of a substantial premium increase on policies with a fixed or limited premium paying period as defined in subsection (D)(4), an insurer shall:
- Offer the insured the option of reducing policy benefits under the current coverage consistent with the requirements of R20-6-1025 so that required premium payments are not increased;
  - Offer to convert the coverage to paid-up status where the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. The insured may elect this option at any time during the 120-day period referenced in subsection (D)(4); and
  - Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (D)(4) is deemed to be the election of the offer to convert under subsection (D)(6)(b) if the ratio is 40% or more.
7. For any long-term care policy issued on or after November 10, 2017, that an insurer issued at least 20 years prior to the effective date of a substantial premium increase, the insurer shall use a rate increase value of 0% in place of all values in the above tables.
- E. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (D)(3) but not subsection (D)(4), mean any of the following:
- Attained age rating is defined as a schedule of premiums starting from the issue date that increases age at least 1% per year before age 50, and at least 3% per year beyond age 50.
  - For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or

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days of benefits shall be determined as specified in subsection (E)(3).

3. The standard nonforfeiture credit equals 100% of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. The minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (F).
  4. When the nonforfeiture benefit begins.
    - a. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years, and thereafter.
    - b. Notwithstanding subsection (E)(4)(a), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
      - i. The end of the tenth year following the policy or certificate issue date, or
      - ii. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
  5. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.
- F.** All benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status shall not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.
- G.** There shall be no difference in the minimum nonforfeiture benefits for group and individual policies.
- H.** The requirements in this Section are effective on or after November 10, 2005 and shall apply as follows:
1. Except as provided in subsection (H)(2) and (H)(3), this Section applies to any long-term care policy issued in this state on or after January 10, 2005.
  2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a group long-term care insurance policy as defined in A.R.S. § 20-1691(5)(a), that was in force on January 10, 2005.
  3. The provisions of this Section that apply to fixed or limited premium paying period policies shall only apply to policies issued on or after November 10, 2017.
- I.** Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of R20-6-1013, R20-6-1014 or R20-6-1015, whichever is applicable, treating the policy as a whole.
- J.** To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (D)(3) or (D)(4), a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium the insured paid when first buying the policy from the original insurer.
- K.** An insurer shall offer a nonforfeiture benefit for a qualified long-term care insurance contract that is a level premium contract and the benefit shall meet the following requirements:

1. The nonforfeiture provision shall be separately captioned using the term "nonforfeiture benefit" or a substantially similar caption;
2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the insurer may adjust the amount of the benefit initially granted only as needed to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Director under to A.R.S. § 20-1691.08 for the same contract form; and
3. The nonforfeiture provision shall provide at least one of the following:
  - a. Reduced paid-up premiums,
  - b. Extended term insurance,
  - c. Shortened benefit period, or
  - d. Other similar offerings that the Director has approved.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1020. Standards for Benefit Triggers**

- A.** A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Except as otherwise provided in R20-6-1021, eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.
- B.** Activities of daily living shall include at least the following as defined in R20-6-1003(A)(1) and in the policy:
1. Bathing,
  2. Continence,
  3. Dressing,
  4. Eating,
  5. Toileting, and
  6. Transferring.
- C.** An insurer may use additional activities of daily living to trigger covered benefits if the activities are defined in the policy.
- D.** An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections (A), (B) and (C).
- E.** For purposes of this Section the determination of a deficiency shall not be more restrictive than:
1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
  2. If the deficiency is due to the presence of a cognitive impairment, requiring supervision or verbal cueing by another person to protect the insured or others.
- F.** Licensed or certified professionals, such as physicians, nurses or social workers, shall perform assessments of activities of daily living and cognitive impairment.
- G.** The requirements in this Section are effective on and after November 10, 2005 and shall apply as follows:
1. Except as provided in subsection (G)(2), the provisions of this Section apply to a long-term care policy issued in this state on or after January 10, 2005.
  2. The provisions of this Section do not apply to certificates issued on or after January 10, 2005, under a long-term



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care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), which policy was in force on January 10, 2005.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-term Care Insurance Contracts**

- A. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided under a plan of care prescribed by a licensed health care practitioner, which is not subject to approval or modification by the insurer.
- B. A qualified long-term care insurance contract shall condition the payment of benefits on a certified determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.
- C. Licensed health care practitioners shall perform the certified determinations regarding activities of daily living and cognitive impairment required under subsection (B).
- D. Certified determinations required under subsection (B) may be performed at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certified determination may not be rescinded and additional certified determinations may not be performed until after the expiration of the 90-day period.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1022. Standard Format Outline of Coverage**

- A. The outline of coverage prescribed in A.R.S. § 20-1691.06 shall be a free-standing document, using no smaller than 10 point type, and shall contain no advertising or promotional material.
- B. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that give prominence equivalent to capitalization or underscoring.
- C. An insurer shall use the text and sequence of text in the standard format outline of coverage prescribed in Appendix J, unless otherwise specifically indicated.

**Historical Note**

New Section R20-6-1022 renumbered from R20-6-1015 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

**R20-6-1023. Requirement to Deliver Shopper's Guide**

- A. All prospective applicants of a long-term care insurance policy or certificate shall receive a long-term care insurance shopper's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners.

1. In the case of insurance producer solicitation, an insurance producer shall deliver the shopper's guide before presenting an application or enrollment form.
  2. In the case of direct response solicitations, the insurer shall provide the shopper's guide with any application or enrollment form.
- B. A prospective applicant for a life insurance policy or rider containing accelerated long-term care benefits is not required to receive the guide described in subsection (A), but shall receive the policy summary required under A.R.S. § 20-1691.06.

**Historical Note**

New Section R20-6-1023 renumbered from R20-6-1016 and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1024. Availability of New Health Care Services or Providers**

- A. An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or health care providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months of the date the new policy series is made available for sale in this state.
- B. Notwithstanding subsection (A), notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.
- C. The insurer shall make the new coverage available in one of the following ways:
  1. By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;
  2. By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;
  3. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or
  4. By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the Director.
- D. An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general

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public. Policyholders who purchased such a new proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

- E. Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to R20-6-1010(A), (C) through (G) and R20-6-1018 and are not subject to the reporting requirements of R20-6-1010(I)(1), (I)(2)(a) through (I)(2)(c).
- F. Where an employer, labor organization, professional, trade or occupational association offers the policy, the required notification in subsection (A) shall be made to the offering entity. However, if the policy is issued to a group defined in A.R.S. § 20-1691(5), the notification shall be to each certificateholder.
- G. Nothing in this Section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium, to add such new services or providers.
- H. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- I. This Section shall become effective on or after November 10, 2017.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Section R20-6-1024 renumbered to R20-6-1026; new Section R20-6-1024 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1025. Right to Reduce Coverage and Lower Premiums**

- A. Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
  1. Reducing the maximum benefit; or
  2. Reducing the daily, weekly or monthly benefit amount.
- B. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.
- C. In the event the reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholder to continue the benefit amount in effect at the time of the reduction.

- D. The provision in subsection (A) shall include a description of the process for requesting and implementing a reduction in coverage.
- E. The premium for the reduced coverage shall:
  1. Be based on the same age and underwriting class used to determine the premium for the coverage currently in force, and
  2. Be consistent with the approved rate table.
- F. The issuer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.
- G. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by R20-6-1005(F).
- H. This Section does not apply to life insurance policies or riders containing accelerated long-term benefits.
- I. The requirements of subsections (A) through (H) shall apply to any long-term care policy issued in this state on or after November 10, 2017.
- J. A premium increase notice required by R20-6-1008(G) shall include:
  1. An offer to reduce policy benefits provided by the current coverage consistent with the requirements of this Section;
  2. A disclosure stating that all options available to the policyholder may not be of equal value; and
  3. In the case of a partnership policy, a disclosure that some benefit reduction options may result in a loss in partnership status that may reduce policyholder protections.
- K. The requirements of subsection (J) shall apply to any rate increase implemented in this state on or after November 10, 2017.

**Historical Note**

New Section R20-6-1025 made by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**R20-6-1026. Instructions for Appendices**

Information that is designated as a "Drafting Instruction" in a form appended to this Article is not required to be included as part of the form. Any person using the form shall abide by the instructions when drafting, preparing, or completing the form.

**Historical Note**

New Section R20-6-1026 renumbered from R20-6-1024 by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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## Appendix A. Long-term Care Insurance Personal Worksheet

Long-term Care Insurance  
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

## Premium Information

Policy Form Numbers \_\_\_\_\_

The premium for the coverage you are considering will be [\$ \_\_\_\_\_ per month, or \$ \_\_\_\_\_ per year,] [a one-time single premium of \$ \_\_\_\_\_.]

Type of Policy (noncancellable/guaranteed renewable): \_\_\_\_\_

## The Company's Right to Increase Premiums:

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

## Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

**(Drafting Instruction:** A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.)

## Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 50%?]

**(Drafting Instruction:** The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.)

What is your annual income? (check one) ☐ Under \$10,000 ☐ \$[10-20,000] ☐ \$[20-30,000] ☐ \$[30-50,000] ☐ Over \$50,000

**(Drafting Instruction:** The issuer may choose the numbers to put in the brackets to fit its suitability standards.)

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

*If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.*

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

*The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.*

**(Drafting Instruction:** The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.)

What elimination period are you considering? Number of days \_\_\_\_\_ Approximate cost \$ \_\_\_\_\_ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

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☐ From my Income      ☐ From my Savings/Investments      ☐ My Family will Pay

**Questions Related to Your Savings and Investments**

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under \$20,000      ☐ \$20,000-\$30,000      ☐ \$30,000-\$50,000      ☐ Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same      ☐ Increase      ☐ Decrease

*If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.*

**Disclosure Statement**

☐ The answers to the questions above describe my financial situation.

**or**

☐ I choose not to complete this information.

(Check one.)

☐ I acknowledge that the carrier and/or its insurance provider (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] **I understand the above disclosures. I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: \_\_\_\_\_

(Applicant)

(Date)

☐ I explained to the applicant the importance of completing this information.

Signed: \_\_\_\_\_

(Insurance Producer)

(Date)

Insurance Producer's Printed Name: \_\_\_\_\_]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My insurance provider has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: \_\_\_\_\_

(Applicant)

(Date)

**(Drafting Instruction:** Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.)

*The company may contact you to verify your answers.*

**(Drafting Instruction:** When the Long-term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the document may be removed.)

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix A renumbered to Appendix C; new Appendix A made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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**Appendix B. Long-term Care Insurance Potential Rate Increase Disclosure Form****Instructions:**

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

**Insurers shall provide all of the following information to the applicant:**

**Long-term Care Insurance  
Potential Rate Increase Disclosure Form**

- [Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][(\$\_\_\_\_\_)]
- The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**
- Rate Schedule Adjustments:**  
The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): \_\_\_\_\_.
- Potential Rate Revisions:**  
**This policy is Guaranteed Renewable.** This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

**If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:**

- ☐ Pay the increased premium and continue your policy in force as is.
- ☐ Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- ☐ Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- ☐ Exercise your contingent nonforfeiture rights.\* (This option may be available if you do not purchase a separate nonforfeiture option.)

**\*Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

**Example:**

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy.)

<b>Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That qualifies for Contingent Nonforfeiture</b>	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
<b>Issue Age</b>	<b>Percent Increase Over Initial Premium</b>
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%

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61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). Former Appendix B renumbered to Appendix D; new Appendix B made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2). Amended by final rulemaking at 29 A.A.R. 3621 (November 24, 2023), effective January 7, 2024 (Supp. 23-4). Effective date corrected (Supp. 23-4, Ver. 2).

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**Appendix C. Notice to Applicant Regarding Replacement of Individual Health or Long-term Care Insurance****NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL HEALTH OR LONG-TERM CARE INSURANCE**

[Insurance company's name and address]

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY [INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:  
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under your new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all of the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

\_\_\_\_\_  
(Signature of Insurance Producer or Other Representative)

\_\_\_\_\_  
(Typed Name and Address of Insurance Producer)

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Signature)

**Historical Note**

Adopted effective August 10, 1992 (Supp. 92-3). New Appendix C renumbered from Appendix A and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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## Appendix D. Notice to Applicant Regarding Replacement of Health or Long-term Care Insurance

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

## SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with the long-term care insurance policy being delivered and issued by [company name] Insurance Company. Your new policy gives you thirty (30) days to decide, without cost, whether you want to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, even though a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

**Historical Note**

New Appendix D renumbered from Appendix B and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).



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Appendix E. Long-Term Care Insurance Replacement and Lapse Reporting Form

**Long-term Care Insurance  
Replacement and Lapse Reporting Form**

For the State of \_\_\_\_\_  
For the Reporting Year of \_\_\_\_\_

Company Name: \_\_\_\_\_ Due: June 30 annually  
Company Address: \_\_\_\_\_ Company NAIC Number: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

**Instructions**

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Every insurer shall maintain the following records for each insurance producer: (1) the amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and (2) the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the 10% of the insurer's insurance producers with the greatest percentages of replacements and lapses.

**Listing of the 10% of Insurance Producers with the Greatest Percentage of Replacements**

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Replaced By This Insurance Producer	Number of Replacements as % of Number of Policies Sold By This Insurance Producer

**Listing of the 10% of Insurance Producers with the Greatest Percentage of Lapses**

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Lapsed By This Insurance Producer	Number of Lapses As % of Number Sold By This Insurance Producer

**Company Totals**

Percentage of Replacement Policies Sold to Total Annual Sales \_\_\_\_\_%  
Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) \_\_\_\_\_%  
Percentage of Lapsed Policies to Total Annual Sales \_\_\_\_\_%  
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) \_\_\_\_\_%

**Historical Note**

New Appendix E made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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## Appendix F. Long-term Care Insurance Claims Denial Reporting Form

Long-term Care Insurance  
Claims Denial Reporting FormFor the State of \_\_\_\_\_  
For the Reporting Year of \_\_\_\_\_Company Name: \_\_\_\_\_ Due: June 30 annually  
Company Address: \_\_\_\_\_Company NAIC Number: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Line of Business: Individual Group**Instructions**

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

- ☐ Per Claimant - counts each individual who makes one or a series of claim requests  
☐ Per Transaction - counts each claim payment request

“Denied” means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

**Inforce Data**

	State Data	Nationwide Data <sup>1</sup>
Total Number of Inforce Policies [Certificates] as of December 31st		

**Claims & Denial Data**

	State Data	Nationwide Data <sup>1</sup>
1 Total Number of Long-Term Care Claims Reported		
2 Total Number of Long-Term Care Claims Denied/Not Paid		
3 Number of Claims Not Paid due to Preexisting Condition Exclusion		
4 Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5 Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6 Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7 Number of Long-Term Care Claim Denied due to:		
8 • Long-Term Care Services Not Covered under the Policy <sup>2</sup>		
9 • Provider/Facility Not Qualified under the Policy <sup>3</sup>		
10 • Benefit Eligibility Criteria Not Met <sup>4</sup>		
11 • Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

**Historical Note**

New Appendix F made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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Appendix G. Rescission Reporting Form for Long-term Policies

RESCISSION REPORTING FORM FOR  
LONG-TERM CARE POLICIES

FOR THE STATE OF \_\_\_\_\_  
FOR THE REPORTING YEAR \_\_\_\_\_

Company Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Due: March 1 annually

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Name and Title (please type) \_\_\_\_\_

Date \_\_\_\_\_

**Historical Note**

New Appendix G made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4).

## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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## Appendix H. Things You Should Know Before You Buy Long-term Care Insurance

**Things You Should Know Before You Buy  
Long-term Care Insurance**

**Long-Term  
Care  
Insurance**

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- **[WARNING!]** You should **not** buy this insurance policy unless you can afford to pay the premiums every year. You are making a multi-year financial commitment.] [Remember that the company can increase premiums in the future.]

**(Drafting Instruction:** For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.)

**Medicare  
Medicaid**

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare does **not** pay for most long-term care.
- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

**Shopper's  
Guide**

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

**Counseling**

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

**Facilities**

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

**Historical Note**

New Appendix H made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

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**Appendix I. Long-term Care Insurance Suitability Letter****Long-term Care Insurance Suitability Letter**

Dear [Applicant]:

Your recent application for long-term care insurance included a “personal worksheet,” which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet “Shopper’s Guide to Long-Term Care Insurance” and the page titled “Things You Should Know Before Buying Long-Term Care Insurance.” Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

**(Drafting Instruction:** Choose the paragraph that applies.)

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

*Please check one box and return in the enclosed envelope.*

- ☐ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

**Drafting Instruction:** Delete the phrase in brackets if the applicant did not answer the questions about income.

- ☐ **No**. I have decided not to buy a policy at this time.

\_\_\_\_\_  
APPLICANT’S SIGNATURE

\_\_\_\_\_  
DATE

*Please return to [issuer] at [address] by [date].*

**Historical Note**

New Appendix I made by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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## Appendix J. Long-term Care Insurance Outline of Coverage

[COMPANY NAME]  
 [ADDRESS - CITY & STATE]  
 [TELEPHONE NUMBER]  
 LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE  
 [Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, shall appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].
2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!
3. FEDERAL TAX CONSEQUENCES  
 This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED
  - (a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:
    - (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.
    - (2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.
  - (b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]
  - (c) [Describe waiver of premium provisions or state that there are not such provisions;]
5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.  
 [In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]
6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.
  - (a) [Provide a brief description of the right to return - "free look" provision of the policy.]
  - (b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]
7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.
  - (a) [For insurance producers] Neither [insert company name] nor its [agents or insurance producers] represent Medicare, the federal government or any state government.
  - (b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.
8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute-care unit of a hospital, such as in a nursing home, in the community or in the home.  
 This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]
9. BENEFITS PROVIDED BY THIS POLICY.
  - (a) [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]
  - (b) [Institutional benefits, by skill level.]

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(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be defined and described as part of the outline of coverage.]

[Any additional benefit triggers shall be explained in this Section. If these triggers differ for different benefits, explanation of the triggers shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities and providers;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This Section shall provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6 above.]

**THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.**

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

**Historical Note**

New Appendix J renumbered from Appendix C and amended by final rulemaking at 10 A.A.R. 4661, effective January 3, 2005 (Supp. 04-4). Amended by final exempt rulemaking at 23 A.A.R. 1119, effective November 10, 2017 (Supp. 17-2).

**ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE**

**R20-6-1101. Incorporation by Reference and Modifications**

A. The Department incorporates by reference the Model Regulation to Implement the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act, Fall 2023 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 100 N. 15th Ave., Suite 261, Phoenix, AZ 85007-2630 and available on its website at: <https://difi.az.gov/insurance-division-rulemaking>. The Model Regulation is also available from the National Association of Insurance Commissioners, Publications Department, 1100 Walnut Street, Suite 1500, Kansas City, MO 64106-2197.

B. The Model Regulation is modified as follows:

1. In addition to the terms defined in the Model Regulation, the following definitions apply:

a. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).

b. "Commissioner" means the Director of the Arizona Department of Insurance and Financial Institutions.

c. "HMO" and "health maintenance organization" mean a health care services organization as defined in A.R.S. § 20-1051(6).

d. "Regulation" means Article.

2. Section 3(A)(2) reads:

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state including association plans.

3. Section 8(A)(7)(c) reads:

c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss of the group health plan and pays the premium attributable to the supplemental policy period, effective as of the date of termination of enrollment in the group health plan.

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4. Section 8.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.

5. Section 8.1(A)(7)(c) is revised to read as follows:

Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

6. Section 9.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.

7. Section 9.2 is revised to insert the citation to A.R.S. § 20-1133 as follows:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued

to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of A.R.S. § 20-1133.

8. Section 15(G) is revised as follows:

An insurer shall not file or request approval of a rate structure for its Medicare supplement policies or certificates based upon attained-age rating as a structure or methodology.

9. Section 23 is revised as follows:

- A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.
- B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

**Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1101 recodified from R4-14-1101 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3). Amended by final rulemaking at 15 A.A.R. 996, effective June 2, 2009 (Supp. 09-2). Amended by final rulemaking at 25 A.A.R. 1923, effective September 8, 2019 (Supp. 19-3). Amended by final rulemaking at 30 A.A.R. 479 (March 22, 2024), effective May 6, 2024 (Supp. 24-1).

**R20-6-1102. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1102 recodified from R4-14-1102 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1102.01 Repealed**



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**Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1103. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1103 recodified from R4-14-1103 (Supp. 95-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1104. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1104 recodified from R4-14-1104 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1105. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1105 recodified from R4-14-1105 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1106. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1106 recodified from R4-14-1106 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section

repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1107. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted with changes effective May 28, 1992 (Supp. 92-2). R20-6-1107 recodified from R4-14-1107 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1108. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1108 recodified from R4-14-1108 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1109. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1109 recodified from R4-14-1109 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1110. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1110 recodified from R4-14-1110 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1111. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1111 recodified from R4-14-1111 (Supp. 95-1). Amended by final rulemaking at 8

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A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1112. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1112 recodified from R4-14-1112 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1113. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1113 recodified from R4-14-1113 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910 effective March 3, 1999 (Supp. 99-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1114. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1114 recodified from R4-14-1114 (Supp. 95-1). Amended effective August 16, 1996 (Supp. 96-3). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1115. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1115 recodified from R4-14-1115 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1116. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1116 recodified from R4-14-1116 (Supp. 95-1). Section repealed by final rulemaking

at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1117. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1117 recodified from R4-14-1117 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1118. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1118 recodified from R4-14-1118 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1119. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1119 recodified from R4-14-1119 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1120. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). R20-6-1120 recodified from R4-14-1120 (Supp. 95-1). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**R20-6-1121. Repealed****Historical Note**

New Section adopted by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Section repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**Appendix A. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days

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(Supp. 91-4). Emergency rule adopted again and correction made to heading of form on last page of Appendix A effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Appendix A repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**Appendix B. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again and corrections made to Plan C (Medicare (Part B) - Medical Services - Per Calendar Year) and Plan J (Other Benefits) effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Amended by final rulemaking at 8 A.A.R. 2454, effective May 13, 2002 (Supp. 02-2). Appendix B repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**Appendix C. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Appendix C repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**Appendix D. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Amended effective August 16, 1996 (Supp. 96-3). Appendix D repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**Appendix E. Repealed****Historical Note**

Emergency rule adopted effective December 18, 1991, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 91-4). Emergency rule adopted again effective March 17, 1992, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 92-1). Adopted effective May 28, 1992 (Supp. 92-2). Appendix E repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**Appendix F. Repealed****Historical Note**

Appendix F adopted effective August 16, 1996 (Supp. 96-3). Amended effective June 15, 1998 (Supp. 98-2). Amended by final rulemaking at 5 A.A.R. 910, effective March 3, 1999 (Supp. 99-1). Appendix F repealed by final rulemaking at 11 A.A.R. 3671, effective November 12, 2005 (Supp. 05-3).

**ARTICLE 12. HIV/AIDS: PROHIBITED AND REQUIRED PRACTICES****R20-6-1201. Definitions**

- A. "AIDS" means Acquired Immune Deficiency Syndrome.
- B. "Applicant" means an applicant for a life or disability insurance policy or coverage under a health care plan, as well as any potential certificate holder or dependent covered under such policy or plan.
- C. "Insurer" means life and disability insurers (including but not limited to health insurers), hospital and medical service corporations, and health care services organizations, including all employees, contractors, and agents thereof.
- D. "Person" means any individual, company, insurer, association, organization, society, reciprocal or inter-insurance exchange, partnership, syndicate, business trust, corporation, or entity.

**Historical Note**

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1201 recodified from R4-14-1201 (Supp. 95-1).

**R20-6-1202. Applications for Insurance**

- A. Insurers shall not use questions on applications for life or disability policies or health care plans that inquire directly or indirectly about:
  - 1. The sexual orientation of an applicant;
  - 2. An applicant's receipt of transfusions of blood or blood products; or
  - 3. Whether or not the applicant has had any HIV-related test, except as provided in subsection (B) of this rule.
- B. Insurers may include specific questions on applications for life or disability insurance policies or health care plans asking if the applicant has ever been diagnosed or treated for AIDS or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus. No adverse underwriting decision shall be made on the basis of any prior positive HIV-related test or tests unless the insurer has verified that the prior test(s) consisted of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturer's directions for use, including but not limited to the manufacturers' specified interpretation of positivity.

**Historical Note**

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1202 recodified from R4-14-1202 (Supp. 95-1).

**R20-6-1203. Testing for HIV; Consent Form**

- A. An insurer may test for HIV infection in the same way that the insurer tests for other conditions that affect mortality and morbidity. No adverse underwriting decision shall be made on the basis of a positive result to an HIV-related test unless the result consists of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot. All such tests used shall be approved and licensed by the Food and Drug Administration and conducted in accordance with the manufacturers' directions for

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use, including but not limited to the manufacturers' specified interpretation of positivity.

- B. If an applicant is requested to take an HIV-related test in connection with an application for a life or disability insurance policy or a health care plan, the insurer shall reveal the use of such test to the applicant and shall obtain the written consent of the applicant prior to the administration of such test. The insurer shall allow the applicant up to 10 days within which to decide whether or not to sign the consent form, and no adverse underwriting decision may be made on the basis of the applicant's delay during this time period. Insurers need not provide pretest counseling to applicants but shall advise applicants of the availability of counseling in accordance with subsection (C) of this rule.
- C. The written consent form, which shall be approved by the Director in advance of its use, shall contain the following information:
  1. Purpose of the consent form. The form shall contain a clear disclosure that the test to be performed is a test for the presence of HIV antibodies, antigens, or the virus, and that underwriting decisions will be based on the results of such test. The form shall further provide notice of a period of not less than 10 days during which the applicant may decide whether or not to sign the form, along with a disclosure that the applicant's refusal to be tested may be used as a reason to deny coverage.
  2. Information on HIV. The form shall provide clear, concise, and accurate information on how the disease is spread and what behavior places persons at risk of contracting the virus.
  3. Pretest counseling considerations. The written consent form shall contain information advising the applicant that counseling is recommended by many public health organizations and that the applicant may obtain such counseling at the applicant's own expense. The form shall contain current information as provided by the Department regarding the availability in Arizona of free confidential or anonymous counseling through county health departments and through other governmental or government-funded agencies.
  4. Disclosure of test results. The form shall advise the applicant that all test results shall be treated confidentially and that results shall be released only to the applicant and the named insurer or upon the applicant's written consent or as otherwise required or allowed by law, including but not limited to the release of information to the Department of Health Services as provided by law.
  5. Meaning of positive test results. The form shall advise the applicant of the type of test (including but not limited to antibody, antigen, or viral culture) to be used, and that a positive test result indicates that the applicant has been infected with HIV but does not necessarily have AIDS. The form shall explain that a positive test result will adversely affect the application for insurance.
  6. Consent. The consent form shall contain an attestation to be signed by the applicant or, if the applicant lacks legal capacity to consent, a person authorized pursuant to law to consent on behalf of the applicant, that he or she has read and understands the written consent form and voluntarily consents to the performance of a test for HIV and to the disclosure of the test results as described in the consent form. The applicant or the applicant's legal representative shall have the right to request and receive a copy of

the written consent form. A photocopy of the form shall be as valid as the original.

7. Optional release of information to personal physician. In addition to the release of information to the insurer provided in the consent form, the applicant may, at the applicant's option, consent to the release of information to the applicant's personal physician. The form shall provide for such release to be separately signed and dated by the applicant, or if the applicant lacks legal capacity to consent, by a person authorized pursuant to law to consent on behalf of the applicant.
8. Time period during which release of information is effective. The consent form shall specify the time period during which any and all release provisions of the consent form shall be effective, but in no case shall such time period exceed 180 days from the date the consent form is signed by the applicant or the applicant's legal representative. No HIV-related information shall be released to any person after the expiration of that time period unless the insurer obtains the express written consent, pursuant to R20-6-1204, of the applicant or, if the applicant lacks legal capacity to consent, by a person authorized by law to consent on behalf of the applicant.

**Historical Note**

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1203 recodified from R4-14-1203 (Supp. 95-1).

**R20-6-1204. Release of Confidential HIV-related Information; Release Form**

- A. Except as required by law or authorized pursuant to a written consent to be tested, an insurer shall not disclose confidential HIV-related information to any person unless a written release form is executed by the applicant or, if the applicant lacks legal capacity to consent to such release, by a person authorized by law to consent to the release of information on behalf of the applicant. The applicant or the applicant's legal representative shall be entitled to receive a copy of the release. A photocopy shall be as valid as the original.
- B. Such written release form shall contain the following information:
  1. The name and address of the person to whom the information shall be disclosed;
  2. The specific purpose for which disclosure is to be made; and
  3. The time period during which the written release is to be effective but in no case shall such time period exceed 180 days from the date the release is signed by the applicant or the applicant's legal representative;
  4. The signature of the applicant or of the person authorized by law to consent to such release, and the date the release form was signed.

**Historical Note**

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1204 recodified from R4-14-1204 (Supp. 95-1).

**R20-6-1205. Benefits; Prohibited Practices**

- A. Life and disability insurance policies or health care plans that provide benefits for prescription drugs shall provide benefits for any and all drugs and pharmaceutical forms of treatment for HIV and/or AIDS approved by the Food and Drug Administration pursuant to 21 U.S.C. Chapter 9 or licensed by the Food and Drug Administration pursuant to 42 U.S.C. Chapter 6A, including but not limited to Zidovudine, formerly Azido-

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thymidine (“AZT”), Didanosine (ddI) and Zalcitabine (ddC), to the same extent as other prescription drugs and treatments.

- B. Insurers shall provide benefits for HIV, AIDS, and AIDS-related conditions in the same manner and to the same extent as those benefits provided for all other diseases.

**Historical Note**

Adopted effective March 7, 1994 (Supp. 94-1). R20-6-1205 recodified from R4-14-1205 (Supp. 95-1).

**ARTICLE 13. MENTAL HEALTH PARITY****R20-6-1301. Definitions**

The definitions in A.R.S. § 20-3501 and the following definitions apply to this Article:

“Arizona Mental Health Parity Act” means the statutes found at A.R.S. §§ 20-3501 through 20-3505.

“Coverage unit” has the meaning prescribed at 45 CFR § 146.136(a) “Coverage unit.”

“Department of Insurance and Financial Institutions (Department)” has the meaning prescribed at A.R.S. § 20-101.

“CMS MHPAEA tool” means the Microsoft Excel Mental Health Parity tool maintained by the Center for Medicare and Medicaid Services.

“Financial requirements (FR)” has the meaning at 45 CFR § 146.136(a) “Financial requirements.”

“Health care insurer” has the meaning prescribed at A.R.S. § 20-3501(2).

“Health plan” has the meaning prescribed at A.R.S. § 20-3501(3).

“Inpatient, in-network benefits” are benefits furnished on an inpatient basis and within a network of contracted providers under a health plan.

“Inpatient, out-of-network benefits” are benefits furnished on an inpatient basis by providers without a contract under a health plan or for a health plan that has no network of providers.

“Large group health plan” is a health plan issued to an employer group that is not a small employer as defined at A.R.S. § 20-2301(A)(20).

“Medical/surgical (Med/Surg) benefits” has the meaning prescribed at 45 CFR § 146.136(a) “Medical/surgical benefits.”

“Mental (MH) health benefits” has the meaning prescribed at 45 CFR § 146.136(a) “Mental health benefits.”

“MHPAEA” means the Mental Health Parity and Addiction Equity Act prescribed in A.R.S. § 20-3501(4).

“Nonquantitative treatment limitation (NQTL)” is a limitation that restricts the scope or duration of benefits for treatment under a health plan or coverage. Illustrations of NQTLs include: medical management standards limiting or excluding benefits based on medical necessity or appropriateness or based on whether the treatment is experimental or investigative as identified under 45 CFR 146.136(c)(4)(ii)(A); formulary design for prescription drugs as identified under 45 CFR 146.136(c)(4)(ii)(B); network tier design (for health plans with multiple network tiers such as preferred providers and participating providers) as identified under 45 CFR 146.136(c)(4)(ii)(C); standards for provider admission to participate in a network, including reimbursement rates as identified

under 45 CFR 146.136(c)(4)(ii)(D); methods for determining usual, customary, and reasonable charges as identified under 45 CFR 146.136(c)(4)(ii)(E); refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first policies” or “step therapy protocols”) as identified under 45 CFR 146.136(c)(4)(ii)(F); exclusions based on failure to complete a course of treatment; and restrictions based on geographic location as identified under 45 CFR 146.136(c)(4)(ii)(G), facility type, provider specialty, and other criteria than limit the scope or duration of benefits for services provided under the health plan or coverage as identified under 45 CFR 146.136(c)(4)(ii)(H).

“Outpatient, in-network benefits” are benefits furnished on an outpatient basis and within a network of providers established or recognized under a health plan.

“Outpatient, out-of-network benefits” are benefits furnished on an outpatient basis and outside any network of providers established or recognized under a health plan or under a health plan that has no network of providers.

“Predominant test” means that if a type of FR or QTL applies to substantially all of the Med/Surg benefits in a classification, the predominant level of the FR or QTL is the level that applies to more than 1/2 of the Med/Surg benefits in that classification subject to the FR or QTL. If no single level can be determined, the health plan (or health insurance issuer) may combine levels until the combination of levels applies to more than 1/2 of Med/Surg benefits subject to the FR or QTL in the classification. The least restrictive level within the combination is considered the predominant level of that type of classification. For this purpose, a health plan may combine the most restrictive levels first with each less restrictive level added to the combination until the combination applies to more than 1/2 of the benefits subject to the FR or QTL.

“Quantitative treatment limitation (QTL)” is a limitation on the scope or duration of a benefit that can be expressed numerically that includes day or visit limits such as “50 outpatient visits per year.” QTLs include annual, episode, and lifetime day and visit limits such as number of treatments, number of visits, or days of coverage.

“Substance use disorder (SUD) benefits” has the meaning prescribed at 45 CFR § 146.136(a) “Substance use disorder benefits.”

“Substantially all test” means that a FR or QTL applies to at least 2/3 of all Med/Surg benefits in a classification of benefits for a coverage unit. (For this purpose, benefits expressed as subject to a zero level of a type of FR are treated as not subject to that type of FR. In addition, benefits expressed as subject to an unlimited QTL are treated as not subject to that type of QTL.) If a type of FR or QTL does not apply to at least 2/3 of all Med/Surg benefits in a classification, then that type of FR or QTL cannot be applied to MH or SUD benefits in that classification.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

**R20-6-1302. Medical Necessity Criteria and NQTL Reporting**

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- A. Health care insurers subject to the reporting requirement. A health care insurer that issues health plans in Arizona is required to file the reports required by this Section with the Department.
- B. Health plans subject to reporting. A health care insurer shall submit a report for all health plans it offers in this state (including grandfathered and non-grandfathered health plans) that meet all of the criteria listed in subsections (B)(1) through (4). If a health care insurer determines that the information to be reported varies by network plan, or varies in the individual, small group, or large group market, the health care insurer must submit a separate report for each variation.
  - 1. The health plan offers MH and/or SUD benefits in addition to Med/Surg benefits.
  - 2. The health plan offers MH and/or SUD benefits in at least one of the following classifications:
    - a. Inpatient, in-network;
    - b. Inpatient, out-of-network;
    - c. Outpatient, in-network;
    - d. Outpatient, out-of-network;
    - e. Emergency care; or
    - f. Prescription drugs.
  - 3. The health plan is offered on a group (large or small) or individual basis.
  - 4. The health plan has not received and notified the Department of an increased cost exemption pursuant to 45 CFR 146.136(g).
- C. Health plans exempt from reporting. A health plan that meets the criteria of subsection (B) is exempt from reporting under this Article if it is one of the following types of health plans:
  - 1. A small group grandfathered health plan;
  - 2. A small group non-grandfathered health plan subject to the HHS transitional policy; or
  - 3. A health plan that meets the definition of excepted benefit provided in 45 CFR 146.145(b) or 45 C.F.R. 148.220.
- D. Required reports. A health care insurer shall file a separate report for each fully insured product network type the health care insurer issues in Arizona. If the information to be reported varies by network or health plan, or varies in the individual, small group or large group market, the health care insurer must file a separate report for each variation.
- E. Triennial Reports.
  - 1. Existing health care insurers. Beginning on March 15, 2023 and every third year thereafter, a health care insurer issuing health plans and collecting premium in Arizona as of January 1, 2022 shall file a triennial report with the Department for each health plan subject to reporting.
  - 2. Entering or re-entering health care insurers. On or before March 15 of the second year an entering or re-entering health care insurer issues health plans and collects premiums in Arizona, the health care insurer shall file an original triennial report with the Department for each health plan subject to reporting. Following the filing of the original triennial report, the health care insurer shall submit subsequent triennial reports on the schedule described in subsection (E)(1).
  - 3. Due date for triennial reports. Triennial reports are due on or before March 15 of each reporting year.
  - 4. Content of the original triennial report. Health care insurers shall file an original triennial report with the Department under A.R.S. § 20-3502(B) that provides the required information in Exhibit A.
  - 5. Subsequent triennial reports.
    - a. A health care insurer must file an updated triennial report, including the information required in Exhibit A, unless the health care insurer can attest that it has made no changes since the previously filed triennial report.
    - b. As required by A.R.S. § 20-3502(E), a health care insurer shall file the following with the Department for each health plan subject to reporting:
      - i. An updated triennial report, including the information required in Exhibit A; or
      - ii. The last triennial report filed with the Department and a written attestation that the health care insurer has made no changes since it filed the previous triennial report.
- F. Annual Reports. Pursuant to A.R.S. § 20-3502(E), on or before March 15 of each intervening year between the filing of a triennial report, a health care insurer shall file:
  - 1. A report that summarizes any changes made to its medical necessity criteria and NQTLs (Exhibit A, Parts I, II, and III);
  - 2. A written attestation by an officer or director of the health care insurer that the health care insurer is in compliance with MHPAEA; and
  - 3. If requested by the Department, any additional data required by the Department including Exhibit A, Part IV.
- G. Additional information. At any time after a health care insurer files a report under this Section, the Department may request additional information, including an updated triennial or annual report, by contacting the health care insurer and making the request in writing. The health care insurer shall provide contact information to the Department when it files any of the reports required by this Section. The Department may set a deadline for a health care insurer to respond to its request and specify the format for the response.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

**R20-6-1303. FR and QTL Reporting**

- A. Method of reporting. A health care insurer that issues health plans in Arizona and whose policy forms are not exempt from the form filing requirement shall demonstrate its compliance with the FR and QTL parity requirements of MHPAEA through its form and rate filings with the Department.
- B. Department's authority to require additional data. In addition to the forms filed by a health care insurer, the Department may require a health care insurer to submit additional data relating to its methods for meeting the MHPAEA FR and QTL standards. The Department may utilize the CMS MHPAEA tool and may request samples of a health care insurer's internal testing to demonstrate compliance with the substantially all and predominant tests within each classification of benefits for a health plan.
- C. Separate consolidated report for large group health plans. The Department may require a health care insurer that issues large group health plans to file a consolidated report that demonstrates compliance with the substantially all and predominant tests within each classification of benefits for a sample of large group health plans with similar benefit structures.
- D. Special rule for FRs - Prescription Drug Classification. The multi-tiered prescription drug benefits exception of A.R.S. § 20-3502(D)(1) applies to the FRs for the prescription drug classification. For example, a health plan applies 4 tiers as fol-

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lows: Tier 1: Generic Drugs for which the health plan pays 90%; Tier 2: Preferred Brand-name Drugs for which the health plan pays 80%; Tier 3: Non-preferred Brand-name Drugs for which the health plan pays 60%; and Tier 4: Specialty Drugs for which the health plan pays 50%. These FRs are applied without regard to whether a drug is prescribed for Med/Surg or MH/SUD benefits. In addition, the process for certifying a particular drug within a tier complies with the rules for NQTLs. Therefore, the FRs applied to prescription drug benefits meet the parity requirements under MHPAEA.

**E. Special rules for FRs and QTLs.**

1. In-network Classifications. The multiple network tiers exception of A.R.S. § 20-3502(D)(2) applies to the FRs and QTLs for the in-network classifications. For example, a health plan has two tiers of in-network providers: Tier 1: Preferred provider; and Tier 2: Participating provider. Placement of a provider into a tier complies with the rules for NQTLs and is determined without regard to whether the provider specializes in the treatment of Med/Surg conditions or MH/SUD disorders. The in-network classifications are divided into two subclassifications: 1. In-network preferred; and 2. In-network participating. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to all Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the in-network subclassifications that reflect the provider tiers meet the parity requirements under MHPAEA.
2. Outpatient Classifications. The subclassification permitted for the office visits exception of A.R.S. § 20-3502(D)(3) applies to the FRs and QTLs for the outpatient classifications. For example, a health plan divides the outpatient, in-network classification into two subclassifications: 1. In-network office visits; and 2. All other outpatient, in-network items and services. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the

predominant FR or QTL that applies to Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the outpatient subclassifications for office visits and all other outpatient items and services meet the parity requirements under MHPAEA.

3. The health plan cannot use a subclassification for generalists and specialists. The only subclassifications permitted for the in-network classifications are: 1. Office visits (such as physician visits); and 2. All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

**R20-6-1304. Additional Information or Data**

According to A.R.S. § 20-3502(F), the Department is not prohibited from otherwise requesting information or data that is necessary to verify compliance with MHPAEA and the Arizona Mental Health Parity Act.

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

**R20-6-1305. Confidentiality of Information**

According to A.R.S. § 20-3502(G), all documents, reports, or other materials provided to the Department under this Article are confidential and are not subject to disclosure and are subject to the restrictions of A.R.S. § 20-157.01(B).

**Historical Note**

New Section made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

**Exhibit A. Medical Necessity Criteria and NQTL Reports**

**Exhibit A**  
**Medical Necessity Criteria and NQTL Reports**

**Instructions for Exhibit A:**

Submit an Exhibit A for each fully insured, major medical health plan subject to reporting under Section R20-6-1302(B). Please submit the information in a word-searchable PDF file which is organized and identified by the numbered sections that appear below.

**Part I: Identify Plan and Reporting Year.****Instructions for Part I:**

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit A.

<b>Reporting Year:</b>		
<b>Health Care Insurer Name:</b>		
<b>Health Care Insurer NAIC Company Code:</b>		
<b>Network Name(s):</b>		
<b>Service Area:</b> (List all counties in the service area for these networks)		
<b>Covered Lives:</b> (List the number of covered lives enrolled in plans in these networks in the reporting year)		
<b>Plan Types:</b> (Check all that apply)	<input type="checkbox"/> Individual ACA-Compliant	<input type="checkbox"/> Small Group ACA-Compliant
	<input type="checkbox"/> Individual Transitional, plans include MH/SUD benefits	<input type="checkbox"/> Small Group Transitional, plans include MH/SUD benefits
	<input type="checkbox"/> Individual Grandfathered, plans include MH/SUD benefits	<input type="checkbox"/> Large Group Fully Insured, plans include MH/SUD benefits

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<b>Product Types:</b> (Check all that apply)	<input type="checkbox"/> PPO	<input type="checkbox"/> HMO (HCSO)
	<input type="checkbox"/> POS	<input type="checkbox"/> Indemnity

**Part II: Medical necessity criteria.****Instructions for Part II:**

To comply with A.R.S. § 20-3502(B)(1), describe the process that is used to develop or select medical necessity criteria for the plan and reporting year identified in Part I. When the plan describes the process used to develop or select criteria for MH/SUD benefits, then it must also describe the process used to develop or select criteria for Med/Surg benefits.

To comply with A.R.S. § 20-3502(B)(1), report:

- A. Describe the process used to develop or select medical necessity criteria for MH/SUD benefits.
- B. Describe the process used to develop or select medical necessity criteria for Med/Surg benefits.

**Part III: Identify all NQTLs.****Instructions for Part III:**

To comply with A.R.S. § 20-3502(B)(2), identify all NQTLs that are applied to MH/SUD benefits and all NQTLs that are applied to Med/Surg benefits for the plan and reporting year identified in Part I. NQTLs shall be identified within each classification of benefits.

- A. Identify and report all NQTLs applied to MH/SUD benefits:
  1. All NQTLs applied to In-Patient, In-Network Classification.
  2. All NQTLs applied to In-Patient, Out-of-Network Classification.
  3. All NQTLs applied to Out-Patient, In-Network Classification.
  4. All NQTLs applied to Out-Patient, Out-of-Network Classification.
  5. All NQTLs applied to Emergency Care.
  6. All NQTLs applied to Prescription Benefits.
- B. Identify and report all NQTLs applied to Med/Surg benefits:
  1. All NQTLs applied to In-Patient, In-Network Classification.
  2. All NQTLs applied to In-Patient, Out-of-Network Classification.
  3. All NQTLs applied to Out-Patient, In-Network Classification.
  4. All NQTLs applied to Out-Patient, Out-of-Network Classification.
  5. All NQTLs applied to Emergency Care.
  6. All NQTLs applied to Prescription Benefits.

**Part IV: Demonstrate parity through analysis.****Instructions for Part IV:**

To comply with A.R.S. § 20-3502(B)(3), for each NQTL listed in Part III, demonstrate through analysis that the process, strategy, evidentiary standard, and other factor of applying the NQTL to MH/SUD benefits in a classification of benefits, as written and in operation, is comparable to, and applied not more stringently than, any process, strategy, evidentiary standard or other factor used in applying the NQTL to Med/Surg benefits in the same classification. The report should define each "Other Factor" and include qualitative and quantitative statistical data to support and explain the analysis.

Identify and report on the NQTLs reported in Part III as follows:

- A. Classification - Inpatient, in-network
  1. Process
    - a. Process applying NQTL to MH/SUD benefit.
    - b. Process applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  2. Strategy
    - a. Strategy applying NQTL to MH/SUD benefit.
    - b. Strategy applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  3. Evidentiary Standard
    - a. Evidentiary standard applying NQTL to MH/SUD benefit.
    - b. Evidentiary standard applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  4. Other Factor
    - a. Other factor applying NQTL to MH/SUD benefit.
    - b. Other factor applying NQTL to Med/Surg benefit.
    - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.



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- d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- B. Classification - Inpatient, out-of-network**
  - 1. Process
    - a. Process applying NQTL to MH/SUD benefit.
    - b. Process applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 2. Strategy
    - a. Strategy applying NQTL to MH/SUD benefit.
    - b. Strategy applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 3. Evidentiary Standard
    - a. Evidentiary standard applying NQTL to MH/SUD benefit.
    - b. Evidentiary standard applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 4. Other Factor
    - a. Other factor applying NQTL to MH/SUD benefit.
    - b. Other factor applying NQTL to Med/Surg benefit.
    - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- C. Classification - Outpatient, in-network**
  - 1. Process
    - a. Process applying NQTL to MH/SUD benefit.
    - b. Process applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 2. Strategy
    - a. Strategy applying NQTL to MH/SUD benefit.
    - b. Strategy applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 3. Evidentiary Standard
    - a. Evidentiary standard applying NQTL to MH/SUD benefit.
    - b. Evidentiary standard applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 4. Other Factor
    - a. Other factor applying NQTL to MH/SUD benefit.
    - b. Other factor applying NQTL to Med/Surg benefit.
    - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- D. Classification - Outpatient, out-of-network**
  - 1. Process
    - a. Process applying NQTL to MH/SUD benefit.
    - b. Process applying NQTL to Med/Surg benefit.

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- c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 2. Strategy
    - a. Strategy applying NQTL to MH/SUD benefit.
    - b. Strategy applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 3. Evidentiary Standard
    - a. Evidentiary standard applying NQTL to MH/SUD benefit.
    - b. Evidentiary standard applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 4. Other Factor
    - a. Other factor applying NQTL to MH/SUD benefit.
    - b. Other factor applying NQTL to Med/Surg benefit.
    - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- E. Classification - Emergency care
  - 1. Process
    - a. Process applying NQTL to MH/SUD benefit.
    - b. Process applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 2. Strategy
    - a. Strategy applying NQTL to MH/SUD benefit.
    - b. Strategy applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 3. Evidentiary Standard
    - a. Evidentiary standard applying NQTL to MH/SUD benefit.
    - b. Evidentiary standard applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 4. Other Factor
    - a. Other factor applying NQTL to MH/SUD benefit.
    - b. Other factor applying NQTL to Med/Surg benefit.
    - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.
- F. Classification - Prescription benefits
  - 1. Process
    - a. Process applying NQTL to MH/SUD benefit.
    - b. Process applying NQTL to Med/Surg benefit.
    - c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
    - d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
  - 2. Strategy
    - a. Strategy applying NQTL to MH/SUD benefit.

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- b. Strategy applying NQTL to Med/Surg benefit.
- c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
- d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
- 3. Evidentiary Standard
  - a. Evidentiary standard applying NQTL to MH/SUD benefit.
  - b. Evidentiary standard applying NQTL to Med/Surg benefit.
  - c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
  - d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
- 4. Other Factor
  - a. Other factor applying NQTL to MH/SUD benefit.
  - b. Other factor applying NQTL to Med/Surg benefit.
  - c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
  - d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

**Historical Note**

New Exhibit A made by final rulemaking at 28 A.A.R. 1824 (July 29, 2022), effective September 4, 2022 (Supp. 22-3).

**ARTICLE 14. INSURANCE HOLDING COMPANY****R20-6-1401. Definitions**

- A. "The Act" means the Insurance Holding Company Systems Act, A.R.S. §§ 20-481 through 20-481.32.
- B. "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.
- C. "Ultimate controlling person" means that person which is not controlled by any other person.
- D. Unless the context otherwise requires, other terms found in these regulations and in A.R.S. § 20-481 are used as defined in the Act. Other nomenclature or terminology is according to Title 20, A.R.S. or industry usage if not defined by Title 20, A.R.S.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1401 recodified from R4-14-1401 (Supp. 95-1).  
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

**R20-6-1402. Acquisition of Control – Statement Filing**

- A. A person required to file a statement pursuant to A.R.S. § 20-481.02 shall furnish the required information on Form A, attached hereto as Appendix A and on Form E, attached hereto as Appendix E, and described in subsections (D) and (E) of this Section.
- B. The applicant shall promptly advise the Director of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the Director's disposition of the application.
- C. If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of A.R.S. § 20-481.02(G), the name of the domestic insurer on the cover page should be indicated as follows: "[ABC Insurance Company], a subsidiary of [XYZ Holding Company]." Where a A.R.S. § 20-481.02(G) insurer is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.
- D. If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant

to A.R.S. § 20-481.02(A), that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to A.R.S. § 20-481.25(C).

- E. Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to A.R.S. § 20-481.25, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of A.R.S. § 20-481.25 as set forth in A.R.S. § 20-481.25(B).
- F. In addition to the information required by Form E, the Director may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1402 recodified from R4-14-1402 (Supp. 95-1).  
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

**R20-6-1403. Annual Registration of Insurers – Statement Filing**

- A. An insurer required to file an annual registration statement pursuant to A.R.S. § 20-481.09 shall furnish the required information on Form B, attached hereto as Appendix B, in accordance with the instructions contained in Appendix G.
- B. Amendments to Form B shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page "Amendment No. (insert number) to Form B for (insert year)" and shall indicate the date of the amendment and not the date of the original filings.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1403 recodified from R4-14-1403 (Supp. 95-1).  
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

**R20-6-1404. Summary of Registration – Statement Filing**

An insurer required to file an annual registration statement pursuant to A.R.S. § 20-481.09 is also required to furnish information required on Form C, attached hereto as Appendix C.

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**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1404 recodified from R4-14-1404 (Supp. 95-1).  
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

**R20-6-1405. Alternative and Consolidated Registrations**

- A.** Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under A.R.S. § 20-481.09. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:
1. The statement or report contains substantially similar information required to be furnished on Form B; and
  2. The filing insurer is the principal insurance company in the insurance holding company system.
- B.** The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.
- C.** With the prior approval of the Director, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subsection (A) above.
- D.** Any insurer may take advantage of the provisions of A.R.S. §§ 20-481.15 or 20-481.16 without obtaining the prior approval of the Director. The Director, however, reserves the right to require individual filings if he or she deems such filings necessary in the interest of clarity, ease of administration or the public good.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1405 recodified from R4-14-1405 (Supp. 95-1).  
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

**R20-6-1406. Disclaimers and Termination of Registration**

- A.** A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person, hereinafter referred to in this rule as the "subject," shall contain the following information:
1. The number of authorized, issued and outstanding voting securities of the subject;
  2. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of shares concerning which there is a right to acquire, directly or indirectly;
  3. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;
  4. A statement explaining why the person should not be considered to control the subject.
- B.** A request for termination of registration shall be deemed to have been granted unless the director, within 30 days after receipt of the request, notifies the registrant otherwise.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1406 recodified from R4-14-1406 (Supp. 95-1).  
Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

**R20-6-1407. Transactions Subject to Prior Notice – Notice Filing**

- A.** An insurer required to give notice of a proposed transaction pursuant to A.R.S. § 20-481.12 shall furnish the required information on Form D, attached hereto as Appendix D, in accordance with the instructions in Appendix G.
- B.** Agreements for cost sharing services and management services shall at a minimum and as applicable:
1. Identify the person providing services and the nature of such services;
  2. Set forth the methods to allocate costs;
  3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;
  4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;
  5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;
  6. Define records and data of the insurer to include all records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claim files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records, or similar records within the possession, custody, or control of the affiliate;
  7. Specify that all records and data of the insurer are and remain the property of the insurer, and;
    - a. Are subject to control of the insurer;
    - b. Are identifiable; and
    - c. Are segregated from all other persons' records and data and are readily capable of segregation at no additional cost to the insurer;
  8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;
  9. Include standards for termination of the agreement with and without cause;
  10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate the provisions of the agreement required in subsections (B)(11), (B)(12), (B)(13), (B)(14), and (B)(15);
  11. Specify that, if the insurer is placed into supervision, conservatorship, or receivership by the Director pursuant to A.R.S. §§ 20-169(3), 20-171(A), 20-172, or the Arizona Receivership Act:
    - a. All of the rights of the insurer under the agreement extend to the receiver or Director to the extent permitted by the law of Arizona;
    - b. All records and data of the insurer shall be identifiable and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the Director;
    - c. A complete set of records and data of the insurer will immediately be made available to the receiver or the

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Director, shall be made available in a usable format and shall be turned over to the receiver or Director immediately upon the receiver or the Director's request, and the cost to transfer data to the receiver or Director shall be fair and reasonable; and

- d. The affiliated person or persons will make available all employees essential to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or Director;
12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, conservatorship, or receivership pursuant to A.R.S. §§ 20-169(3), 20-171(A), 20-172, or the Arizona Receivership Act;
13. Specify that the affiliate will provide the essential services for a minimum period of time after termination of the agreement, if the insurer is placed into supervision, conservatorship, or receivership pursuant to A.R.S. §§ 20-169(3), 20-171(A), 20-172, or the Arizona Receivership Act, as ordered or directed by the receiver or Director. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, Director, or supervising court;
14. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding supervision, conservatorship or receivership pursuant to A.R.S. §§ 20-169(3), 20-171(A), 20-172, or the Arizona Receivership Act, and will make them available to the receiver or Director as ordered or directed by the receiver or Director for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, Director, or supervising court; and
15. Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association or associations and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, conservatorship, or receivership pursuant to A.R.S. §§ 20-169(3), 20-171(A), 20-172, or the Arizona Receivership Act, and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under subsections (B)(11), (B)(12), (B)(13), and (B)(14) will extend to those guaranty association or associations.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1407 recodified from R4-14-1407 (Supp. 95-1).

Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

**R20-6-1408. Enterprise Risk Report; Group Capital Calculation**

- A. The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to A.R.S. § 481.10(D) shall furnish the required information on Form F, attached hereto as Appendix F.

- B. The lead state Commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation if the lead state Commissioner makes a determination based upon the filing that the insurance holding company system meets all of the following criteria:

1. Has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program of less than \$1,000,000,000;
2. Has no insurers within its holding company structure that are domiciled outside of the United States or one of its territories;
3. Has no banking, depository, or other financial entity that is subject to an identified regulatory capital framework within its holding company structure;
4. The holding company system attests that there are no material changes in the transactions between insurers and non-insurers in the group that have occurred since the last filing of the annual group capital calculation; and
5. The non-insurers within the holding company system do not pose a material financial risk to the insurer's ability to honor policyholder obligations.

- C. Where an insurance holding company system has previously filed the annual group capital calculation at least once, the lead state Commissioner has the discretion to accept, in lieu of the group capital calculation, a limited group capital filing if the insurance holding company system has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of less than \$1,000,000,000 and all of the following additional criteria are met:

1. Has no insurer within its holding company structure that are domiciled outside of the United States or one of its territories;
2. Does not include a banking, depository, or other financial entity that is subject to an identified regulatory capital framework; and
3. The holding company system attests that there are no material changes in transactions between insurers and non-insurers in the group that have occurred since the last filing of the report to the lead state Commissioner and the non-insurers within the holding company system do not pose a material financial risk to the insurers' ability to honor policyholder obligations.

- D. For an insurance holding company that has previously met an exemption with respect to the group capital calculation pursuant to subsections (B) or (C), the lead state Commissioner may require, at any time, the ultimate controlling person to file an annual group capital calculation, completed in accordance with the NAIC Group Capital Calculation Instructions, if any of the following criteria are met:

1. Any insurer within the insurance holding company system is in a Risk-Based Capital action level event as set forth in A.R.S. § 20-488.02 or a similar standard for a non-U.S. insurer;
2. Any insurer within the insurance holding company system meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in A.R.S. § 20-220.01; or
3. Any insurer within the insurance holding company system otherwise exhibits qualities of a troubled insurer as determined by the lead state Commissioner based on

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unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

**E.** A non-U.S. jurisdiction is considered to “recognize and accept” the group capital calculation if it satisfies the following criteria:

1. With respect to A.R.S. § 20-481.10(D)(2)(a)(iv):
  - a. The non-U.S. jurisdiction recognizes the U.S. state regulatory approach to group supervision and group capital by providing confirmation by a competent regulatory authority in such jurisdiction, that insurers and insurance groups whose lead state is accredited by the NAIC, under the NAIC Accreditation Program, shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the lead state and will not be subject to group supervision, including worldwide group governance, solvency and capital, and reporting, at the level of the worldwide parent undertaking of the insurance or reinsurance group by the non-U.S. jurisdiction; or
  - b. Where no U.S. insurance groups operate in the non-U.S. jurisdiction, the non-U.S. jurisdiction indicates formally in writing to the lead state, with a copy to the International Association of Insurance Supervisors, that the group capital calculation is an acceptable international capital standard. This will serve as documentation otherwise required in subsection (E)(1)(a).
2. The non-U.S. jurisdiction provides confirmation by a competent regulatory authority in such jurisdiction, that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the lead state Commissioner in accordance with a memorandum of understanding or similar document between the Commissioner and such jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC. The Commissioner shall determine, in consultation with the NAIC Committee Process, if the requirements of the information sharing agreements are in force.

**F.** A list of non-U.S. jurisdictions that “recognize and accept” the group capital calculation will be published through the NAIC Committee Process:

1. A list of jurisdictions that “recognize and accept” the group capital calculation pursuant to A.R.S. § 20-481.10(D)(2)(a)(iv), is published through the NAIC Committee Process to assist the lead state Commissioner in determining which insurers shall file an annual group capital calculation. The list will clarify those situations in which a jurisdiction is exempted from filing under A.R.S. § 20-481.10(D)(2)(a)(iv). To assist with a determination under A.R.S. § 20-481.10(D)(2)(b), the list will also identify whether a jurisdiction that is exempted under either A.R.S. § 20-481.10(D)(2)(c) or (d) requires a group capital filing for any U.S. based insurance group’s operations in that non-U.S. jurisdiction.
2. For a non-U.S. jurisdiction where no U.S. insurance groups operate, the confirmation provided to meet the requirement of subsection (E)(1)(b) will serve as support

for recommendation to be published as a jurisdiction that “recognizes and accepts” the group capital calculation through the NAIC Committee Process.

3. If the lead state Commissioner makes a determination pursuant to A.R.S. § 20-481.10(D)(2)(a)(iv) that differs from the NAIC List, the lead state Commissioner shall provide thoroughly documented justification to the NAIC and other states.
4. Upon determination by the lead state Commissioner that a non-U.S. jurisdiction no longer meets one or more of the requirements to “recognize and accept” the group capital calculation, the lead state Commissioner may provide a recommendation to the NAIC that the non-U.S. jurisdiction be removed from the list of jurisdictions that “recognize and accept” the group capital calculation.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1408 recodified from R4-14-1408 (Supp. 95-1). R20-6-1408 repealed; new Section R20-6-1408 made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

**R20-6-1409. Extraordinary Dividends and Other Distributions**

**A.** Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

1. The amount of the proposed dividend;
2. The date established for payment of the dividend;
3. A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;
4. A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:
  - a. The amounts, dates and form of payment of all dividends or distributions, including regular dividends but excluding distributions of the insurer’s own securities, paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;
  - b. Surplus as regards policyholders, total capital and surplus, as of the 31st day of December next preceding;
  - c. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;
  - d. If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-months periods; and
  - e. If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer’s own securities in the preceding two calendar years.
5. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Director and the end of the month preceding the month in which the request for dividend approval is submitted; and

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6. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

- B. Subject to A.R.S. § 20-481.19, each registered insurer shall report to the Director all dividends and other distributions to shareholders within five business days following the declaration thereof and at least 10 business days before payment of the dividend or distribution, including the same information required by subsection (A)(4)(a) through (e) of this Section.

**Historical Note**

New Section made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 23 A.A.R. 3311, effective January 16, 2018 (Supp. 17-4). Amended by final rulemaking at

30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

**R20-6-1410. Adequacy of Surplus**

The factors set for in A.R.S. §§ 20-481.01(F) and 20-481.24 are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The Director instead will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Director will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Director will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

**Historical Note**

New Section made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4).

**Appendix A. Form A - Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer**

**STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER**

[Name of Domestic Insurer]

By

[Name of Acquiring Person (Applicant)]

Filed with the Arizona Department of Insurance and Financial Institutions

Dated: \_\_\_\_\_, 20\_\_\_\_

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

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**ITEM 1. METHOD OF ACQUISITION**

[State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired. State the federal identification number and the NAIC number of the domestic insurer.]

**ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT**

- [(a) State the name and address of the applicant seeking to acquire control over the insurer.]
- [(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.]
- [(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant, including NAIC numbers for all insurers. No affiliate need be identified if its total assets are equal to less than one-half of 1% of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate, the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.]

**ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT**

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[On the biographical affidavit, include a third party background check, and state the following with respect to (1) the applicant if they are an individual, or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual.

- (a) Name and business address;
- (b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;
- (c) Material occupations, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith;
- (d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last 10 years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case;

Such persons may also submit fingerprints and the fingerprint processing fee in accordance with A.R.S. § 20-481.03(B).]

**ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION**

- [(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.]
- [(b) Explain the criteria used in determining the nature and amount of such consideration.]
- [(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.)

**ITEM 5. FUTURE PLANS OF INSURER**

[Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate the insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.]

**ITEM 6. VOTING SECURITIES TO BE ACQUIRED**

[State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.]

**ITEM 7. OWNERSHIP OF VOTING SECURITIES**

[State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.]

**ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER**

[Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom the contracts, arrangements or understandings have been entered into.]

**ITEM 9. RECENT PURCHASES OF VOTING SECURITIES**

[Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement. Include in the description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefore. State whether any such shares so purchased are hypothecated.]



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**ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE**

[Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.]

**ITEM 11. AGREEMENTS WITH BROKER-DEALERS**

[Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.]

**ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS**

- [(a) Financial statements, exhibits, and three-year financial projections of the insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.]
- [(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if the information is available. The statements may be prepared on either an individual basis, or, unless the Director otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of the person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of the state.]

- [(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or Appendix G.)

**ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT**

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within 15 days after the end of the month in which the acquisition of control occurs.

**ITEM 14. SIGNATURE AND CERTIFICATION**

[Signature and certification required as follows:]

**SIGNATURE**

Pursuant to the requirements of A.R.S. § 20-481.02 \_\_\_\_\_ has caused this application to be duly signed on its behalf in the City of \_\_\_\_\_ and State of \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(SEAL)

Name of Applicant

BY \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Title)

Attest:

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(Signature of Officer)

\_\_\_\_\_  
(Title)

**CERTIFICATION**

The undersigned deposes and says that they have duly executed the attached application dated \_\_\_\_\_, 20\_\_\_\_, for and on behalf of \_\_\_\_\_; that they are the \_\_\_\_\_

(Name of Applicant)

(Title of Officer)

of such company and that they are authorized to execute and file such instrument. Deponent further says that they are familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of their knowledge, information and belief.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Type or print name beneath)

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

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## Appendix B. Form B - Insurance Holding Company System Annual Registration Statement

**INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT**

Filed with the Arizona Department of Insurance and Financial Institutions

By

\_\_\_\_\_  
[Name of Registrant]

On Behalf of Following Insurance Companies

Name                      Address

_____	_____
_____	_____
_____	_____

Date: \_\_\_\_\_, 20\_\_\_\_

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning  
This Statement Should Be Addressed:

_____
_____
_____

**ITEM 1. IDENTITY AND CONTROL OF REGISTRANT**

[Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the federal identification number and the NAIC number of each, the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.]

**ITEM 2. ORGANIZATIONAL CHART**

[Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of control. As to each person specified in the chart or listing, indicate the type of organization (e.g., - corporation, trust, partnership) and the state or other jurisdiction of domicile.]

**ITEM 3. THE ULTIMATE CONTROLLING PERSON**

[As to the ultimate controlling person in the insurance holding company system furnish the following information:

- (a) Name;
- (b) Home office address;
- (c) Principal executive office address;
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.;
- (e) The principal business of the person;
- (f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned; and
- (g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.]

**ITEM 4. BIOGRAPHICAL INFORMATION**

[If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, the individual's principal occupation and all offices and positions held during the past five years, and any conviction of

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crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, the individual's principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations.]

**ITEM 5. TRANSACTIONS AND AGREEMENTS**

[Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

- (a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;
- (b) Purchases, sales or exchanges of assets;
- (c) Transactions not in the ordinary course of business;
- (d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;
- (e) All management agreements, service contracts and all cost-sharing arrangements;
- (f) Reinsurance agreements;
- (g) Dividends and other distributions to shareholders;
- (h) Consolidated tax allocation agreements; and
- (i) Any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of A.R.S. § 20-481.09.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Director and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to the transaction, and relationship of the affiliated parties to the Registrant.]

**ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS**

[A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which the litigation or proceeding is or was pending:

- (a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and
- (b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.]

**ITEM 7.a. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS**

[The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.]

**ITEM 7.b. STATEMENT REGARDING CORPORATE GOVERNANCE AND INTERNAL CONTROLS**

[The insurer shall furnish a statement that the insurer's board of directors oversees corporate governance and internal controls of the insurer and that the insurer's officers or senior management have approved, implemented and maintain and monitor corporate governance and internal control procedures.]

**ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS**

- [(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.]

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- (b) If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis; or, unless the Director otherwise requires, on a consolidated basis if consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Director. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Director otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that the statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of that state.

Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the Personal Financial Statements Guide by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

- (c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Forms B and G.]

**ITEM 9. FORM C REQUIRED**

[A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.]

**ITEM 10. SIGNATURE AND CERTIFICATION**

[Signature and certification required as follows:]

**SIGNATURE**

Pursuant to the requirements of A.R.S. § 20-481.09, Registrant \_\_\_\_\_ has caused this annual registration statement to be duly signed on its behalf in the City of \_\_\_\_\_ and State of \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(SEAL)

Name of Applicant

BY \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Title)

Attest:

\_\_\_\_\_  
(Signature of Officer)

## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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(Title)

**CERTIFICATION**

The undersigned deposes and says that they have duly executed the attached application dated \_\_\_\_\_, 20\_\_\_\_, for and on behalf of \_\_\_\_\_; that they are the \_\_\_\_\_ (Name of Applicant) \_\_\_\_\_ (Title of Officer) of such company and that they are authorized to execute and file such instrument. Deponent further says that they are familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of their knowledge, information and belief.

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(Signature)

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(Type or print name beneath)

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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## Appendix C. Form C - Summary of Changes to Registration Statement

**SUMMARY OF CHANGES TO REGISTRATION STATEMENT**

Filed with the Arizona Department of Insurance and Financial Institutions

By

\_\_\_\_\_  
[Name of Registrant]

On Behalf of Following Insurance Companies

Name          Address


Dated: \_\_\_\_\_, 20\_\_\_\_

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:


[Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Director, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10% or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.]

**SIGNATURE AND CERTIFICATION**

[Signature and certification required as follows:]

Pursuant to the requirements of A.R.S. § 20-481.09, Registrant \_\_\_\_\_ has caused this annual registration statement to be duly signed on its behalf in the City of \_\_\_\_\_ and State of \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(SEAL)

Name of Applicant

BY \_\_\_\_\_  
(Name)\_\_\_\_\_  
(Title)

Attest:

## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

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(Signature of Officer)

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(Title)

**CERTIFICATION**

The undersigned deposes and says that they have duly executed the attached annual registration statement dated \_\_\_\_\_, 20\_\_\_\_, for and on behalf of \_\_\_\_\_; that they are the \_\_\_\_\_  
(Name of Applicant) (Title of Officer)

of such company and that they are authorized to execute and file such instrument. Deponent further says that they are familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of their knowledge, information and belief.

---

(Signature)

---

(Type or print name beneath)

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).



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Appendix D. Form D - Prior Notice of a Transaction

**PRIOR NOTICE OF A TRANSACTION**

Filed with the Arizona Department of Insurance and Financial Institutions

By

\_\_\_\_\_  
[Name of Registrant]

On Behalf of Following Insurance Companies

Name            Address

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Dated: \_\_\_\_\_, 20\_\_\_\_

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

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**ITEM 1. IDENTITY OF PARTIES TO TRANSACTION**

[Furnish the following information for each of the parties to the transaction:

- (a) Name;
- (b) Home office address;
- (c) Principal executive office address;
- (d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.;
- (e) A description of the nature of the parties' business operations;
- (f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties;
- (g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.]

**ITEM 2. DESCRIPTION OF THE TRANSACTION**

[Furnish the following information for each transaction for which notice is being given:

- (a) A statement as to whether notice is being given under A.R.S. § 20-481.12(B);
- (b) A statement of the nature of the transaction;
- (c) If a notice for amendments or modifications, the reasons for the change and the financial impact on the domestic insurer;
- (d) A statement of how the transaction meets the "fair and reasonable" standard of A.R.S. § 20-481.12(A)(1); and
- (e) The proposed effective date of the transaction.]

**ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS**

[Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities

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being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders, or (b) in the case of life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

**ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE**

[If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of funds, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.]

**ITEM 5. REINSURANCE**

[If the transaction is a reinsurance agreement or modification thereto, as described by A.R.S. § 20-481.12(B)(3)(b), or a reinsurance pooling agreement or modification thereto as described by A.R.S. § 20-481.12(B)(3)(a), furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or change in the insurer's liabilities in any of the next three years, in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding. Notice shall be given for all reinsurance pooling agreements including modifications thereto.]

**ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS**

[For management and service agreements, furnish:

- (a) A brief description of the managerial responsibilities, or services to be performed;
- (b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.]

[For cost-sharing arrangements, furnish:

- (a) A brief description of the purpose of the agreement;
- (b) A description of the period of time during which the agreement is to be in effect;
- (c) A brief description of each party's expenses or costs covered by the agreement;
- (d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement;]
- (e) A brief statement as to the effect of the transaction upon the insurer's policyholder surplus;

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- (f) A statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market." If market based, rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable; and
- (g) A statement regarding compliance with the NAIC Accounting Practices and Procedure Manual regarding expense allocation.]

**ITEM 7. SIGNATURE AND CERTIFICATION**

[Signature and certification required as follows:]

**SIGNATURE**

Pursuant to the requirements of A.R.S. § 20-481.09, \_\_\_\_\_ has caused this application to be duly signed on its behalf in the City of \_\_\_\_\_ and State of \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

(SEAL)

\_\_\_\_\_  
Name of Applicant

By \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Title)

Attest:

\_\_\_\_\_  
(Signature of Officer)

\_\_\_\_\_  
(Title)

**CERTIFICATION**

The undersigned deposes and says that they have duly executed the attached application dated \_\_\_\_\_, 20\_\_\_\_, for and on behalf of \_\_\_\_\_; that they are the \_\_\_\_\_

(Name of Applicant)

(Title of Officer)

of such company and that they are authorized to execute and file such instrument. Deponent further says that they are familiar with the instrument and the contents thereof, and that the facts therein set forth are true to the best of their knowledge, information and belief.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Type or print name beneath)

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). Amended by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

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**Appendix E. Form E - Pre-acquisition Notification Form Regarding the Potential Competitive Impact of a Proposed Merger or Acquisition by a Non-domiciliary Insurer Doing Business in this State or by a Domestic Insurer**

**PRE-ACQUISITION NOTIFICATION FORM  
REGARDING THE POTENTIAL COMPETITIVE IMPACT  
OF A PROPOSED MERGER OR ACQUISITION BY A  
NON-DOMICILIARY INSURER DOING BUSINESS IN THIS  
STATE OR BY A DOMESTIC INSURER**

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Name of Other Person Involved in Merger or Acquisition

**Filed with the Arizona Department of Insurance and Financial Institutions**

Dated: \_\_\_\_\_, 20\_\_\_\_

Name, title, address and telephone number of person completing this statement:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ITEM 1. NAME AND ADDRESS**

[State the name and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.]

**ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES**

[State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.]

**ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION**

[State the nature and purpose of the proposed merger or acquisition.]

**ITEM 4. NATURE OF BUSINESS**

[State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.]

**ITEM 5. MARKET AND MARKET SHARE**

[State specifically what market and market share in each relevant insurance market the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in A.R.S. § 20-481.25(D). If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.]

For purposes of this question, market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). Appendix E. *Instructions on Forms*, renumbered to Appendix G; new Appendix E. Form E made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

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Appendix F. Form F - Enterprise Risk Report

ENTERPRISE RISK REPORT

Filed with the Arizona Department of Insurance and Financial Institutions

By

\_\_\_\_\_  
Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

Name Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dated: \_\_\_\_\_, 20\_\_\_\_

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ITEM 1. ENTERPRISE RISK**

[The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in A.R.S. § 20-481(4), provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;

Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities with the insurance holding company system;

Any changes of shareholders of the insurance holding company system exceeding 10% or more of voting securities;

Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;

Business plan of the insurance holding company system and summarized strategies for next 12 months;

Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in last year;

Identification of insurance holding company system capital resources and material distribution patterns;

Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (include both the rating score and outlook);

Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

[The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.]

## TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

## CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS - INSURANCE DIVISION

**ITEM 2. OBLIGATION TO REPORT**

[If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.]

**Historical Note**

Appendix F, Form F made by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

**Appendix G. Instructions on Forms A, B, C, D, E and F****INSTRUCTIONS ON FORMS A, B, C, D, E AND F****FORMS - GENERAL REQUIREMENTS**

Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by A.R.S. §§ 20-481.02, 20-481.09, 20-481.12 and 20-481.25. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

One original paper statement excluding exhibits, and all other papers and documents shall be filed with the Director. The statement shall be signed in the manner prescribed on the form. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement. All paper filings shall be by personal delivery or mail addressed to: Arizona Department of Insurance and Financial Institutions, Insurance Financial Affairs Division.

In addition to the filed paper statement, a copy of the statement, including exhibits, and all other papers and documents filed as a part thereof, shall be filed electronically.

All filed documents shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

If an applicant requests a hearing on a consolidated basis under A.R.S. § 20-481.07, in addition to filing the Form A with the Director, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

**FORMS - INCORPORATION BY REFERENCE, SUMMARIES AND OMISSIONS**

Information required by any item of Form A, Form B, Form D, Form E or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form D, Form E or Form F provided the document is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Director which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Director which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which the documents differ from the documents, a copy of which is filed.

**FORMS - INFORMATION UNKNOWN OR UNAVAILABLE AND EXTENSION OF TIME TO FURNISH**

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there shall be filed with the Director as a separate document:

- (1) Identifying the information, document or report in question;
- (2) Stating why the filing thereof at the time required is impractical; and

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- (3) Requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Director within 60 days after receipt thereof enters an order denying the request.

**FORMS - ADDITIONAL INFORMATION AND EXHIBITS**

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E and Form F, the Director may request such further information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the forms. The exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, D, E or F shall include on the top of the cover page the phrase: "Change No. (insert number) to" and shall indicate the date of the change and not the date of the original filing.

**Historical Note**

Appendix G. *Instructions on Forms*, renumbered from Appendix E. *Instructions on Forms*, with heading amended to include new Appendix F, by exempt rulemaking at 21 A.A.R. 54, effective February 14, 2015 (Supp. 14-4). Amended by final rulemaking at 30 A.A.R. 482 (March 22, 2024), effective May 7, 2024 (Supp. 24-1).

**ARTICLE 15. RESERVED****ARTICLE 16. CREDIT FOR REINSURANCE**

A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1601. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1601 recodified from R4-14-1601 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). Amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1601 renumbered to R20-6-A1601 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1602. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1602 recodified from R4-14-1602 (Supp. 95-1). R20-6-1602 renumbered to R20-6-1607; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1602 renumbered to R20-6-A1602 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1603. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1603 recodified from R4-14-1603 (Supp. 95-1). R20-6-1603 renumbered to R20-6-1608; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1603 renumbered to R20-6-A1603 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1604. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1604 recodified from R4-14-1604 (Supp. 95-1). Amended effective October 9, 1998 (Supp. 98-4). R20-6-1604 renumbered to R20-6-1609; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1604 renumbered to R20-6-A1604 by final rulemaking at 28

**R20-6-1605. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1605 recodified from R4-14-1605 (Supp. 95-1). R20-6-1605 renumbered to R20-6-1610; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1605 renumbered to R20-6-A1605 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1606. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1606 recodified from R4-14-1606 (Supp. 95-1). R20-6-1606 renumbered to R20-6-1611; new Section made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1606 renumbered to R20-6-A1606 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1607. Renumbered****Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-1607 recodified from R4-14-1607 (Supp. 95-1). Section R20-6-1607 renumbered to R20-6-1612; new Section R20-6-1607 renumbered from R20-6-1602 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1607 renumbered to R20-6-A1607 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1608. Renumbered****Historical Note**

New Section R20-6-1608 renumbered from R20-6-1603 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1608 renumbered to R20-6-A1608 by final

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rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1609. Repealed****Historical Note**

New Section R20-6-1609 renumbered from R20-6-1604 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). Repealed by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1610. Renumbered****Historical Note**

New Section R20-6-1610 renumbered from R20-6-1605 by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1610 renumbered to R20-6-B1601 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1611. Renumbered****Historical Note**

New Section R20-6-1611 renumbered from R20-6-1606 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1611 renumbered to R20-6-B1602 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-1612. Renumbered****Historical Note**

New Section R20-6-1612 renumbered from R20-6-1607 and amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). R20-6-1612 renumbered to R20-6-B1603 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**PART A. CREDIT FOR REINSURANCE****R20-6-A1601. Credit for Reinsurance – Reinsurer Licensed in Arizona**

Pursuant to A.R.S. § 20-3602(C) the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that was licensed in Arizona as of any date on which statutory financial statement credit for reinsurance is claimed.

**Historical Note**

New Section R20-6-A1601 renumbered from R20-6-1601 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-A1602. Credit for Reinsurance – Accredited Reinsurers**

**A.** Pursuant to A.R.S. § 20-3602(D) the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is accredited as a reinsurer in Arizona as of the date on which statutory financial statement credit for reinsurance is claimed.

**B.** An accredited reinsurer must:

1. File a properly executed Form AR-1, attached as Exhibit A to this Part, as evidence of its submission to the Director's jurisdiction and to the Director's authority to examine its books and records;
2. File with the Director a certified copy of a certificate of authority or other acceptable evidence that it is licensed

to transact insurance or reinsurance in at least one state, or, in the case of a U.S. branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

3. File annually with the Director a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and
  4. Maintain a surplus as regards policyholders in an amount not less than \$20 million, or obtain the affirmative approval of the Director upon a finding that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.
- C.** If the Director determines that the assuming insurer has failed to meet or maintain any of these qualifications, the Director may upon written notice and opportunity for hearing, suspend or revoke the accreditation. Credit shall not be allowed a domestic ceding insurer under this Section if the assuming insurer's accreditation has been revoked by the Director, or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the Director.

**Historical Note**

New Section R20-6-A1602 renumbered from R20-6-1602 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; clerical error under subsection (B)(1) referencing Form AR-1 as an Appendix A corrected to Exhibit A (Supp. 22-1).

**R20-6-A1603. Credit for Reinsurance – Reinsurer Domiciled in Another State**

**A.** Pursuant to A.R.S. § 20-3602(E) the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that as of any date on which statutory financial credit for reinsurance is claimed:

1. Is domiciled in (or, in the case of a U.S. branch of an alien assuming insurer, is entered through) a state that employs standards regarding credit for reinsurance substantially similar to those applicable under A.R.S. Title 20, Chapter 30 and this Part;
2. Maintains a surplus as regards policyholders in an amount not less than \$20 million; and
3. Files a properly executed Form AR-1 (Exhibit A) with the Director as evidence of the submission to the Director's authority to examine its books and records.

**B.** The provisions of this Section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this Section, "substantially similar" standards means credit for reinsurance standards that the Director determines equal or exceed the standards of A.R.S. Title 20, Chapter 30 and this Part.

**Historical Note**

New Section R20-6-A1603 renumbered from R20-6-1603 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-A1604. Credit for Reinsurance – Reinsurers Maintaining Trust Funds**

**A.** Pursuant to A.R.S. § 20-3602(F) and (F)(1), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory



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financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified U.S. financial institution as defined in A.R.S. § 20-3601 for the payment of the valid claims of its U.S. domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Director substantially the same information as that required to be reported on the National Association of Insurance Commissioners (NAIC) annual statement form by licensed insurers, to enable the Director to determine the sufficiency of the trust fund.

**B.** The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. domiciled insurers, and in addition, the assuming insurer shall maintain a trustee surplus of not less than \$20 million, except as provided in subsection (B)(2).
2. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities, attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.
3. The trust fund for a group including incorporated and individual unincorporated underwriters:
  - a. Shall consist of:
    - i. For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, funds in trust in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group;
    - ii. For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this Part, funds in trust in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and
    - iii. In addition to these trusts, the group shall maintain a trustee surplus of which \$100 million shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.
  - b. The incorporated members of the group shall not be engaged in any business other than underwriting as a

member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the Director:

- i. An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or
  - ii. If a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group.
4. The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of \$10 billion (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC) and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall:
    - a. Consist of funds in trust in an amount no less than the assuming insurers' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group;
    - b. Maintain a joint trustee surplus of which \$100 million shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group; and
    - c. File a properly executed Form AR-1 (Exhibit A) as evidence of the submission to the Director's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination.
    - d. Within 90 days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the Director an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, prepared by independent public accountants, of each underwriter member of the group.
- C.** Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled.
1. The trust instrument shall provide that:
    - a. Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States;
    - b. Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's U.S. ceding insurers, their assigns and successors in interest;
    - c. The trust shall be subject to examination as determined by the commissioner;

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- d. The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust; and
  - e. No later than February 28 of each year the trustee of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year-end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.
2. Notwithstanding any other provisions in the trust instrument;
- a. If the trust fund is inadequate because it contains an amount less than the amount required by this Section or if the granter of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.
  - b. The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.
  - c. If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.
  - d. The granter shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.
- D.** For purposes of this Section, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and, shall include:
- 1. For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:
    - a. Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;
    - b. Reserves for losses reported and outstanding;
    - c. Reserves for losses incurred but not reported;
    - d. Reserves for allocated loss expenses; and
    - e. Unearned premiums.
  - 2. For business ceded by domestic insurers authorized to write life, health and annuity insurance:
    - a. Aggregate reserves for life policies and contracts net of policy loans and net due, and deferred premiums;
    - b. Aggregate reserves for accident and health policies;
    - c. Deposit funds and other liabilities without life or disability contingencies; and
    - d. Liabilities for policy and contract claims.
- E.** Assets deposited in trusts established pursuant to A.R.S. § 20-3602 and this Section shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in A.R.S. § 20-3601, clean, irrevocable, unconditional, and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution as defined in A.R.S. § 20-3601, and investments of the type specified in this subsection, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed 5% of total investments. No more than 20% of the total of the investments in the trust may be foreign investments authorized under subsections (E)(1)(e), (E)(3), (E)(6)(b), or (E)(7), and no more than 10% of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of A.R.S. § 20-3602 shall be invested only as follows:
- 1. Government obligations that are not in default as to principal or interest that are valid and legally authorized and that are issued, assumed, or guaranteed by:
    - a. The United States or by any agency or instrumentality of the United States;
    - b. A state of the United States;
    - c. A territory, possession, or other governmental unit of the United States;
    - d. An agency or instrumentality of a governmental unit referred to in subsections (E)(1)(b) and (E)(1)(c) if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this subsection (E)(1)(d) if payable solely out of special assessments on properties benefited by local improvements; or
    - e. The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;
  - 2. Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:
    - a. Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;
    - b. Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure

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- obligations in Arizona and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or
- c. Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;
3. Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;
4. An investment made pursuant to the provisions of subsections (E)(1), (E)(2), or (E)(3) shall be subject to the following additional limitations;
- a. An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed 5% of the assets of the trust;
- b. An investment in any one mortgage-related security shall not exceed 5% of the assets of the trust;
- c. The aggregate total investment in mortgage-related securities shall not exceed 25% of the assets of the trust; and
- d. Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under subsections (E)(2)(a) and (E)(2)(c), but shall not exceed 2% of the assets of the trust.
5. As used in this Section:
- a. "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:
- i. Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that: (1) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and (2) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. 1703; or
- ii. Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of subsection (E)(5)(a)(i);
- b. "Promissory note," when used in connection with a manufactured home, shall also include a loan, advance, or credit sale as evidenced by a retail installment sales contract or other instrument.
6. Equity interests.
- a. Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:
- i. Its obligations and preferred shares, if any, are eligible as investments under this Section; and
- ii. The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. 78a - 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the Financial Industry Regulatory Authority, or successor organization. A trust shall not invest in equity interests under this Section an amount exceeding 1% of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company;
- b. Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:
- i. All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and
- ii. The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;
- c. An investment in or loan upon any one institution's outstanding equity interests shall not exceed 1% of the assets of the trust. The cost of an investment in equity interests made pursuant to this subsection (E)(6), when added to the aggregate cost of other investments in equity interests then held pursuant to this subsection (E)(6), shall not exceed 10% of the assets in the trust;
7. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.
8. Investment companies.
- a. Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15

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U.S.C. 80a, are permissible investments if the investment company:

- i. Invests at least 90% of its assets in the types of securities that qualify as an investment under subsection (E)(1), (E)(2), or (E)(3) or invests in securities that are determined by the Director to be substantively similar to the types of securities set forth in subsection (E)(1), (E)(2), or (E)(3); or
- ii. Invests at least 90% of its assets in the types of equity interests that qualify as an investment under subsection (E)(6)(a);
- b. Investments made by a trust in investment companies under this subsection (E)(8) shall not exceed the following limitations:
  - i. An investment in an investment company qualifying under subsection (E)(8)(a)(i) shall not exceed 10% of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed 25% of the assets in the trust, and
  - ii. Investments in an investment company qualifying under subsection (E)(8)(a)(ii) shall not exceed 5% of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to subsection (E)(6)(a).

9. Letters of Credit.

- a. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Director) to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.
- b. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct, or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

- F. A specific security provided to a ceding insurer by an assuming insurer pursuant to Section R20-6-A1607 shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this Section.

**Historical Note**

New Section R20-6-A1604 renumbered from R20-6-1604 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" was removed when followed by a subsection reference (Supp. 22-1).

**R20-6-A1605. Credit for Reinsurance – Certified Reinsurers**

- A. Pursuant to A.R.S. §§ 20-3602(G), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in Arizona at all times for which statutory financial statement credit for reinsurance is claimed under this Section. The credit allowed shall

be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the Director. The security shall be in a form consistent with the provisions of A.R.S. §§ 20-3602(G), and 20-3603 and R20-6-A1608 or R20-6-A1609(A). The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

1. Ratings Security Required
  - a. Secure-1 0%
  - b. Secure-2 10%
  - c. Secure-3 20%
  - d. Secure-4 50%
  - e. Secure-5 75%
  - f. Vulnerable-6 100%
2. Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.
3. The Director shall require the certified reinsurer to post 100%, for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer.
4. In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the Director. The one year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:
  - a. Line 1: Fire
  - b. Line 2: Allied Lines
  - c. Line 3: Farmowners multiple peril
  - d. Line 4: Homeowners multiple peril
  - e. Line 5: Commercial multiple peril
  - f. Line 9: Inland Marine
  - g. Line 12: Earthquake
  - h. Line 21: Auto physical damage
5. Credit for reinsurance under this Section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract covering any risk for which collateral was provided previously, shall only be subject to this Section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.
6. Nothing in this Section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this Section.

**B. Certification Procedure.**

1. The Director shall post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The Director may not take final action on the application until at

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least 30 days after posting the notice required by this subsection (B)(1).

2. The Director shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with subsection (A). The Director shall publish a list of all certified reinsurers and their ratings.
3. In order to be eligible for certification, the assuming insurer shall meet the following requirements:
  - a. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the Director pursuant to subsection (C).
  - b. The assuming insurer must maintain capital and surplus, or its equivalent, of no less than \$250 million calculated in accordance with subsection (B)(4)(h). This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least \$250 million and a central fund containing a balance of at least \$250 million.
  - c. The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the Director. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the Director in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:
    - i. Standard & Poor's;
    - ii. Moody's Investors Service;
    - iii. Fitch Ratings;
    - iv. A.M. Best Company; or
    - v. Any other Nationally Recognized Statistical Rating Organization.
  - d. The certified reinsurer must comply with any other requirements reasonably imposed by the Director.
4. Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:
  - a. The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the Table 1. The Director shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification as outlined in Table 1.
  - b. The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;
- c. For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers);
- d. For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (instructions attached as Exhibit C) for property/casualty reinsurers or Form CR-S (instructions attached as Exhibit D) for life and health reinsurers;
- e. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than 90 days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;
- f. Regulatory actions against the certified reinsurer;
- g. The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subsection (B)(4)(h);
- h. For certified reinsurers not domiciled in the U.S., audited financial statements, regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the Director will consider audited financial statements for the last two years filed with its non-U.S. jurisdiction supervisor;
- i. The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;
- j. A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The Director shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and
- k. Any other information deemed relevant by the Director.

5. Based on the analysis conducted under subsection (B)(4)(e) of a certified reinsurer's reputation for prompt payment of claims, the Director may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the Director shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under subsection (B)(4)(a) if the Director finds that:
  - a. More than 15% of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of 90 days or more which are not in dispute and which exceed \$100 thousand for each cedent; or
  - b. The aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by 90 days or more exceeds \$50 million.

6. The assuming insurer must submit a properly executed Form CR-1 (attached as Exhibit B) as evidence of its submission to the jurisdiction of Arizona, appointment of the

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Director as an agent for service of process in Arizona, and agreement to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The Director shall not certify any assuming insurer that is domiciled in a jurisdiction that the Director has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

7. The certified reinsurer must agree to meet applicable information filing requirements as determined by the Director, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under A.R.S. § 20-158 and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:
  - a. Notification within ten days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefore;
  - b. Annually, Form CR-F or CR-S, as applicable;
  - c. Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subsection (B)(7)(d);
  - d. Annually, the most recent audited financial statements, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last two years filed with the certified reinsurer's supervisor;
  - e. At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;
  - f. A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and
  - g. Any other information that the Director may reasonably require.
8. Change in Rating or Revocation of Certification.
  - a. In the case of a downgrade by a rating agency or other disqualifying circumstance, the Director shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of subsection (B)(4)(a).
  - b. The Director shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this Section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the Director to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.
  - c. If the rating of a certified reinsurer is upgraded by the Director, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the Director shall require the certified reinsurer to post security under the previ-

ously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the Director, the Director shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

- d. Upon revocation of the certification of a certified reinsurer by the Director, the assuming insurer shall be required to post security in accordance with R20-6-A1607 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with R20-6-A1604, the Director may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the Director to be at high risk of uncollectibility.

C. Qualified Jurisdictions.

1. If, upon conducting an evaluation under this Section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the Director determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the Director shall publish notice and evidence of such recognition in an appropriate manner. The Director may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.
2. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the Director shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The Director shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the Director as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the Director with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the Director, include but are not limited to the following:
  - a. The framework under which the assuming insurer is regulated.
  - b. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.
  - c. The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.
  - d. The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.

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- e. The domiciliary regulator's willingness to cooperate with U.S. regulators in general and the Director in particular.
  - f. The history of performance by assuming insurers in the domiciliary jurisdiction.
  - g. Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the Director has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.
  - h. Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.
  - i. Any other matters deemed relevant by the Director.
3. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The Director shall consider this list in determining qualified jurisdictions. If the Director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Director shall provide thoroughly documented justification with respect to the criteria provided under subsections (C)(2)(a) through (C)(2)(i).
  4. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.
- D. Recognition of Certification Issued by an NAIC Accredited Jurisdiction.**
1. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Director has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 (Exhibit B) and such additional information as the Director requires. The assuming insurer shall be considered to be a certified reinsurer in Arizona.
2. Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in Arizona as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the Director of any change in its status or rating within ten days after receiving notice of the change.
  3. The Director may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with subsection (B)(8).
  4. The Director may withdraw recognition of the other jurisdiction's certification at any time with written notice to the certified reinsurer. Unless the Director suspends or revokes the certified reinsurer's certification in accordance with subsection (B)(8), the certified reinsurer's certification shall remain in good standing in this State for a period of three months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in Arizona.
- E. Mandatory Funding Clause.** In addition to the clauses required under R20-6-A1609(B), reinsurance contracts entered into or renewed under this Section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this Section for reinsurance ceded to the certified reinsurer.
- F.** The Director shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

**Historical Note**

New Section R20-6-A1605 renumbered from R20-6-1605 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" and word "below" were removed when by followed a subsection reference (Supp. 22-1).

**Table 1. Financial Strength Ratings**

Ratings	Best	S&P	Moody's	Fitch
Secure – 1	A++	AAA	Aaa	AAA
Secure – 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure – 3	A	A+, A	A1, A2	A+, A
Secure – 4	A-	A-	A3	A-
Secure – 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable – 6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

**Historical Note**

Table 1 renumbered from R20-6-1605 by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

**R20-6-A1606. Credit for Reinsurance - Reciprocal Jurisdictions; Credit for Reinsurance Required by Law**

- A.** Credit for reinsurance to a reciprocal jurisdiction assuming insurer. Pursuant to A.R.S. § 20-3602(H), (I), (J), (K), (L), and (R), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a reciprocal jurisdiction, and which meets the other requirements of this Part.
- B.** A "reciprocal jurisdiction" is a jurisdiction, as designated by the Director pursuant to subsection (D) that meets one of the following:
  1. A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subsection, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a

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- ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;
2. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or
  3. A qualified jurisdiction, as determined by the Director pursuant to A.R.S. § 20-3602(G)(3) and Section R20-6-A1605(C), which is not otherwise described in subsections (B)(1) or (B)(2) and which the Director determines meets all of the following additional requirements:
    - a. Provides that an insurer who has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S.-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;
    - b. Does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;
    - c. Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups who are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the Director or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; and
    - d. Provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the Director in accordance with a memorandum of understanding or similar document between the Director and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.
- C. Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to a reciprocal jurisdiction assuming insurer meeting each of these conditions:
1. The assuming insurer must be licensed to transact insurance by, and have its head office or be domiciled in, a reciprocal jurisdiction;
  2. The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, and confirmed as set forth in subsection (C)(7) according to the methodology of its domiciliary jurisdiction, in the following amounts:
    - a. No less than \$250 million; or
    - b. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:
      - i. Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least \$250 million; and
      - ii. A central fund containing a balance of the equivalent of at least \$250 million.
  3. The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:
    - a. If the assuming insurer has its head office or is domiciled in a reciprocal jurisdiction as defined in subsection (B)(1), the ratio specified in the applicable covered agreement;
    - b. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subsection (B)(2), a risk-based capital (RBC) ratio of 300% of the authorized control level, calculated in accordance with the formula developed by the NAIC; or
    - c. If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subsection (B), after consultation with the reciprocal jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the Director determines to be an effective measure of solvency.
  4. The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Form RJ-1 (Exhibit E), of its agreement to the following:
    - a. The assuming insurer must agree to provide prompt written notice and explanation to the Director if it falls below the minimum requirements set forth in subsections (C)(2) or (C)(3), or if any regulatory action is taken against it for serious noncompliance with applicable law;
    - b. The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the Director as agent for service of process.
      - i. The Director may also require that such consent be provided and included in each reinsurance agreement under the Director's jurisdiction.
      - ii. Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;
    - c. The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained;
    - d. Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding



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- insurer or by its legal successor on behalf of its estate, if applicable;
- e. The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involved this state's ceding insurers, and agrees to notify the ceding insurer and the Director and to provide 100% security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of A.R.S. §§ 20-3602(G) and 20-3603, R20-6-A1608, or R20-6-A1609(A). For purposes of this Section, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed class members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction; and
  - f. The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in subsection (C)(5).
5. The assuming insurer or its legal successor must provide, if requested by the Director, on behalf of itself and any legal predecessors, the following documentation to the Director:
    - a. For the two years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;
    - b. For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;
    - c. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and
    - d. Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in subsection (C)(6).
  6. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:
    - a. More than 15% of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported by the Director;
    - b. More than 15% of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed for each ceding insurer \$100 thousand, or as otherwise specified in a covered agreement; or
    - c. The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds \$50 million, or as otherwise specified in a covered agreement.
  7. The assuming insurer's supervisory authority must confirm to the Director on an annual basis that the assuming insurer complies with the requirements set forth in subsections (C)(2) and (C)(3).
  8. Nothing in this provision precludes an assuming insurer from providing the Director with information on a voluntary basis.
- D. The Director shall timely create and publish a list of reciprocal jurisdictions.
    1. A list of reciprocal jurisdictions is published through the NAIC committee process. The Director's list shall include any reciprocal jurisdiction as defined under subsections (B)(1) and (B)(2), and shall consider any other reciprocal jurisdiction included on the NAIC list. The Director may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions as provided by applicable law, regulation, or in accordance with criteria published through the NAIC committee process.
    2. The Director may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a reciprocal jurisdiction, as provided by applicable law, regulation, or in accordance with a process published through the NAIC committee process, except that the Director shall not remove from the list a reciprocal jurisdiction as defined under subsections (B)(1) and (B)(2). Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to A.R.S. Title 20, Chapter 30 and this Part.
  - E. The Director shall timely create and publish a list of reciprocal jurisdiction assuming insurers that have satisfied the conditions set forth in this Section and to which cessions shall be granted credit in accordance with this subsection.
    1. If an NAIC accredited jurisdiction has determined that the conditions set forth in subsection (C) have been met, the Director has the discretion to defer to that jurisdiction's determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The Director may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirement of subsection (C).
    2. When requesting that the Director defer to another NAIC accredited jurisdiction's determination, an assuming insurer must submit a properly executed Form RJ-1 (Appendix E) and additional information as the Director may require. A state that has received such a request will notify other states through the NAIC committee process and provide relevant information with respect to the determination of eligibility.
  - F. If the Director determines that a reciprocal jurisdiction assuming insurer no longer meets one or more of the requirements

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under this Section, the Director may revoke or suspend the eligibility of the reciprocal jurisdiction assuming insurer for recognition under this Section.

1. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with R20-6-A1607.
  2. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Director and consistent with the provisions of R20-6-A1607.
- G.** Before denying statement credit or imposing a requirement to post security with respect to subsection (F) or adopting any similar requirement that will have substantially the same regulatory impact as security, the Director shall:
1. Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in subsection (C);
  2. Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;
  3. After the expiration of 90 days or less, as set out in subsection (G)(2), if the Director determines that no or insufficient action was taken by the assuming insurer, the Director may impose any of the requirements as set out in this subsection (G); and
  4. Provide a written explanation to the assuming insurer of any of the requirements set out in this subsection (G).
- H.** If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring the reciprocal jurisdiction assuming insurer to post security for all outstanding liabilities.
- I.** Credit for reinsurance required by law. Pursuant to A.R.S. § 20-3602(M), the Director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of A.R.S. §§ 20-3602(C) through (G) but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this Section, "jurisdiction" means state, district, or territory of the United States and any lawful national government.

**Historical Note**

New Section R20-6-A1606 renumbered from R20-6-1606 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" and word "above" were removed when followed by a subsection reference (Supp. 22-1).

**R20-6-A1607. Asset or Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer not Meeting the Requirements of R20-6-A1601 through R20-6-A1606**

- A.** Pursuant to A.R.S. § 20-3603, the Director shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of A.R.S. § 20-3602 in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the reinsurance contract. The security shall be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in A.R.S. § 20-3601. This security may be in the form of any of the following:
1. Cash;
  2. Securities listed by the Securities Valuation Office of the NAIC, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;
  3. Clean, irrevocable, unconditional, and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in A.R.S. § 20-3601, effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or
  4. Any other form of security acceptable to the Director.
- B.** An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this Section shall be allowed only when the requirements of R20-6-A1609(B) and the applicable portions of R20-6-A1608 or R20-6-A1609(A) have been satisfied.

**Historical Note**

New Section R20-6-A1606 renumbered from R20-6-1606 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant word "Section" was removed before a Chapter Section number (Supp. 22-1).

**R20-6-A1608. Trust Agreements Qualified under R20-6-A1607; Letters of Credit Qualified under R20-6-A1607**

- A.** Trust agreements - definitions. As used in subsections (B) through (G):
1. "Beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver, or conservator.
  2. "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.
  3. "Obligations," as used in subsection (B)(11), means:
    - a. Reinsured losses and allocated loss expenses paid by the ceding company but not recovered from the assuming insurer;

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- b. Reserves for reinsured losses reported and outstanding;
  - c. Reserves for reinsured losses incurred but not reported; and
  - d. Reserves for allocated reinsured loss expenses and unearned premiums.
- B. Trust agreements - required conditions.**
1. The trust agreement shall be entered into between the beneficiary, the grantor, and a trustee which shall be a qualified United States financial institution as defined in A.R.S. § 20-3601.
  2. The trust agreement shall create a trust account into which assets shall be deposited.
  3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States.
  4. The trust agreement shall provide that:
    - a. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;
    - b. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;
    - c. It is not subject to any conditions or qualifications outside of the trust agreement; and
    - d. It shall not contain references to any other agreements or documents except as provided for in subsections (B)(11) and (B)(12).
  5. The trust agreement shall be established for the sole benefit of the beneficiary.
  6. The trust agreement shall require the trustee to:
    - a. Receive assets and hold all assets in a safe place;
    - b. Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;
    - c. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;
    - d. Notify the grantor and the beneficiary within ten days, of any deposits to or withdrawals from the trust account;
    - e. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and
    - f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.
  7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.
  8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled.
  9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying commission to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Director), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.
  10. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct, or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.
  11. Notwithstanding other provisions of subsections (A) through (G), when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:
    - a. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;
    - b. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102% of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or
    - c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in A.R.S. § 20-3601 apart from its general assets, in trust for such uses and purposes specified in subsections (11)(a) and (11)(b) as may remain executory after such withdrawal and for any period after the termination date.
  12. Notwithstanding other provisions of subsections (A) through (G), when a trust agreement is established to meet the requirements of R20-6-A1607 in conjunction with a reinsurance agreement covering life, annuities, or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of

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the ceding insurer or the assuming insurer, only for the following purposes:

- a. To pay or reimburse the ceding insurer for:
  - i. The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and
  - ii. The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provision of the policies reinsured under the reinsurance agreement.
- b. To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer, or
- c. Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in subsections (12)(a) and (12)(b) as may remain executory after withdrawal and for any period after the termination date.

13. Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by the Insurance Code, or any combination of the above, provided investments in or issued by an entity controlling, controlled by, or under common control with either the grantor or the beneficiary of the trust shall not exceed 5% of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities, or accident and health risks, then the provisions required by this subsection must be included in the reinsurance agreement.

C. Trust agreements - permitted conditions.

1. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than 90 days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after the trustee and the beneficiary receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

2. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.
3. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in current fair market value to the assets withdrawn and that are consistent with the restrictions in subsection (D)(1)(b).
4. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.
5. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

D. Trust agreements - additional conditions applicable to reinsurance agreements:

1. A reinsurance agreement may contain provisions that:
  - a. Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;
  - b. Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;
  - c. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and
  - d. Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver, or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:
    - i. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured

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- under the reinsurance agreement because of cancellations of such policies; and
    - ii. To pay or reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement; and
    - iii. To pay or reimburse the ceding insurer for any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding reinsurer; or
    - iv. To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.
  - 2. The reinsurance agreement also may contain provisions that:
    - a. Give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:
      - i. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or
      - ii. After withdrawal and transfer, the current fair market value of the trust account is no less than 102% of the required amount.
    - b. Provide for the return of any amount withdrawn in excess of the actual amounts required for subsection (D)(1)(d), and for interest payments at a rate not in excess of the prime rate of interest on such amounts;
    - c. Permit the award by any arbitration panel or court of competent jurisdiction of:
      - i. Interest at a rate different from that provided in subsection (D)(2)(b);
      - ii. Court or arbitration costs;
      - iii. Attorney's fees; and
      - iv. Any other reasonable expenses.
- E. Trust agreements - financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the Director in compliance with the provisions of this Part when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.
- F. Trust agreements - existing agreements. Notwithstanding the effective date of this Part, any trust agreement or underlying reinsurance agreement in existence and approved by the Director prior to the effective date of this Part will continue to be acceptable until December 31, 2016, at which time the agreements will have to fully comply with subsections (A) through (G) for the trust agreement to be acceptable.
- G. Trust agreements - failure to identify beneficiary. The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (A)(1) shall not be construed to affect any actions or rights that the Director may take or possess pursuant to the provisions of the laws of Arizona.
- H. Letters of credit. The letter of credit must be clean, irrevocable, unconditional, and issued or confirmed by a qualified United States financial institution as defined A.R.S. § 20-3601. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in subsection (N)(1). As used in this Section, "beneficiary" includes any successor by operation of law of the named beneficiary, including without limitation any liquidator, rehabilitator, receiver, or conservator. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).
- I. Letters of credit - heading. The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.
- J. Letters of credit - required statements and clauses.
  - 1. A letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.
  - 2. The letter of credit shall state whether it is subject to and governed by the laws of Arizona or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98). All drafts of letters of credit drawn according to UCP 600 or ISP98 shall be presentable at an office in the United States of a qualified United States financial institution.
  - 3. The letter of credit shall contain an "evergreen clause" in compliance with subsection (K).
- K. Letters of credit - term of the letter of credit. The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for no less than 30 days' notice prior to expiration date or nonrenewal.
- L. Letters of credit made subject to UCP 600 or ISP98. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), then the letter of credit shall specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of UCP 600 occur.
- M. Letters of credit - additional requirements. If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified United States financial institution

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as described in subsection (H), then the following additional requirements shall be met:

1. The issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and
  2. The “evergreen clause” shall provide for 30 days’ notice prior to expiration date or nonrenewal.
- N. Letters of credit - reinsurance agreement provisions.
1. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:
    - a. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;
    - b. Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:
      - i. To pay or reimburse the ceding insurer for the assuming insurer’s share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;
      - ii. To pay or reimburse the ceding insurer for the assuming insurer’s share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and
      - iii. To pay or reimburse the ceding insurer for any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;
      - iv. Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer’s entire obligations under the reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer’s share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in subsections (N)(1)(b)(i), (N)(1)(b)(ii), and (N)(1)(b)(iii) as may remain after withdrawal and for any period after the termination date.
    - c. All of the provisions of subsections (N)(1)(a) and (N)(1)(b) shall be applied without diminution

because of insolvency on the part of the ceding insurer or assuming insurer.

2. Nothing contained in subsection (N)(1) shall preclude the ceding insurer and assuming insurer from providing for:
  - a. An interest payment, at a rate not in excess of the prime rate of interest on the amounts held pursuant to subsection (N)(1)(b); or
  - b. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

**Historical Note**

New Section R20-6-A1608 renumbered from R20-6-1608 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase “of this Section” was removed when followed by a subsection reference, and the word “Section” was removed before a Chapter Section number (Supp. 22-1).

**R20-6-A1609. Other Security; Reinsurance Contract; Contracts Affected**

- A. Other Security. A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.
- B. Reinsurance Contract. Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of R20-6-A1601 through R20-6-A1605 or R20-6-A1607 of this Article or otherwise in compliance with A.R.S. § 20-3602 after the adoption of this Part unless the reinsurance agreement:
  1. Includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to A.R.S. § 20-261(C);
  2. Includes a provision pursuant to A.R.S. § 20-3602 whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute-resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give the court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of the court or panel; and
  3. Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.
- C. Contracts affected. All new and renewal reinsurance transactions entered into after the effective date of this Part shall conform to the requirements of A.R.S. Title 20, Chapter 30 and this Part if credit is to be given to the ceding insurer for such reinsurance.

**Historical Note**

New Section R20-6-A1609 renumbered from R20-6-1609 and amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant word “Section” was removed before a Chapter Section number (Supp. 22-1).

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## Exhibit A. Form AR-1, Certificate of Assuming Insurer

## FORM AR-1, CERTIFICATE OF ASSUMING INSURER

I, \_\_\_\_\_, \_\_\_\_\_,  
(name of officer) (title of officer)

of \_\_\_\_\_, the assuming insurer  
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in

\_\_\_\_\_, hereby certify that  
(name of state)

\_\_\_\_\_, (“Assuming Insurer”):  
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in

\_\_\_\_\_  
(ceding insurer’s state of domicile)

for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer’s rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Director of the Arizona Department of Insurance and Financial Institutions (“Director”) as its lawful attorney upon whom may be served any lawful process in any action, suit or legal proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the Director to examine its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in \_\_\_\_\_ reinsured by Assuming Insurer and  
(ceding insurer’s state of domicile)

undertakes to submit additions to or deletions from the list to the Director at least once per calendar quarter.

Dated: \_\_\_\_\_  
(name of assuming insurer)

BY: \_\_\_\_\_  
(name of officer)

\_\_\_\_\_  
(title of officer)

**Historical Note**

Adopted effective February 3, 1993 (Supp. 93-1). Exhibit A amended by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4). Exhibit A amended by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022 (Supp. 22-1).

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**FORM CR-1, CERTIFICATE OF CERTIFIED REINSURER**

(title of officer)

Adopted effective February 3, 1993 (Supp. 93-1). Exhibit B repealed; new Exhibit B made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).



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**Exhibit C. Form CR-F Instructions****Form CR-F Instructions****Part 1 - Assumed Reinsurance as of December 31, Current Year (000 Omitted)**

Create a spreadsheet with the following columns (total each column 5 through 15):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Name of Reinsured
4. Domiciliary Jurisdiction
5. Assumed Premium
6. Reinsurance on Paid Losses and Loss Adjustment Expenses
7. Reinsurance on Known Case Losses and LAE
8. Cols. 6 + 7
9. Contingent Commissions Payable
10. Assumed Premium Receivable
11. Unearned Premium
12. Funds Held By or Deposited With Reinsured Companies
13. Letters of Credit Posted
14. Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit
15. Amount of Assets Pledged or Collateral Held in Trust

Each row shall list each insurer for which reinsurance is assumed for the calendar year.

**Part 2 - Ceded Reinsurance as of December 31, Current Year (000 Omitted)**

Create a spreadsheet with the following columns (total each column 6 through 19):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Name of Reinsurer
4. Domiciliary Jurisdiction
5. Reinsurance Contracts Ceding 75% or More of Direct Premiums Written
6. Reinsurance Premiums Ceded
7. Reinsurance Recoverable on Paid Losses
8. Reinsurance Recoverable on Paid LAE
9. Reinsurance Recoverable on Known Case Loss Reserves
10. Reinsurance Recoverable on Known Case LAE Reserves
11. Reinsurance Recoverable on IBNR Loss Reserves
12. Reinsurance Recoverable on IBNR LAE Reserves
13. Reinsurance Recoverable on Unearned Premiums
14. Reinsurance Recoverable on Contingent Commissions
15. Cols. 7 through 14 Totals
16. Reinsurance Payable Ceded Balances Payable
17. Reinsurance Payable Other Amounts Due to Reinsurers
18. Net Amount Recoverable From Reinsurers, Cols. 15 – [16 + 17]
19. Funds Held by Company Under Reinsurance Treaties

Each row shall list each insurer to whom reinsurance was ceded for the calendar year.

**Historical Note**

Exhibit C made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

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**Exhibit D. Form CR-S Instructions****Form CR-S Instructions**

**Part 1 – Section 1.** Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year

Create a spreadsheet with the following columns (total each column 7 through 12):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Reinsured
5. Location
6. Type of Reinsurance Assumed
7. Amount of In Force at End of Year
8. Reserve
9. Premiums
10. Reinsurance Payable on Paid and Unpaid Losses
11. Modified Coinsurance Reserve
12. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was assumed (life insurance, annuities, deposit funds and other liabilities without life or disability contingencies, and related benefits) for the calendar year.

**Part 1 – Section 2.** Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

Please create a spreadsheet with the following columns (total columns 7 through 12):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Reinsured
5. Domiciliary Jurisdiction
6. Type of Reinsurance Assumed
7. Premiums
8. Unearned Premiums
9. Reserve Liability Other Than For Unearned Premiums
10. Reinsurance Payable on Paid and Unpaid Losses
11. Modified Coinsurance Reserve
12. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was assumed (accident and health insurance) for the calendar year.

**Part 2.** Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

Create a spreadsheet with the following columns (total each column 6 and 7):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location
6. Paid Losses
7. Unpaid Losses

Each row shall list each insurer for which reinsurance on paid and unpaid losses is recoverable.

**Part 3 – Section 1.** Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year

Create a spreadsheet with the following columns (total each column 7 through 14):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location

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6. Type of Reinsurance Ceded
7. Amount in Force at End of Year
8. Reserve Credit Taken Current Year
9. Reserve Credit Taken Prior Year
10. Premiums
11. Outstanding Surplus Relief Current Year
12. Outstanding Surplus Relief Prior Year
13. Modified Coinsurance Reserve
14. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was ceded (life insurance, annuities, deposit funds and other liabilities without life or disability contingencies and related benefits).

**Part 3 – Section 2.** Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year  
Create a spreadsheet with the following columns (total each column 7 through 13):

1. ID Number/Company Code
2. This column is intentionally left blank
3. Effective Date
4. Name of Company
5. Location
6. Type
7. Premiums
8. Unearned Premiums (Estimated)
9. Reserve Credit Taken other than for Unearned Premiums
10. Outstanding Surplus Relief Current Year
11. Outstanding Surplus Relief Prior Year
12. Modified Coinsurance Reserve
13. Funds Withheld Under Coinsurance

Each row shall list each insurer for which reinsurance was ceded (accident and health insurance).

**Historical Note**

Exhibit D made by final exempt rulemaking, under Laws 2015, Ch. 119, § 3, effective November 30, 2015 (Supp. 15-4).

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**FORM RJ-1,  
CERTIFICATE OF REINSURER DOMICILED IN RECIPROCAL JURISDICTION**

December 31, 2024

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**B. Exemptions.** Part B of this Article does not apply to the following situations:

1. Reinsurance of:
  - a. Policies that satisfy the criteria for exemption set forth in A.R.S. § 20-510 and which are issued before the later of:
    - i. The effective date of this Part B; and
    - ii. The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020;
  - b. Portions of policies that satisfy the criteria for exemption set forth in A.R.S. § 20-510 and which are issued before the later of:
    - i. The effective date of this Part B; and
    - ii. The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than January 1, 2020;
  - c. Any universal life policy that meets all of the following requirements:
    - i. Secondary guarantee period, if any, if five years or less;
    - ii. Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Director's Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and
    - iii. The initial surrender charge is not less than 100% of the first year annualized specified premium for the secondary guarantee period;
  - d. Credit life insurance;
    - i. Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or
    - ii. Any group life insurance certificate unless the certificate provides for a stated and implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.
2. Reinsurance ceded to an assuming insurer that meets the applicable requirements of A.R.S. § 20-3602(F); or
3. Reinsurance ceded to an assuming insurer that meets the applicable requirements of A.R.S. §§ 20-3602(C), (D), or (E), and that, in addition:
  - a. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to the Statement of Statutory Accounting Principles No. 1 ("SSAP 1"); and
  - b. Is not a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in A.R.S. § 20-488 when its Risk-Based Capital ("RBC") is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same

may be amended by the NAIC from time to time, without deviation; or

4. Reinsurance ceded to an assuming insurer that meets the applicable requirements of A.R.S. §§ 20-3602(C), (D), or (E), and that, in addition:
  - a. Is not an affiliate, as that term is defined in A.R.S. § 20-481, of:
    - i. The insurer ceding the business to the assuming insurer; or
    - ii. Any insurer that directly or indirectly ceded the business to that ceding insurer;
  - b. Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;
  - c. Is both:
    - i. Licensed or accredited in at least ten states including its state of domicile; and
    - ii. Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and
  - d. Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in A.R.S. § 20-488 when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus; or
5. Reinsurance ceded to an assuming insurer that meets the requirements of A.R.S. § 20-3604(D)(2); or
6. Reinsurance not otherwise exempt under subsections (B)(1) through (B)(5) if the Director, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:
  - a. The risks are clearly outside of the intent and purpose of this Part B;
  - b. The risks are included within the scope of this regulation only as a technicality; and
  - c. The application of this Part B to those risks is not necessary to provide appropriate protection to policyholders. The Director shall publicly disclose any decision made pursuant to this subsection (B)(6) to exempt a reinsurance treaty from this Part B, as well as the general basis for the decision including a summary of the treaty.

**C. Part B Definitions:**

1. "Actuarial Method" means the methodology used to determine the Required Level of Primary Security, as described in R20-6-B1602.
2. "Covered Policies" means policies, other than Grandfathered Policies and policies that are not exempt under subsection (B), of the following policy types:
  - a. Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or

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- b. Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.
- 3. "Grandfathered Policies" means Covered Policies that were:
  - a. Issued prior to January 1, 2015; and
  - b. Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in subsection (B).
- 4. "Non-Covered Policies" means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.
- 5. "Other Security" means any security acceptable to the Director other than security meeting the definition of Primary Security.
- 6. "Primary Security" means the following forms of security:
  - a. Cash meeting the requirements of A.R.S. § 20-3603(B)(1);
  - b. Securities listed by the Securities Valuation Office meeting the requirements of A.R.S. § 20-3603(B)(2), but excluding any synthetic letter of credit, contingent note, credit-linked note, or other similar security that operates in a manner similar to a letter of credit excluding any securities issued by the ceding insurer or any of its affiliates; and
  - c. For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:
    - i. Commercial loans in good standing of CM3 quality and higher;
    - ii. Policy loans; and
    - iii. Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.
- 7. "Required Level of Primary Security" means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.
- 8. "Valuation Manual" means the Valuation Manual adopted by the NAIC as described in A.R.S. § 20-510, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.
- 9. "VM-20" means "Requirements for Principle-Based Reserves for Life Products" including all relevant definitions from the Valuation Manual.
- D. Severability. If any provision of this Part B is held invalid, the remainder shall not be affected.
- E. Prohibition against avoidance. No insurer that has Covered Policies to which this Part B applies, as set forth in subsection (A), shall take any action or series of actions or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of the action, transaction, or arrangement or series is to avoid the requirements of this Part B or to circumvent its purpose and intent.

**Historical Note**

New Section R20-6-B1601 renumbered from R20-6-1610 and repealed; new Section R20-6-B1601 made by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" was removed when followed by a subsection refer-

ence, and the word "Section" was removed before a Chapter Section number (Supp. 22-1).

**R20-6-B1602. The Actuarial Method**

- A. Actuarial Method. The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this Part B shall be VM-20, applied on a treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual then in effect, applied as follows:
  - 1. For Covered Policies described in R20-6-B1601(C)(2)(a), the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in R20-6-B1601(C)(2)(b), the ceding insurer may elect to instead use subsection (A)(2) as the Actuarial Method for the entire reinsurance agreement. Whether subsection (A)(1) or (A)(2) is used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.
  - 2. For Covered Policies described in R20-6-B1601(C)(2)(b), the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met.
  - 3. Except as provided in subsection (A)(4), the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.
  - 4. If the reinsurance treaty cedes less than 100% of the risk with respect to the Covered Policies, then the Required Level of Primary Security may be reduced as follows:
    - a. If a reinsurance treaty cedes only a quota share of some of all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under subsection (A)(4)(c), may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;
    - b. If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM-20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cessation of mortality risk on a yearly renewable term basis in an exempt arrangement;
    - c. If a portion of the covered policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Pri-

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mary Security may be reduced by the amount resulting by applying the Actuarial Method including the reinsurance section of VM-20 to the portion of the covered policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to January 1, 2017, this adjustment is not to exceed  $[cx / (2 * \text{number of reinsurance premiums per year})]$  where cx is calculated using the same mortality table used in calculating the Net Premium Reserve; and

- d. For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss, and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security. It is possible for any combination of subsections (A)(4)(a), (A)(4)(b), (A)(4)(c), and (A)(4)(d) to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than 100% of the risk. The adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

5. In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.
6. If the ceding insurer cedes risk with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this Part B, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this Part B.
7. If a reinsurance treaty subject to this Part B cedes risk on both Covered and Non-Covered Policies, credit for the ceded reserves shall be determined as follows:
  - a. The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies, and R20-6-B1603 shall be used to determine the reinsurance credit for the covered policy reserves; and
  - b. Credit for the non-covered policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of subsection (A)(7)(a), is held by or on behalf of the ceding insurer in accordance with A.R.S. §§ 20-3602 and 20-3603. Any Primary Security used to meet the requirements of this subsection (A)(7)(b) may not be used to satisfy the Required Level of Primary Security for the Covered Policies.

- B. Valuation used for Purposes of Calculations. For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

1. For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding

insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

2. For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the NAIC's Life Actuarial (A) Task Force no later than the December 31st on or immediately preceding the valuation date for which the Required Level of Primary Security is being calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

**Historical Note**

New Section R20-6-B1602 renumbered from R20-6-1611 and repealed; new Section R20-6-B1602 made by final rulemaking at 28 A.A.R. 493 (March 4, 2022), effective April 9, 2022; the redundant phrase "of this Section" and word "below" were removed when followed by a subsection reference, and the word "Section" was removed before a Chapter Section number (Supp. 22-1).

**R20-6-B1603. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation**

- A. Requirements. Subject to the exemptions described in R20-6-B1601(B) and the provisions of subsection (B), credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to Covered Policies pursuant to A.R.S. §§ 20-3602 or 20-3603 if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

1. The ceding insurer's statutory policy reserves with respect to the Covered Policies are established in full and in accordance with the applicable requirements of A.R.S. § 20-510 and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation does not exceed the proportionate share of those reserves ceded under the contract; and
2. The ceding insurer determines the Required Level of Primary Security with respect to each reinsurance treaty subject to this Part B and provides support for its calculation as determined to be acceptable to the Director; and
3. Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of A.R.S. § 20-3603, on a funds withheld, trust, or modified coinsurance basis; and
4. Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to subsection (A)(3), are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of A.R.S. § 20-3603; and
5. Any trust used to satisfy the requirements of this Section shall comply with all of the conditions and qualifications of R20-6-A1608(A) through (G), except that:
  - a. Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in R20-6-B1602(B), be valued according to the valua-

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tion rules set forth in R20-6-B1602(B), as applicable; and

- b. There are no affiliate investment limitations with respect to any security held in the trust if such security is not needed to satisfy the requirements of subsection (A)(3); and
- c. The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by subsection (A)(3) 102% of the level required by subsection (A)(3) at the time of the withdrawal or substitution; and
- d. The determination of reserve credit under R20-6-A1608(E) shall be determined according to the valuation rules set forth in R20-6-B1602(B), as applicable; and

6. The reinsurance treaty has been approved by the Director.

**B. Requirements at inception date and on an on-going basis; remediation:**

1. The requirements of subsection (A) must be satisfied as of the date that risks under Covered Policies are ceded (if such date is on or after the effective date of this Part B) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under subsections (A)(3) or (A)(4) with respect to any reinsurance treaty under which Covered Policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.
2. Prior to the due date of each quarterly or annual statement, each life insurance company that has ceded reinsurance within the scope of subsection R20-6-B1601(A) shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which Covered Policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of subsections (A)(3) and (A)(4) were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to subsection (A)(3), unless either:
  - a. The requirements of subsections (A)(3) and (A)(4) were fully satisfied as of the valuation date as to the reinsurance treaty; or
  - b. Any deficiency has been eliminated before the due date of the quarterly or annual statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of subsections (A)(3) and (A)(4) to be fully satisfied as of the valuation date.
3. Nothing in subsection (B)(2) shall be construed to allow a ceding company to maintain any deficiency under subsection (A)(3) or (A)(4) for any period of time longer than is reasonably necessary to eliminate it.

**Historical Note**

New Section R20-6-B1603 renumbered from R20-6-1612 and repealed; new Section R20-6-B1603 made by final rulemaking at 28 A.A.R. 493 (March 4, 2022),

effective April 9, 2022; the redundant phrase “of this Section” and word “below” were removed when followed by a subsection reference, and the word “Section” was removed before a Chapter Section number (Supp. 22-1).

**ARTICLE 17. EXAMINATIONS**

**R20-6-1701. Definitions**

- A. “Company” means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the Director.
- B. “Examination” shall be defined for purposes of this Article to mean any examination relating to the financial condition of a company.
- C. “Examiner” means any individual or firm having been authorized by the Director to conduct an examination under this Article.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1701 recodified from R4-14-1701 (Supp. 95-1).

**R20-6-1702. Authority, Scope, and Scheduling of Examinations**

- A. The Director shall examine an insurer under A.R.S. § 20-156(A) at least once every five years.
- B. Instead of the examination under subsection (A), the Director may accept the most recent examination report prepared by the National Association of Insurance Commissioners insurance regulatory authority of another state on any foreign or alien insurer if:
  1. The insurance regulatory authority was accredited under the National Association of Insurance Commissioners’ Financial Regulation Standards and Accreditation Program at the time of the examination,
  2. A National Association of Insurance Commissioners accredited insurance regulatory authority supervised the examination, or
  3. At least one examiner employed or contracted by a National Association of Insurance Commissioners accredited insurance regulatory authority:
    - a. Participated in and reviewed the examination work papers and report, and
    - b. Signed an affidavit stating that the examination was performed in a manner consistent with the standards and procedures required by the National Association of Insurance Commissioners accredited insurance regulatory authority.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). Amended effective October 27, 1993 (Supp. 93-4). R20-6-1702 recodified from R4-14-1702 (Supp. 95-1). Amended by final rulemaking at 11 A.A.R. 2975, effective September 10, 2005 (Supp. 05-3).

**R20-6-1703. Conduct of Examinations**

- A. Upon determining that an examination should be conducted, the Director or the Director’s designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination.
- B. Nothing contained in this Article shall be construed to limit the Director’s authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to



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the insurance laws of this state or to pursue such action concurrent with the examination.

- C. The Director may disclose the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of any other state or country or to law enforcement officials of this or any other state or agency of the federal government at any time. Prior to making such disclosure, the Director may require such other department or office to agree in writing to hold as confidential the examination report, preliminary examination report or results or any matter relating thereto until such time as the examination report, preliminary examination report or results or matter relating thereto are made public by the Director.

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1703 recodified from R4-14-1703 (Supp. 95-1).

**R20-6-1704. Examination Reports**

- A. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find warranted from the facts.
- B. No later than 60 days following completion of the examination, the examiner in charge shall submit to the Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not less than 10 days nor more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report.
- C. Within 30 days after the end of the period allowed for the receipt of written submissions or rebuttals, the Director shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and shall:
1. File the examination report as submitted or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Director, the Director may order the company to take any action necessary and appropriate to cure such violation; or
  2. Reject the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and resubmission pursuant to subsection (B).

**Historical Note**

Adopted effective February 22, 1993 (Supp. 93-1). R20-6-1704 recodified from R4-14-1704 (Supp. 95-1).

**ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS****R20-6-1801. Definitions**

In this Article the following definitions apply:

"Appointment" means a first-available, initial, non-emergent, diagnostic visit to a dentist.

"Board certified" means a dentist who is recognized by the appropriate specialty board of the Commission on Accreditation of Dental Education of the American Dental Association.

"Board eligible" means a dentist who successfully completes an approved training program in a specialty field recognized by the American Dental Association.

"BODEX" means the Arizona State Board of Dental Examiners.

"Chief executive officer" means the person who has the authority and responsibility for the operation of an Organization according to applicable legal requirements and policies approved by the governing authority.

"Dental hygienist" means a person who is licensed to practice dental hygiene under A.R.S. § 32-1281 et seq.

"Dentist" means a person who is licensed to practice dentistry under A.R.S. § 32-1201 et seq.

"Department" means the Arizona Department of Insurance and Financial Institutions.

"Diagnostic service" means a dental service intended to identify a dental abnormality, and includes a radiograph and a clinical exam.

"Director" has the meaning prescribed at A.R.S. § 20-102.

"Emergency dental service" means a dental service intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain, and includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the dentist.

"General dentist" means a dentist whose practice is not limited to a specific area and who is not board certified.

"Governing authority" means the persons, including a board of trustees or board of directors, who have the ultimate authority and responsibility for the direction of a prepaid dental plan Organization.

"Organization" means a prepaid dental plan organization as defined in A.R.S. § 20-1001.

"Patient" means a person who is being attended by a dentist or dental hygienist to receive an examination, diagnosis, or dental treatment, or a combination of an examination, diagnosis, and dental treatment.

"Preventive service" means dental care intended to maintain dental health and prevent dental disease, including any combination of oral hygiene education, routine prophylaxis, and application of fluorides.

"Prophylaxis" means cleaning the teeth of a patient with healthy tissue using mild abrasives and dental instruments to remove plaque, calculus, and stains above the gum line.

"Provider directory" means an Organization's published listing of all contracted network dentists.

"Radiograph" means a picture produced on a sensitive surface by a form of radiation other than light, including x-ray.

"Restorative service" means the use of a metal or composite filling or crown.

"Specialist" means a dentist whose practice is limited to one of the nine specialty categories recognized by the American Dental Association: endodontics, oral and maxillofacial surgery, oral and maxillofacial radiology, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, oral pathology, or dental public health.

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“Treatment plan” means a statement of the services to be performed to eliminate or alleviate a patient’s symptoms or disease, based on a dentist’s assessment of the patient’s dental history, the clinical examination, and the dentist’s diagnosis.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**R20-6-1802. Application for Certificate of Authority**

- A.** A person who wishes to operate as prepaid dental plan organization in Arizona shall file an application for certificate of authority under A.R.S. § 20-1003 for the Director’s review and approval under A.R.S. § 20-1004. The application shall contain all the information required in A.R.S. § 20-1003 and this Section.
- B.** An authorized insurer shall issue the fidelity bond required under A.R.S. § 20-1004(A)(4).
- C.** An Organization shall not commence operation of, or service under, a prepaid dental plan without approval of the Director under A.R.S. § 20-1004.
- D.** An application is deemed filed with the Director when the Director receives it.
- E.** An applicant not domiciled in this state shall file a power of attorney as required by A.R.S. § 20-1003(A)(11) on a Department-prescribed form, with the application.
- F.** At the time it submits its application for certificate of authority, an Organization shall submit a written program of compliance with supporting documents that specify how the Organization will comply with the provisions of this Article. The written program of compliance shall contain the following:
  - 1. The responsibilities of and qualifications for the following positions:
    - a. The Organization’s chief executive officer, and
    - b. The Organization’s dental director;
  - 2. A plan for provision of basic dental services required under subsection R20-6-1806(A) and a copy of the schedule of benefits required under subsection R28-6-1806(B);
  - 3. A description of the system for delivery of services under Section R20-6-1807;
  - 4. A description of the geographic area designated under Section R20-6-1808;
  - 5. A plan for compliance with contract requirements under Section R20-6-1809 and a copy of a contract with a general dentist and a specialist;
  - 6. A plan for compliance with records requirements under Section R20-6-1810; and
  - 7. The Organization’s quality improvement plan under Section R20-6-1811.
- G.** An application shall include the following information:
  - 1. The proposed number of members, and
  - 2. A copy of a letter from each network dentist that documents the dentist’s intent to contract with the Organization to provide services to patients under the Organization’s prepaid dental plan.
- H.** The Director may require that an applicant for a certificate of authority under A.R.S. § 20-1003(A)(14) submit information that discloses biographical, employment and business financial history, criminal activity, fingerprints, or any information that relates to the ability to operate a prepaid dental plan for principals, principal officers, controlling persons, and insur-

ance producers of the applicant, if necessary for the protection of residents of this State.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**R20-6-1803. Chief Executive Officer**

- A.** The governing authority shall appoint a chief executive officer (CEO). The CEO shall have:
  - 1. The education and experience to manage the Organization, and
  - 2. Responsibility for the geographic area in Arizona that the Organization serves, including:
    - a. Implementing the policies of the governing authority, and
    - b. Maintaining adequate personnel to ensure compliance with applicable Arizona statutes and rules.
- B.** The governing authority shall notify the Department within ten days after the effective date of a change in the appointment of the CEO.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

**R20-6-1804. Dental Director**

- A.** The governing authority or CEO shall appoint as the Organization’s dental director a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia.
- B.** The dental director shall perform at least the following functions for the Organization’s geographic area in Arizona:
  - 1. Participate on the Organization’s quality improvement committee required under Section R20-6-1811;
  - 2. Oversee the Organization’s program and processes for:
    - a. Maintaining and improving clinical quality of care, including continuity of care;
    - b. Provider relations;
    - c. Facility and dental record reviews; and
    - d. Provider credentialing and recredentialing;
  - 3. Be knowledgeable about and participate in decisions regarding the Organization’s operations;
  - 4. Comply with A.R.S. § 20-2510(B) and (C) when directly denying, on the basis of medical necessity, a health care provider’s request for prior authorization; and
  - 5. Timely respond to matters within the Organization’s Arizona geographic area that require personal onsite attention or ensure that a designee who meets the requirements specified in subsection (D) timely responds to those matters.
- C.** Matters that require personal onsite attention include:
  - 1. Urgent patient care issues that require examination of dental records or X-rays;
  - 2. Prompt personal discussion with a provider of urgent concerns relating to credentialing, disciplinary problems, access to care, or quality of care.
- D.** Any designee acting under subsection (B)(5) shall:
  - 1. Be a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia;
  - 2. Have expedient access to the dental director, the CEO, and other organization management personnel as necessary to resolve any matter requiring personal onsite attention; and

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3. Have the education, experience, and Organizational knowledge required to address the matter requiring personal onsite attention.
- E. The Organization shall notify the Department in writing within ten days after the effective date of a change in the appointment of the dental director or any designee.
- F. The requirements for a designee under subsections (B)(5), (D), and (E) shall not apply to an Organization with fewer than 2,000 members in Arizona.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**R20-6-1805. Required Reporting**

- A. On or before March 1 of each year, an Organization shall submit the following information to the Department for the previous calendar year:
  1. Member satisfaction survey results and supporting data;
  2. A spreadsheet that lists the name, address, and telephone number of each provider and whether the provider: is accepting new members, is a general dentist or specialist, and has graduated from a specialty graduate program accredited by the American Dental Association;
  3. A list of all contracted network general dentists and specialists that have been added or deleted since the previous annual report;
  4. The total number of members and the number of members assigned to each general dentist's office;
  5. The average member wait time measured in weeks for an appointment for each network dentistry office; and
  6. A website link to its current provider directory.
- B. If a network dental office that is open to new members has an appointment wait time of longer than nine weeks for three consecutive calendar quarters, the Organization shall report to the Director who may require the Organization to close the office to new members until the wait time is less than nine weeks.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**R20-6-1806. Basic Dental Services**

- A. A prepaid dental plan shall provide the basic dental services listed below:
  1. Emergency dental services on a 24-hour-per-day basis,
  2. Diagnostic services,
  3. Preventive services, and
  4. Restorative services.
- B. An Organization shall publish and make available to its members and purchasers a schedule of benefits that includes the dental plan's basic dental services and other available dental services and any associated copays.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

**R20-6-1807. System for Delivery of Services**

- A. An Organization shall have a system for delivery of services that includes:

1. An adequate network of general dentists. To determine network adequacy, the Department shall consider the following:
  - a. Geographic distribution of network general dentists' offices,
  - b. The number of dental offices accepting new members,
  - c. The percentage of all network members who are able to schedule an appointment within nine weeks,
  - d. The availability of trained clinical support staff in the Arizona geographic area,
  - e. The ratio of population growth to the increase or decrease in the number of dentists in the Arizona geographic area, and
  - f. Current availability for appointments in all general dentist practices in Arizona; and
2. Provision for using specialists for dental services that cannot be provided by the Organization's network of contracted specialists, if the services are covered benefits.

- B. If more than 15% of the network offices that are open to new members have an appointment wait time of longer than nine weeks, the Organization shall submit a plan to the Department under which the Organization will, within 90 days, reduce the wait time to less than nine weeks. If the Organization does not reduce the wait time to less than nine weeks within the 90 day period the Organization shall refer the members who are waiting for an appointment to another network general dentist or a non-network general dentist who can schedule the member for an appointment in less than nine weeks. The member may choose to continue dental care under the prepaid dental plan with the referred dentist for the remainder of the member's enrollment period. The Organization shall provide the non-network services to the referred member at a cost that is no greater than if the services are provided by the member's assigned network dentist.
- C. An Organization shall pay for emergency dental services provided to a member by a dentist licensed in the jurisdiction where the services are provided, subject to plan limitations disclosed in the dental care plan, including emergency dental services that occur:

1. Within the geographic area served by the member's designated provider but the provider is unavailable, or
2. Occurs outside of the member's designated geographic service area.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**R20-6-1808. Geographic Areas**

- A. An Organization shall designate the geographic areas in Arizona in which the Organization intends to provide dental services that are reasonably convenient to the prospective members. The Organization shall provide a description of the geographic areas and locations of all facilities in which dental care will be provided under the prepaid dental plan. This information shall accompany or be included in any advertisements or sales materials provided to prospective employer groups and prospective members.
- B. An Organization shall define its geographic areas by local government jurisdictions, such as cities or counties.

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**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**R20-6-1809. Contract Requirements**

- A. An Organization shall have a written contract with each provider that documents the requirements for providing services under the prepaid dental plan and the terms of the agreements between the parties. The Organization shall ensure that the provider complies with all contract requirements.
- B. In addition to the requirements in subsection (A), an Organization shall ensure that its contract with a provider includes the following provisions:
  1. That the Organization has authority to review the provider's records,
  2. That the provider is responsible to implement and maintain a process to inform assigned members of the need to schedule periodic preventive dental services based on the member's oral health status, and
  3. That the provider is responsible to complete any procedure undertaken upon a member if the contract is terminated or expires.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

**R20-6-1810. Records**

- A. Dental records are the property of the provider and shall not be removed from the provider's possession, except:
  1. With the patient's permission, including for routing records to a dental or medical practitioner for consultation or evaluation; or
  2. When subpoenaed by a court or BODEX.
- B. An Organization shall maintain at its principal office a copy of each issued or delivered advertising matter or sales material, letter of solicitation, evidence of coverage, provider directory, certificate, agreement, or contract. The Organization shall note the date each advertising matter or sales material is filed with the Department and the date of distribution to any person. The advertising matter or sales material shall be maintained for at least three years.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

**R20-6-1811. Quality Improvement**

- A. An Organization shall have a governing authority.
- B. The governing authority shall appoint a quality improvement committee that consists of the chief executive officer or designee, the dental director, the person who manages the Organization's quality improvement process, and at least one dental health professional. The committee may also include network allied health professionals and members of the plan.
- C. The quality improvement committee shall:
  1. Meet at least quarterly,
  2. Review and evaluate dental services delivered under the Organization's plan, and
  3. Establish procedures for recordkeeping and distribution of committee reports.
- D. An Organization shall maintain a written quality improvement plan that contains procedures for each of the following:
  1. Ensuring that a dentist licensed in any state or territory of the United States or District of Columbia reviews and

evaluates dental care and services provided by each contracted general dentist at least once every three years;

2. Allocation of the Organization's resources to analyze a problem or any identified deficiency;
3. Implementing a corrective action plan and methods for monitoring improvement;
4. Notifying a member in writing of the member's responsibility to cooperate with those providing dental care services and of the member's rights to:
  - a. Voice concerns about the Organization or care provided;
  - b. Be provided with information about the Organization, its services, providers, and member rights and responsibilities;
  - c. Participate in decisions about the member's dental care; and
  - d. Be treated with respect and have the right to privacy recognized;
5. Monitoring and improving membership satisfaction;
6. Maintaining an accurate provider directory that meets at least the following requirements:
  - a. Lists only credentialed providers who are currently scheduling members for diagnosis and treatment; and
  - b. Clearly designates providers who are not accepting new members;
7. Review by the dental director of the following for initial credentialing of network providers:
  - a. Query to the National Practitioner Data Bank;
  - b. Query to BODEX;
  - c. Valid United States Drug Enforcement Administration certificate, if applicable;
  - d. Evidence of current malpractice insurance; and
  - e. Documentation that each specialist has graduated from an accredited specialty graduate program as required by the Council on Dental Education and Licensure, American Dental Association; and
8. Recredentialing, at least every three years, that updates information obtained in subsections (D)(7)(b) through (d), for the dental director's review.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**R20-6-1812. Confidentiality of Records**

An Organization shall not disclose information obtained pertaining to the diagnosis, treatment, or health of a member to any person except:

1. To the extent necessary to carry out this Article;
2. Upon the express written consent of the member, applicant, provider, or Organization, as appropriate; or
3. Under statute or court order for the production or discovery of evidence or as part of a civil or criminal investigation.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

**R20-6-1813. Assignment of Members**

- A. Within 30 days of enrollment, an Organization shall assign a member to the provider the member chooses. The Organiza-

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tion, however, shall choose and assign a provider to a member within 30 days of any of the following:

1. Receipt of a member enrollment form that does not designate a provider, or receipt of a member enrollment form that designates a provider who is unavailable;
  2. The date of the notice that the member's assigned provider intends to cease providing services; or
  3. The date the member's assigned provider becomes unavailable, for any reason.
- B.** An Organization shall give each member the option of selecting a network provider other than the provider assigned by the Organization under subsection (A).
- C.** An Organization shall maintain a continuous assignment process in compliance with subsections (A) and (B), allowing no more than 4% of members to be unassigned at any time.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 28 A.A.R. 654 (March 25, 2022), effective May 7, 2022 (Supp. 22-1).

**ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT****R20-6-1901. Applicability**

- A.** This Article applies to:
1. All proposed and existing health care services organizations (HCSOs), and
  2. Each product offered by an HCSO under the HCSO's certificate of authority.
- B.** The Department shall not issue a certificate of authority to an HCSO unless the HCSO meets the requirements of this Article.
- C.** The Department shall not require an existing HCSO to re-file information already on file with the Department, but the HCSO shall modify its operations and procedures as may be necessary to comply with this Article and file with the Department all additional information necessary to make statements complete and current.
- D.** This Article applies to inpatient emergency care, but does not apply to emergency services.
- E.** This Article applies only to covered services.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1902. Definitions**

In addition to the definitions provided in A.R.S. § 20-1051, the following terms apply to this Article:

1. "Access" or "accessibility" means the extent to which an enrollee can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location.
2. "Adult" means an enrollee in the age group the HCSO has designated for an adult.
3. "Adult PCP" means a primary care provider practicing in any specialty the HCSO designates as adult primary care.
4. "Ancillary provider" means a provider of laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, or speech therapy, home health services, dialysis, and durable medical equipment or medical supplies dispensed by order or prescription of a provider with the appropriate prescribing authority.

5. "Available" or "availability" means the extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services.
6. "Chief executive officer" or "CEO" means the person who has the authority and responsibility for the operation of the health care services organization according to applicable legal requirements and policies approved by the governing authority.
7. "Child" means an enrollee in the age group the HCSO has designated for children.
8. "Contracted" means a provider has a current written agreement or an employment arrangement with an HCSO to provide covered services to an enrollee, or a current written agreement or an employment arrangement with a contracted provider to provide covered services to an enrollee.
9. "Covered" or "covered services" means the health care services described as covered benefits in the HCSO's evidence of coverage.
10. "Day" means calendar day unless specified otherwise.
11. "Department" means the Department of Insurance and Financial Institutions.
12. "Director" has the meaning stated at A.R.S. § 20-102.
13. "Effective process" means written policies and procedures that:
  - a. Outline the steps that the HCSO implements and consistently follows internally,
  - b. The HCSO subjects to internal quality improvement, and
  - c. The HCSO communicates to providers when established or changed.
14. "Emergency services" has the meaning stated at A.R.S. § 20-2801(3).
15. "Facility" means an institution that is licensed or authorized to furnish health care services in this state, including general hospitals, special hospitals, residential treatment centers, residential rehabilitation centers, skilled nursing facilities, urgent care centers, and ambulatory surgical treatment centers.
16. "Governing authority" means a person or body such as a board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the HCSO is vested.
17. "HCSO" means a health care services organization.
18. "High profile" means one of no fewer than four specialties designated by the HCSO, and does not include obstetrics-gynecology. An HCSO may designate a specialty as high profile on the basis of high volume or other basis the HCSO reasonably determines is directly related to providing covered services to a member.
19. "Hospital" means a facility that provides inpatient care, medical services, and continuous nursing services for the diagnosis and treatment of patients.
20. "Inpatient care" means the covered services that an enrollee who is admitted to a hospital receives for at least 24 consecutive hours.
21. "Inpatient emergency care" means covered services that would be emergency services if provided in a licensed hospital emergency facility.
22. "License" means documented authorization issued by the appropriate state of Arizona agency to operate a facility in Arizona, or to practice a health care profession in Arizona.

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23. "Medically necessary" has the meaning set forth in the HCSO's evidence of coverage.
24. "Network" means the group of providers contracted with an HCSO to provide covered services to an enrollee covered under the HCSO's health benefit plan.
25. "Network exception" means an enrollee receives covered services from a non-contracted provider either:
  - a. Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or
  - b. For any reason the HCSO determines it is in the enrollee's best interests to receive care from a non-contracted provider.
26. "Non-contracted" means a provider that does not have a contract with an HCSO to provide services to an enrollee.
27. "Normal business hours" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state or national holidays.
28. "Outpatient care" means covered services that an enrollee who is not an inpatient receives.
29. "Pediatric primary care provider" means a physician or practitioner practicing in any specialty the HCSO designates as pediatric primary care.
30. "Physician" means a licensed doctor of allopathic, chiropractic, optometric, osteopathic, or podiatric medicine.
31. "Practitioner" means any individual other than a physician who is licensed to furnish health care services, including behavioral health care services, in this state.
32. "Preventive care" means health maintenance care the HCSO provides or arranges to prevent illness and to improve the general health of an enrollee, including:
  - a. Immunizations,
  - b. Health education,
  - c. Health evaluation and follow-up,
  - d. Early disease detection,
  - e. Screening tests appropriate for a person's age and gender, and
  - f. Periodic health care examinations.
33. "Primary care" means any specialty the HCSO designates as primary care.
34. "Primary care physician" or "PCP" means a physician or practitioner practicing in a specialty the HCSO designates as primary care.
35. "Quality improvement" means an HCSO's system for assessing and improving the level of performance of key process and outcomes.
36. "Routine care" means covered primary care for an enrollee's non-urgent, symptomatic condition.
37. "Rural" means a zip code area with fewer than 1,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.
38. "Service area" means any geographic area designated by any HCSO and approved by the Director under A.R.S. § 20-1053(A)(11).
39. "Special hospital" means a hospital that is licensed to provide hospital services within a specific area of medicine, or limits patient admission according to age, gender, type of disease, or medical condition.
40. "Specialty" or "specialty care" means a specific area of medicine practiced by a physician or practitioner who has education, training, or qualifications in that specific area of medicine in addition to the education or qualifications required for the physician's or practitioner's license.
41. "Specialty care provider" or "SCP" means a physician or practitioner who has education, training, or qualifications in a specialty, other than primary care, beyond the education or qualifications required for the license.
42. "Suburban area" means any zip code area with 1,000-3,000 persons per square mile, as calculated annually by a population data gathering service designated by the Director.
43. "Telemedicine" has the same meaning as "telehealth" found at A.R.S. § 20-1057(G).
44. "Timely" means services are provided at the time when medically necessary.
45. "Travel expenses" has the meaning set forth in writing by an HCSO.
46. "Urban area" means a zip code with more than 3,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.
47. "Urgent care" means unscheduled services for an enrollee's condition that requires medical attention not amenable to scheduling in order to avoid a serious risk of harm.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 30 A.A.R. 3519 (November 22, 2024), effective January 5, 2025 (Supp. 24-4).

**R20-6-1903. Documentation**

The CEO shall ensure that the HCSO's policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, and duty schedules are in writing, compiled and indexed in one or more manuals, and readily available for inspection by the Director.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Amended by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1904. Health Care Plan**

- A. An HCSO shall submit a statement to the Department that describes the proposed health care plan.
- B. The HCSO shall have an organized system for the delivery of health care services contained in subsection (D) that includes the following:
  1. Contracted providers that provide services under the plan;
  2. An effective process to promote a continuing relationship between an enrollee and the same PCP; and
  3. An effective process for referrals that ensures continuity of care to an enrollee.
- C. The HCSO shall list:
  1. The proposed or actual enrollment;
  2. The number and names of contracted, employed, or HCSO-owned providers that will serve the enrollees and the board eligibility or certification of each physician, if applicable; and
  3. The plan for providing covered services to enrollees as required under this Article.
- D. The HCSO's health care plan shall provide within the geographic area served the following basic health care services covered by the monthly charges in the evidence of coverage:

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1. Emergency care that includes emergency services and inpatient emergency care;
  2. Inpatient care;
  3. Specialty care, primary care, or ancillary care that includes diagnostic and therapeutic services;
  4. Outpatient care;
  5. Preventive care; and
  6. Emergency ambulance services under A.R.S. § 20-2801(2), and other ambulance services when approved by a plan physician.
- E. The HCSO shall provide appropriate coverage for out-of-area emergency care to an enrollee traveling outside the area served by the HCSO.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). R20-6-1904 repealed; new Section R20-6-1904 renumbered and amended from R20-6-1906 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1905. Geographic Area**

- A. An applicant shall describe the proposed geographic area in at least one of the following ways:
1. Legal description,
  2. Local governmental jurisdiction such as city or county,
  3. Census tracts,
  4. Street boundaries, or
  5. Area within a specified radius of a specified intersection or a specified primary care center.
- B. An applicant shall submit a map that shows the boundaries for the proposed geographic area.
- C. An applicant shall submit a description of the proposed network including the data required under R20-6-1913(A)(2) and (A)(3).
- D. All advertising matter and sales material provided a prospective enrollee shall include a description of the geographic area in terms readily understandable by the general public.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). R20-6-1905 repealed; new Section R20-6-1905 renumbered and amended from R20-6-1907 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1906. Chief Executive Officer**

- A. The governing authority shall appoint a CEO who has appropriate education and experience to manage the HCSO. The governing authority shall define the authority and duties of the CEO in writing. The CEO is the appointed representative of the governing authority and is the executive officer of the HCSO.
- B. The CEO shall have at least the following duties and responsibilities:
1. Manage the HCSO;
  2. Establish and implement policies, procedures, and effective processes of the HCSO;
  3. Act as liaison between the governing authority and the providers of healthcare and other services to the HCSO; and
  4. Establish a written plan of authority that will be in place in the CEO's absence.
- C. When there is a change of CEO, the governing authority shall notify Department within 10 days after the effective date of change.

- D. The HCSO shall ensure that all HCSO employees and contracted providers are knowledgeable about and qualified to perform the duties assigned to them through employment or by contract.
- E. The HCSO shall designate a central place of business from which the HCSO shall direct administrative activities.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1906 renumbered to R20-6-1904; new Section R20-6-1906 renumbered and amended from R20-6-1908 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 30 A.A.R. 3519 (November 22, 2024), effective January 5, 2025 (Supp. 24-4).

**R20-6-1907. Medical Director**

- A. The HCSO shall designate a physician as medical director.
- B. The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the CEO if the medical director has appropriate education and experience to manage the HCSO.
- C. The medical director responsibilities include:
1. Supervising medical staff;
  2. Performance planning and evaluating medical staff;
  3. Coordinating medical staff activities; and
  4. Developing medical care policies.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1907 renumbered to R20-6-1905; new Section R20-6-1907 renumbered and amended from R20-6-1909 by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1908. Quality Assurance**

- A. The HCSO shall provide an effective process for a continuing review and evaluation of the covered services it provides to enrollees to ensure that:
1. Treatment and level of covered services are appropriate and adequate and
  2. The quality of covered services is acceptable to the HCSO.
- B. The HCSO shall have a quality assurance committee that includes at least the CEO or designee, the medical director, and representative network providers. The quality assurance committee shall:
1. Arrange for physicians or practitioners to review and evaluate covered services provided by others physicians or practitioners within the respective disciplines.
  2. Adopt administrative procedures covering frequency of meetings, recordkeeping, committee reports, and disseminating the reports.
- C. The HCSO's effective process in subsection (A) shall include the following:
1. Standards for health care;
  2. Monitoring of care;
  3. Analysis of any deficiency;
  4. Correcting a deficiency including submitting a schedule for correcting the deficiency, requiring continuing education for the provider, if appropriate, and follow-up and periodic reassessment of the deficiency.

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**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section R20-6-1908 renumbered to R20-6-1906; new Section R20-6-1908 renumbered and amended from R20-6-1911, by final rulemaking at 11 A.A.R. 4861, effective December 31, 2006 (Supp. 05-4).

**R20-6-1909. Evaluation of Network**

Each HCSO shall have an effective process to evaluate the adequacy of its network to provide an enrollee with timely covered services.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-1909 renumbered to R20-6-1907; new Section R20-6-1909 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1910. Process for Referral, Prior Authorization, Precertification, or Network Exception**

- A. An HCSO shall have an effective process for assisting an enrollee to obtain timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available.
- B. An HCSO shall have an effective process during normal business hours for handling referrals, prior authorizations, precertifications, or network exceptions necessary for timely routine care. This process may include the HCSO's procedure for standing referrals required in A.R.S. § 20-1057.01.
- C. Each HCSO shall have an effective process to handle referrals or network exceptions necessary for timely urgent care seven days a week.
- D. An HCSO that requires prior authorization or precertification for urgent care shall have an effective process to handle requests for prior authorization or precertification 24 hours a day, seven days a week.
- E. An HCSO shall have an effective process for handling network exceptions that ensures the HCSO reimburses an enrollee for any out-of-network cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Section repealed; new Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1911. HCSO Communication with Providers**

An HCSO shall have an effective process for communicating with contracted providers regarding the following:

1. The providers in the network,
2. Contractual or administrative changes relating to enrollee access or provider availability, and
3. Procedures for handling claims and grievances submitted by providers.

**Historical Note**

New Section made by exempt rulemaking at 7 A.A.R. 2769, effective July 1, 2001 (Supp. 01-2). Former R20-6-1911 renumbered to R20-6-1908; new R20-6-1911 made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1912. Network Directories**

- A. An HCSO shall publish a provider network directory as follows:

1. An HCSO shall list the name, address, telephone number, specialty, and hospital affiliation for all in-area contracted physicians or practitioners;
2. An HCSO may list ancillary providers by corporate or group name and is not required to list individual physicians or practitioners;
3. An HCSO is not required to list physicians or practitioners in the following areas of specialties or areas of practice:
  - a. Emergency medicine;
  - b. Anesthesiology, except anesthesiologists who provide pain management services;
  - c. Hospital-based pathology;
  - d. Hospital-based radiology; and
  - e. Hospitalists;
4. An HCSO that lists any of the physicians or practitioners in subsections R20-6-1912(A)(3)(a) through (A)(3)(e) may list by corporate or group name and is not required to list individual physicians or practitioners;
5. An HCSO that uses hospitalists is not required to list the hospital affiliations of PCPs who do not admit or attend hospitalized members;
6. An HCSO shall publish a provider network directory that lists all its contracted facilities and contains:
  - a. The name, address, and telephone number of each facility;
  - b. For each hospital at which the HCSO uses hospitalists, if any, a statement that the HCSO uses hospitalists at that hospital; and
  - c. For an HCSO that uses hospitalists and does not list them in the directory, information on how an enrollee can find out what hospitalists or group of hospitalists it uses at each hospital.

- B. The network directory shall conspicuously state in the directory the following:

1. Changes occur in the network after the directory is published and some providers listed in the directory may no longer be contracted,
2. Enrollee coverage may depend on the contract status of the provider,
3. Where the enrollee can obtain more recent directory information,
4. The effective date of the network directory, and
5. The method for an enrollee or prospective enrollee to find out which PCPs are accepting new enrollees from the HCSO.

- C. Each HCSO shall make its current network directory available on paper to enrollees or prospective enrollees upon request.

- D. Each HCSO that has an online network directory shall:

1. Update the online directory at least monthly and in conformance with A.R.S. § 20-3455;
2. Make the online directory easy to use and user friendly; and
3. Explain, in the online directory, how an enrollee or prospective enrollee can request a paper directory.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4). Amended by final rulemaking at 30 A.A.R. 3519



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(November 22, 2024), effective January 5, 2025 (Supp. 24-4).

**R20-6-1913. Demographic Information Reports**

- A. An HCSO shall report the following data to the Department:
- For each enrollee, report annually:
    - Street address,
    - Zip code,
    - Gender, and
    - Year of birth.
  - For all contracted providers, report semiannually:
    - Provider name,
    - Street address or addresses at which the provider provides covered services,
    - Zip code, and
    - Arizona license number,
  - For all contracted physicians or practitioners, report semiannually:
    - Specialty, and
    - Medical or other applicable degree or information that designates the type of physician or practitioner.
- B. The HCSO shall report the information in subsection (A) to the Department by the following deadlines:
- For information in subsection (A)(1) as of December 31 of each calendar year, by February 15 of the next calendar year.
  - For information in subsection (A)(2) as of June 30, by August 15 of the same calendar year.
  - For information in subsection (A)(2) as of December 31, by February 15 of the next calendar year.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1914. Access**

An HCSO shall provide to or arrange for its enrollees services or appointments for services as follows:

- For preventive care services from a contracted PCP, an appointment date within 60 days of the enrollee's request, or sooner if necessary, for the enrollee to be immunized on schedule.
- For routine-care services from a contracted PCP, an appointment date within 15 days of the enrollee's request to the PCP or sooner if medically necessary.
- For specialty care services from a contracted SCP, an appointment date within 60 days of the enrollee's request or sooner if medically necessary.
- In-area urgent care services from a contracted provider seven days per week.
- Timely non-emergency inpatient care services from a contracted facility.
- Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care.
- Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1915. Alternative Access**

- A. As an alternative to providing access to covered services from a physician, an HCSO may provide access to covered services from an appropriately licensed practitioner.

- B. As an alternative to providing access to covered services at a hospital under R20-6-1914, an HCSO may provide access to covered services at another appropriately licensed facility.
- C. As an alternative to providing access to covered services from a physician or practitioner who sees an enrollee in person under R20-6-1914, an HCSO may provide access to necessary covered services through:
- Telephone calls and messages,
  - Electronic mail,
  - Communication with the physician's or practitioner's staff,
  - Coverage by another physician or practitioner, or
  - Telemedicine,
- D. An HCSO that panels enrollees to PCPs may panel enrollees to appropriately licensed practitioners.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1916. Availability Ratios**

- A. An HCSO shall maintain a ratio of contracted adult PCPs to adults that is adequate to provide those adults with covered services. An HCSO with a Medicare Advantage (MA) plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.
- B. An HCSO shall maintain a ratio of contracted pediatric PCPs to children that is adequate to provide those children enrollees with covered services.
- C. An HCSO shall maintain a ratio of contracted high profile SCPs to enrollees that is adequate to provide those enrollees with covered services that include services at contracted facilities. An HCSO with a MA plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1917. Geographic Availability in an Urban Area**

An HCSO shall provide each enrollee living in an urban area of the HCSO's service area the following:

- Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home;
- High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; and
- Inpatient care in a contracted general hospital, or contracted special hospital, within 25 miles or 75 minutes of the enrollee's home.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1918. Geographic Availability in a Suburban Area**

Each HCSO shall provide each enrollee member living in a suburban area within the HCSO's service area the following:

- Primary care from a contracted PCP located within 15 miles or 45 minutes of the enrollee's home;
- High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; and
- Inpatient care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home.

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**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1919. Geographic Availability in a Rural Area**

An HCSO shall provide each enrollee living in a rural area with primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1920. Travel Requirements**

- A. An HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary. Nothing in this Section creates an exception to R20-6-1918 through R20-6-1920.
- B. If the HCSO prior-authorizes services that require an enrollee to travel outside the HCSO service area because the services are not available in the area, the HCSO shall reimburse the enrollee for travel expenses. Except as provided under R20-6-1904(E)(6), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services in-area.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**R20-6-1921. Enforcement Consideration**

In determining the appropriate enforcement action or penalties for failure to comply with these rules, the Department shall consider any documentation the HCSO provides regarding:

1. Whether seasonal shifts in demand affect access and availability of covered services;
2. Whether the HCSO's demographic information has changed significantly since the HCSO's most recent report;
3. Whether an enrollee has refused to accept covered services the HCSO has offered in the time-frames or locations required of the HCSO by this Article;
4. Whether an enrollee has requested and obtained covered services from a contracted provider whose location, or appointment availability, or capacity result in the HCSO's non-compliance; and
5. Whether market factors indicate that on a short-term basis, compliance is not possible. Market factors include shortage of providers, enrollee or provider location, and provider practice or contracting patterns.

**Historical Note**

New Section made by final rulemaking at 11 A.A.R. 4861, effective December 31, 2005 (Supp. 05-4).

**ARTICLE 20. CAPTIVE INSURERS****R20-6-2001. Reserved****R20-6-2002. Fees; Examination Costs**

- A. A corporation applying for a license to do business as a captive insurer shall pay a nonrefundable fee of \$1,000.00 to the Department for issuance of the license under A.R.S. § 20-1098.01(J). A captive insurer that is a protected cell captive insurer, as defined in A.R.S. § 20-1098, also shall pay to the Department a nonrefundable fee of \$1,000 for each participant contract application that establishes a protected cell under

A.R.S. § 20-1098.05(B)(9). The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.

- B. A captive insurer shall pay a nonrefundable annual renewal fee of \$5,500.00 to the Department at the time of filing its annual report under A.R.S. § 20-1098.07. Under A.R.S. § 20-1098.01(J), a captive insurer that is a protected cell captive insurer also shall pay to the Department a nonrefundable annual renewal fee of \$2,500.00 for each protected cell at the time of filing its annual report under A.R.S. § 20-1098.07.
- C. A captive insurer shall pay a nonrefundable fee of \$200.00 to the Department at the time of filing for issuance of an amended certificate of authority.
- D. In addition to the fees prescribed in subsections (A), (B), and (C), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination the Director conducts, under A.R.S. § 20-1098.08.

**Historical Note**

New Section made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 2977, effective September 13, 2005 (Supp. 05-3). Subsection (A) corrected at request of the Department, Office File No. M11-252, filed July 20, 2011 (Supp. 11-3). Section amended by final rulemaking at 29 A.A.R. 3621 (November 24, 2023), effective January 7, 2024 (Supp. 23-4). Effective date corrected (Supp. 23-4, Ver. 2).

**ARTICLE 21. CUSTOMER INFORMATION SECURITY PROGRAM**

*Article 21, consisting of R20-6-2101 through R20-6-2104, made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).*

**R20-6-2101. Definitions**

The following definitions apply in this Article:

1. "Consumer" means an individual, or the individual's legal representative, who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information. Consumer can include a prospective applicant, policyholder, certificateholder, insured, or claimant.
2. "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are used primarily for personal, family, or household purposes.
3. "Customer information" means nonpublic personal information and privileged information about a customer whether in paper, electronic, or other form, that is maintained by or on behalf of an insurance institution, insurance producer, or insurance support organization.
4. "Customer information systems" means the electronic, or physical methods used to access, collect, store, use, transmit, protect, or dispose of customer information.
5. "Insurance institution" has the meaning prescribed in A.R.S. § 20-2102(10).
6. "Insurance producer" means a person required to be licensed under A.R.S. Title 20, Chapter 2, Article 3 to sell, solicit, or negotiate insurance and includes a managing general agent as defined in A.R.S. § 20-311.
7. "Insurance support organization" has the meaning prescribed in A.R.S. § 20-2102(13).

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8. "Licensee" means an insurance institution, insurance producer, or insurance support organization, but does not include a purchasing group or an unauthorized insurer in regard to the excess line business conducted under Title 20, Chapter 2, Article 5.
9. "Personal information" has the meaning prescribed in A.R.S. § 20-2102(19).
10. "Privileged information" has the meaning prescribed in A.R.S. § 20-2102(22).
11. "Service provider" means a person that maintains, processes, or otherwise is permitted access to customer information through its provision of services directly to a licensee.
- b. Training staff to implement the licensee's information security program; and
- c. Regularly testing or otherwise regularly monitoring the key controls, systems and procedures of the information security program. The licensee shall determine the frequency and nature of these tests or other monitoring practices by the licensee's risk assessment.
3. A licensee may oversee service provider arrangements by:
  - a. Exercising appropriate due diligence in selecting its service providers; and
  - b. Requiring its service providers to implement measures designed to meet the objectives of this Article, and, where indicated by the licensee's risk assessment, taking appropriate steps to confirm that its service providers have satisfied these obligations.
4. A licensee may monitor, evaluate, and adjust, as appropriate, its information security program in light of any relevant changes in technology, the sensitivity of its customer information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements, and changes to customer information systems.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

**R20-6-2102. Customer Information Security Program**

A licensee shall implement a comprehensive written customer information security program that includes administrative, technical, and physical safeguards for the protection of customer information. The administrative, technical, and physical safeguards included in the information security program shall be appropriate to the size and complexity of the licensee and the nature and scope of its activities.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

**R20-6-2103. Objectives of Customer Information Security Program**

A licensee's customer information security program shall be designed to:

1. Ensure the security and confidentiality of customer information;
2. Protect against any anticipated threats or hazards to the security or integrity of the information; and
3. Protect against unauthorized access to or use of the information.

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

**R20-6-2104. Guidelines for Methods of Development and Implementation**

A licensee may implement the requirements of R20-6-2102 and R20-6-2103 by the actions and procedures prescribed in this Section, which are non-exclusive illustrations:

1. A licensee may assess risk by:
  - a. Identifying reasonably foreseeable internal or external threats that could result in unauthorized disclosure, misuse, alteration, or destruction of customer information or customer information systems;
  - b. Assessing the likelihood and potential damage of these threats, taking into consideration the sensitivity of customer information; and
  - c. Assessing the sufficiency of policies, procedures, customer information systems, and other safeguards in place to control risks.
2. A licensee may manage and control risk by:
  - a. Designing its information security program to control the identified risks, commensurate with the sensitivity of the information, as well as the complexity and scope of the licensee's activities;

**Historical Note**

New Section made by final rulemaking at 10 A.A.R. 2260, effective July 13, 2004 (Supp. 04-2).

**ARTICLE 22. MILITARY PERSONNEL****R20-6-2201. Military Sales Practices****A. Definitions.**

1. "Active duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. "Active duty" does not include members of the reserve component who are performing active duty or active duty under military calls or orders specifying periods of less than 31 calendar days.
2. "Department of Defense (DoD) personnel" means all active duty service members and all civilian employees, including non-appropriated fund employees and special government employees, of the Department of Defense.
3. "Division" means the Division of Insurance of the Department of Insurance and Financial Institutions.
4. "Door-to-door" means a solicitation or sales method whereby an insurance producer proceeds randomly or selectively from household to household without prior specific appointment.
5. "ERISA" means the Employee Retirement and Income Security Act.
6. "Formal banking relationship" for purposes of subsection (D), means a relationship established between a service member and a depository institution which:
  - a. Provides the service member with a deposit agreement and periodic statements and makes disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301, et seq. and its accompanying regulations; and
  - b. Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.
7. "General advertisement" means an advertisement having as its sole purpose the promotion of the reader's or

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viewer's interest in the concept of insurance, or the promotion of the insurer, or the promotion of the insurance producer.

8. "Insurer" means an insurance company required to be licensed under the laws of Arizona to provide life insurance products, including annuities.
9. "Insurance producer" means a person required to be licensed pursuant to A.R.S. § 20-282.
10. "IRC" means Internal Revenue Code.
11. "Known" or "Knowingly" means the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known at the time of the act or practice complained of, that depending on its use in this Section, the person solicited was either a service member or was a service member with a pay grade of E-4 or below.
12. "Life insurance" has the meaning defined at A.R.S. § 20-254.
13. "Military installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.
14. "MyPay" is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.
15. "Service member" means any active duty officer (commissioned and warrant) or enlisted member of the United States Armed Forces.
16. "SGLI" means Servicemembers' Group Life Insurance.
17. "Side fund" means a fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issued annuities) by rider, endorsement, or other mechanism which accumulates premium, or deposits with interest, or by other means. "Side fund" does not include:
  - a. Accumulated value, or cash value, or secondary guarantees provided by an universal life insurance policy;
  - b. Cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or
  - c. A premium deposit fund which:
    - i. Contains only premiums paid in advance which accumulate at interest;
    - ii. Imposes no penalty for withdrawal;
    - iii. Does not permit funding beyond future required premiums;
    - iv. Is not marketed or intended as an investment; and
    - v. Does not carry a commission, either paid or calculated.
18. "Specific appointment" means a prearranged appointment agreed upon by both parties and definite as to place and time.
19. "U.S." means United States.
20. "U.S. Armed Forces" means all components of the Army, Navy, Air Force, Marine Corps, Coast Guard, and Space Force.
21. "VGLI" means Veterans' Group Life Insurance.

**B. Exemptions.**

1. This Section shall not apply to solicitations or sales involving:
  - a. Credit insurance;
  - b. Group life insurance or group annuities where there is no in-person, face-to-face solicitation of individuals by an insurance producer or where the contract or certificate does not include a side fund;
  - c. An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the Division; or, when a term conversion privilege is exercised among corporate affiliates;
  - d. Individual stand-alone health policies, including disability income policies;
  - e. Contracts offered by SGLI or VGLI, as authorized by 38 U.S.C. §§ 1965 et seq.;
  - f. Life insurance contracts offered through or by a non-profit military association, qualifying under Section 501(c)(23) of the IRC, and which are not underwritten by an insurer; or
  - g. Contracts used to fund:
    - i. An employee pension or welfare benefit plan that is covered by ERISA;
    - ii. A plan described by Sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the IRC, as amended, if established and maintained by an employer;
    - iii. A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;
    - iv. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;
    - v. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or
    - vi. Prearranged funeral contracts.
2. Nothing in this Section shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the U.S. Armed Forces in accordance with Department of Defense DoD Instruction 1344.07 – Personal Commercial Solicitation on DoD Installations or any successor directive.
3. This purposes of this Section, the following do not constitute solicitation:
  - a. General advertisements;
  - b. Direct mail;
  - c. Internet marketing; and
  - d. Telephone marketing if the caller explicitly and conspicuously discloses that the product being marketed is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation.
4. Any in-person, face-to-face meeting resulting from an exempt type of solicitation listed in subsection (B)(3) is not exempt and the insurer or insurance producer is subject to this Section.

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5. The following subsections do not apply to individually issued annuities: (D)(3)(b), (D)(5)(c), (D)(5)(e), (D)(6)(a), (D)(6)(c) and (D)(6)(d).
- C. Practices Declared False, Misleading, Deceptive, or Unfair on a Military Installation.**
1. The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive, or unfair:
    - a. Knowingly soliciting the purchase of any life insurance product door-to-door or without first establishing a specific appointment for each meeting with a prospective purchaser.
    - b. Soliciting service members in a group or "mass" audience or in a "captive" audience where attendance is not voluntary.
    - c. Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.
    - d. Making appointments with or soliciting service members in barracks, day rooms, unit areas, transient personnel housing, or other areas where the installation commander has prohibited solicitation.
    - e. Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.
    - f. Posting unauthorized bulletins, notices, or advertisements.
    - g. Failing to present DD Form 2885, Personal Commercial Solicitation Evaluation, to solicited service members or discouraging solicited service members from completing or submitting a DD Form 2885.
    - h. Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the U.S. Armed Forces without first obtaining a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives, or rules of the DoD or any branch of the U.S. Armed Forces for the insurer's files.
  2. The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences, or inducements and are declared to be false, misleading, deceptive, or unfair:
    - a. Using DoD personnel, directly or indirectly, as a representative or agent in any official or business capacity, with or without compensation, with respect to the solicitation or sale of life insurance to service members.
    - b. Using an insurance producer to participate in any U.S. Armed Forces sponsored education or orientation program.
- D. Practices declared false, misleading, deceptive, or unfair regardless of location.**
1. The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive, or unfair:
    - a. Submitting, processing, or assisting in the submission or processing of any allotment form or similar device used by the U.S. Armed Forces to direct a service member's pay to a third party for the purchase of life insurance. This includes, but is not limited to, using or assisting in using the service member's "MyPay" account or other similar internet or electronic medium. This subsection does not prohibit an insurer or insurance producer assisting a service member by providing the insurer or premium information necessary to complete any allotment form.
    - b. Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship.
    - c. Employing any device or method or entering into any agreement where funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's "Leave and Earnings Statement" or equivalent or successor form as "Savings" or "Checking" and where the service member has no formal banking relationship.
    - d. Entering into any agreement with a depository institution for the purposes of receiving funds from a service member where the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.
    - e. Using DoD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity, with or without compensation, with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade or to their family members.
    - f. Offering or giving anything of value, directly or indirectly, to DoD personnel to procure their assistance in encouraging, assisting, or facilitating the solicitation or sale of life insurance to a service member.
    - g. Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for their attendance to any event where an application for life insurance is solicited.
    - h. Advising a service member with a pay grade of E-4 or below to change their income tax withholding or state of legal residence for the sole purpose of increasing disposable income to purchase life insurance.
  2. The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval, or affiliation and are declared to be false, misleading, deceptive, or unfair:
    - a. Making any representation, or using any device, title, descriptive name, or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer, or product offered is affiliate, connected or associated with, endorsed, sponsored, sanctioned, or recommended by the U.S. government, the U.S. Armed Forces, or any state, federal agency, or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance

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- Conversion Consultant,” or “Veteran’s Benefits Counselor.” An insurance producer may use a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning including, but not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP), Masters of Science in Financial Services (MSFS), or Masters of Science Financial Planning (MS).
- b. Soliciting the purchase of any life insurance product through the use of or in conjunction with any third party organization that promotes the welfare of or assists members of the U.S. Armed Forces in a manner that has a tendency or capacity to confuse or mislead a service member into believing that either the insurer, insurance producer, or insurance product is affiliated, connected or associated with, endorsed, sponsored, sanctioned, or recommended by the U.S. government or the U.S. Armed Forces.
3. The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs, or investment returns and are declared to be false, misleading, deceptive, or unfair:
    - a. Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.
    - b. Misrepresenting the mortality costs of a life insurance product, including a statement or implication that the product costs nothing or is free.
  4. The following acts or practices by an insurer or insurance producer regarding SGLI or VGLI are declared to be false, misleading, deceptive, or unfair:
    - a. Making any representation regarding the availability, suitability, amount, cost, exclusions, or limitations to coverage provided to a service member or dependents by SGLI or VGLI, which is false, misleading, or deceptive.
    - b. Making any representation regarding conversion requirements, including the costs of coverage, or exclusions or limitations of coverage of SGLI or VGLI to private insurers which is false, misleading, or deceptive.
    - c. Suggesting, recommending, or encouraging a service member to cancel or terminate their SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member’s separation from the U.S. Armed Forces.
  5. The following acts or practices by an insurer or insurance producer regarding disclosure are declared to be false, misleading, deceptive, or unfair:
    - a. Deploying, using, or contracting for any lead-generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of life insurance.
    - b. Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-face meeting with a prospective purchaser.
    - c. Failing to clearly and conspicuously disclose that fact that the product being sold is life insurance.
    - d. Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by the Military Personnel Financial Services Protection Act, Public Law 109-290, Sec. 10, p. 16, 10 U.S.C. § 992 note.
    - e. When the sale is conducted in-person and face-to-face with an individual known to be a service member, failing at the time the application is taken to provide to the applicant:
      - i. An explanation of any applicable free look period with instructions on how to cancel if a policy is issued; and
      - ii. Either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of A.R.S. §§ 20-1241 through 20-1241.09, Section R20-6-202 and Section R20-6-209 shall be deemed sufficient to meet this requirement for a written disclosure.
  6. The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive, or unfair:
    - a. Recommending the purchase of any life insurance product which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.
    - b. Offering for sale or selling a life insurance product which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant’s SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant’s insurable needs for life insurance.
      - i. “Insurable needs” are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant’s estate and/or survivors or dependents.
      - ii. “Other military survivor benefits” include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents’ Educational Assistance, Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.
    - c. Offering for sale or selling any life insurance contract which includes a side fund:
      - i. Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

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- ii. Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from year one to year ten and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and
- iii. Which by default diverts or transfers funds accumulated to the side fund to pay, reduce, or offset any premiums due.
- d. Offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 4215, effective January 5, 2008 (Supp. 07-4). Amended by final rulemaking at 28 A.A.R. 687 (April 1, 2022), effective May 7, 2022 (Supp. 22-1).

**ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE****R20-6-2301. Applicability; Definitions**

- A. This Article applies to rates charged by health insurers for individual health insurance. This Article does not apply to rates charged by health insurers for the following:
  - 1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);
  - 2. Grandfathered health plan coverage as defined in 45 CFR 147.140; or
  - 3. Health insurance that covers excepted benefits as described in section 2791(c) of the PHS Act, 42 U.S.C. 300gg-91(c).
- B. In this Article, the following definitions apply:
  - 1. “Department” means the Arizona Department of Insurance and Financial Institutions.
  - 2. “Blanket disability insurance” has the meaning prescribed in A.R.S. § 20-1404(A).
  - 3. “CMS” means the Centers for Medicare & Medicaid Services.
  - 4. “Federal medical loss ratio standard” means the applicable medical loss ratio standard determined under 45 CFR 158, Subpart B.
  - 5. “Health insurance” means disability insurance as defined in A.R.S. § 20-253, a health care plan as defined in A.R.S. § 20-1051(4) and disability insurance or a health care plan offered by a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822.
  - 6. “Health insurer” means an insurer, as that term is defined in A.R.S. § 20-104, authorized to transact disability insurance in Arizona, a health care services organization as defined in A.R.S. § 20-1051(7) or a hospital service corporation, medical service corporation or hospital, medi-

cal, dental and optometric service corporation as defined in A.R.S. § 20-822(3).

- 7. “Individual health insurance” means health insurance that a health insurer issues to either:
  - a. An individual, to cover:
    - i. The individual, or
    - ii. The individual’s dependents, or
    - iii. The individual and the individual’s dependents.
  - b. An association or its individual members to cover the individual members and their dependents, and which the Department would regulate under A.R.S. Title 20, Chapter 6 as individual health insurance if the health insurer did not issue it to an association or individual members of an association.
- 8. “PHS Act” means Part A of Title XXVII of the Public Health Service Act, 42 U.S.C. Chapter 6A.
- 9. “Product” means a discrete package of individual health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area that has its own set of rating and pricing methodologies.
- 10. “Preliminary justification” means a justification that consists of the parts described in R20-6-2302(A).
- 11. “Rate increase” means an increase of the rates for an individual health insurance plan or plans within a product that:
  - a. Results from a change to the underlying rate structure, and
  - b. May result in premium changes.
- 12. “Secretary” means the Secretary of the United States Department of Health and Human Services.
- 13. “Threshold rate increase” means a rate increase that meets or exceeds an Arizona-specific threshold as noticed by the Secretary in 45 CFR 154.200, provided:
  - a. The average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold; and
  - b. If a rate increase that does not otherwise meet or exceed the Arizona-specific threshold meets or exceeds the Arizona-specific threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the Arizona-specific threshold and is subject to threshold rate review that shall include a review of the aggregate rate increases during the applicable 12-month period.
- 14. “Threshold rate review” means the review by the Department under this Article of a threshold rate increase.
- 15. “Unreasonable rate increase” means a rate increase that results in benefits that are not reasonable in relation to the premium the health insurer charges for the product. The following factors are relevant in determining whether a rate increase results in benefits that are unreasonable in relation to premium:
  - a. The rate increase results in a projected medical loss ratio below the federal medical loss ratio standard after accounting for any adjustments allowable under federal law;

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- b. One or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis;
- c. The choice of assumptions or combination of assumptions on which the insurer based the rate increase is unreasonable;
- d. The health issuer provides data or documentation that is incomplete, inadequate or otherwise does not provide a basis upon which the Department can determine the reasonableness of a rate increase; or
- e. The increase results in premium differences between insureds within similar risk categories that are unfairly discriminatory under A.R.S. Title 20, Chapter 2, Article 6.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4). Section amended by final rulemaking at 30 A.A.R. 3767 (December 13, 2024), effective February 3, 2025 (Supp. 24-4).

**R20-6-2302. Disclosure of Preliminary Justification**

- A. Preliminary Justification. For each threshold rate increase for each affected product, a health insurer shall submit to the Department and to CMS, on a form and in the manner prescribed by the Secretary in 45 CFR 154.215, a preliminary justification that contains all of the following:
  - 1. Preliminary Justification Part I. A summary of the content of the threshold rate increase that includes:
    - a. Historical and projected claims experience;
    - b. Trend projections related to utilization, and service or unit cost;
    - c. Any claims assumptions related to benefit changes;
    - d. Allocation of the overall rate increase to claims and non-claims costs;
    - e. Per enrollee per month allocation of current and projected premium; and
    - f. Three year history of rate increases for the product associated with the rate increase.
  - 2. Preliminary Justification Part II. A written description that justifies the rate increase and that contains a simple and brief narrative describing the data and assumptions the health insurer used to develop the rate increase, and includes the following:
    - a. An explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in subsection (A)(1); and
    - b. A brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.
- B. A health insurer may submit a single, combined preliminary justification that contains all the information in subsections (A)(1) and (2) for threshold rate increases that affect more than one product if the health insurer has aggregated the claims experience of all products to calculate the rate increases and the rate increases are the same for all products.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

**R20-6-2303. Timing for Submission of Preliminary Justification**

- A. If R20-6-607 applies to a threshold rate increase, the health insurer shall submit its preliminary justification to the Department

and to CMS on the date on which the health insurer files the rate increase request under R20-6-607.

- B. If R20-6-607 does not apply to a threshold rate increase, the health insurer shall submit the preliminary justification to the Department and to CMS at least 60 days prior to the date the health insurer intends to implement the threshold rate increase in Arizona.
- C. The Department shall provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

**R20-6-2304. Response to Unreasonableness Determination**

If the health insurer receives from CMS a notice that the Department has determined that the health insurer's threshold rate increase is unreasonable, the health insurer shall select one of the following three options:

1. Option to not implement the rate increase determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS that it will not implement the rate increase and request the Department to withdraw the rate increase request;
2. Option to implement a smaller rate increase than the rate determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS, on a form and in the manner prescribed by the Secretary, that it intends to implement a rate increase that is smaller than the one determined unreasonable. One of the following shall apply to this option:
  - a. If the health insurer selects this option and the smaller rate increase is not a threshold rate increase, the smaller rate increase is not subject to this Article;
  - b. If the health insurer selects this option, and R20-6-607 applied to the rate increase the Department determined to be unreasonable, the health insurer shall revise the rate increase filing to reflect the smaller rate increase or file a new rate increase. If the smaller rate increase is a threshold rate increase, the health insurer shall submit a new preliminary justification on the date the health insurer revises the rate increase filing or files a new rate increase; or
  - c. If the health insurer selects this option, and R20-6-607 did not apply to the rate increase the Department determined to be unreasonable, and the smaller increase is a threshold rate increase, the health insurer shall submit to the Department and to CMS a new preliminary justification at least 60 days prior to the date the health insurer intends to implement the smaller increase in Arizona.
3. Option to implement the rate increase determined unreasonable. Within 10 business days after the health insurer either implements the rate increase that the Department determined unreasonable, or receives from CMS the Department's determination, the health insurer shall:
  - a. Submit, to the Department and to CMS, a final justification in response to the Department's determination. The information in the final justification shall be the same as the information submitted by the insurer under R20-6-2302(A)(1) and (2) in the pre-



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- liminary justification supporting the rate increase; and
- b. Prominently post on its website, on a form and in the manner prescribed by the Secretary under 45 CFR 154.230 the following information:
    - i. The Department's determination that the rate increase is unreasonable and Department's explanation of the Department's analysis of the relevant factors set forth in R20-6-2305(A)(1) and (2), and
    - ii. The health insurer's final justification for implementing the rate increase.
  - c. Continue to make the information in subsection (3)(b) available to the public on its website for at least three years.

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

**R20-6-2305. Threshold Rate Increase Documentation Requirements**

- A. For a threshold rate increase, a health insurer shall submit to the Department documentation that is sufficient to allow the Department to assess:
  1. The reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity of the historical data underlying the assumptions, and
  2. The health insurer's data related to past projections and actual experience.
- B. To the extent applicable to the submission under review by the Department, the health insurer shall submit documentation that includes all of the following:
  1. The impact of medical trend changes by major service categories;
  2. The impact of utilization changes by major service categories;
  3. The impact of cost-sharing changes by major service categories, including actuarial values;
  4. The impact of geographic factors and variations;
  5. The impact of changes to all plans within the single risk pool product;
  6. The impact of reinsurance and risk adjustment payments and changes;
  7. The impact of benefit changes;
  8. The impact of changes in enrollee risk profile;
  9. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
  10. The impact of changes in reserve needs;
  11. The impact of changes in administrative costs related to programs that improve health care quality;
  12. The impact of changes in other administrative costs;
  13. The impact of changes in applicable taxes, licensing or regulatory fees;
  14. Medical loss ratio;
  15. The health insurer's capital and surplus; and
  16. Other relevant documentation at the discretion of the Director.
- C. A health insurer shall submit all documentation required under subsection (A) or (B) at the same time that:
  1. The health insurer submits the preliminary justification required under R20-6-2302, or

2. The health insurer submits any new preliminary justification required under R20-6-2304(2)(b) and (c).

**Historical Note**

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4). Section amended by final rulemaking at 30 A.A.R. 3767 (December 13, 2024), effective February 3, 2025 (Supp. 24-4).

**ARTICLE 24. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION****R20-6-2401. Definitions**

The definitions in A.R.S. § 20-3111 and this Section apply to this Article.

1. "Allowed Amount" is the amount reimbursable for a covered service under the terms of the enrollee's benefit plan. The allowed amount includes both the amount payable by the insurer and the amount of the enrollee's cost sharing requirements.
2. "Alternative Arbitrator" is an individual who is mutually agreeable to the health insurer and health care provider to act as the arbitrator of a surprise out-of-network billing dispute. If the person is contracted with the State of Arizona to conduct arbitration proceedings, the provisions of that contract shall apply. Department staff may not serve as an Alternative Arbitrator.
3. "Amount of the enrollee's cost sharing requirements" means the amount determined by the insurer prior to the dispute resolution process to be owed by the enrollee for out-of-network copayment, coinsurance and deductible pursuant to the enrollee's health care policy.
4. "Arbitrator" has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, arbitrator or other alternative dispute resolution professional who is contracted with the Department to arbitrate a surprise out-of-network billing dispute. Department staff may not serve as an Arbitrator.
5. "A.R.S. § 20-3113 Disclosure" means a written, dated document that contains the following information:
  - a. The name of the billing health care provider;
  - b. A statement that the health care provider is not a contracted provider;
  - c. The estimated total cost to be billed by the health care provider or the provider's representative for the health care services being provided;
  - d. A notice that the enrollee or the enrollee's authorized representative is not required to sign the A.R.S. § 20-3113 Disclosure to obtain health care services;
  - e. A notice that if the enrollee or the enrollee's authorized representative signs the A.R.S. § 20-3113 Disclosure, they may have waived any rights to request arbitration of a qualifying surprise out-of-network bill.
6. "Balance bill" means all charges that exceed the enrollee's cost sharing requirements and the amount paid by the insurer.
7. "Date of service" means the latest date on which the health care provider rendered a related health care service that is the subject of a qualifying surprise out-of-network bill.
8. "Days" as used in this Article means calendar days unless specified as business days and does not include the day of the filing of a document.

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9. "Department" means the Arizona Department of Insurance and Financial Institutions or an entity with which it contracts to administer the out-of-network claim dispute resolution process.
10. "Enrollee's authorized representative" means a person to whom an enrollee has given express written consent to represent the enrollee, the enrollee's parent or legal guardian, a person appointed by the court to act on behalf of the enrollee or the enrollee's legal representative. An enrollee's authorized representative shall not be someone who represents the provider's interests.
11. "Final resolution of a health care appeal" means that a member has a final decision under the review process provided by A.R.S. Title 20, Chapter 15, Article 2.
12. "Informal Settlement Teleconference" means a teleconference arranged by the Department that is held to settle the enrollee's qualifying surprise out-of-network bill prior to an Arbitration being scheduled. The parties to the Informal Settlement Teleconference are: (a) the enrollee or the enrollee's authorized representative; (b) the health insurer; and (c) the provider or the provider's representative.
13. "Qualifying surprise out-of-network bill" is a surprise out-of-network bill for health care services provided on or after January 1, 2019, that is disputed by the enrollee and:
  - a. Is for health care services covered by the enrollee's health plan;
  - b. Is for health care services provided in a network health care facility;
  - c. Is for health care services performed by a provider who is not contracted to participate in the network that serves the enrollee's health plan;
  - d. The enrollee has resolved any health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, that the enrollee may have had against the insurer following the health insurer's initial adjudication of the claim;
  - e. The enrollee has not instituted a civil lawsuit or other legal action against the insurer or health care provider related to the surprise out-of-network bill or the health care services provided;
  - f. The amount of the surprise out-of-network bill for which the enrollee is responsible for all related health care services provided by the health care provider whether contained in one or multiple bills, after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement, is at least \$1,000.00; and
  - g. One of the following applies:
    - i. The bill is for emergency services, including under circumstances described by A.R.S. § 20-2803(A);
    - ii. The bill is for health care services directly related to the emergency services that are provided during an inpatient admission to any network facility;
    - iii. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure;
    - iv. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a written dated A.R.S. § 20-3113 Disclosure within a reasonable amount of time before the enrollee received the service;
    - v. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative chose not to sign the Disclosure;
    - vi. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a written dated A.R.S. § 20-3113 Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative signed the Disclosure but the amount actually billed to the enrollee is greater than the estimated cost provided in the signed Disclosure.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1). Section amended by final rulemaking at 29 A.A.R. 3621 (November 24, 2023), effective January 7, 2024 (Supp. 23-4). Effective date corrected (Supp. 23-4, Ver. 2).

**R20-6-2402. Request for Arbitration**

- A. Request for Arbitration. An enrollee may request dispute resolution of a surprise out-of-network bill by filing a timely Request for Arbitration with the Department on a Request for Arbitration form available on the Department's website.
- B. Deadline for filing a Request for Arbitration with the Department. A Request for Arbitration must be received by the Department within one year after the date of service listed on the surprise out-of-network bill. If the enrollee filed a health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, the one year deadline is tolled from the date the enrollee filed the health care appeal to the date of the final resolution of the appeal.
- C. Evaluation of the Request for Arbitration by the Department. Within 15 days after receipt of a Request for Arbitration, the Department shall do one of the following:
  1. Determine that the surprise out-of-network bill is a qualifying surprise out-of-network bill and notify the enrollee, health insurer and health care provider that the Request for Arbitration qualifies for Arbitration;
  2. Determine that the surprise out-of-network bill is not a qualifying surprise out-of-network bill and notify the enrollee of the reason for the Department's determination;
  3. Determine that the Request for Arbitration is incomplete; or
  4. Return the Request for Arbitration to the enrollee without making a determination if the enrollee's request should instead be filed as a health care appeal within the meaning of A.R.S. Title 20, Chapter 15, Article 2.
- D. Request for additional information for an incomplete Request for Arbitration. If the Department determines that the Request for Arbitration is incomplete, the Department may send a written request for additional information to the enrollee, health

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insurer, health care provider or health care provider's billing company.

- E. Time to respond to the Department's Request for Additional Information. The enrollee, health insurer, health care provider or the health care provider's billing company shall have 15 days from the date of the request to respond to the Department's Request for Additional Information.
- F. Failure to respond to the Department's Request for Additional Information.
  - 1. If the enrollee fails to respond to the Department's Request for Additional Information, the Department shall deny the enrollee's Request for Arbitration.
  - 2. If either the health insurer or the health care provider or health care provider's billing company fail to respond to the Department's Request for Additional Information, the Department shall deem that the enrollee's Request for Arbitration qualifies for arbitration.
- G. Receipt of Additional Information. Upon receipt of the additional information requested by the Department under subsection (D) of this Section, the Department shall determine, within seven days, whether the enrollee's Request for Arbitration qualifies for Arbitration and send the notice required under subsection (C)(1) or subsection (C)(2) of this Section, whichever applies.
- H. Final Determination. The Department's determination whether an enrollee's Request for Arbitration qualifies for Arbitration is a final decision and not an appealable agency action within the meaning of A.R.S. § 41-1092(3). A claim that is the subject of a qualifying surprise out-of-network bill is not subject to the timely payment of claims law during the pendency of the Arbitration.
- I. Enrollee's payment responsibility.
  - 1. Notwithstanding any informal settlement or Arbitrator's Final Written Decision, the enrollee is responsible for only the following:
    - a. The amount of the enrollee's cost sharing requirements; and
    - b. Any amount received by the enrollee from the enrollee's health insurer as payment for the health care services at issue in a qualifying surprise out-of-network bill.
  - 2. A health care provider may not issue, either directly or indirectly through its billing company, any additional balance bill to the enrollee for the same health care services.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

**R20-6-2403. Informal Settlement Teleconference**

- A. Deadline to arrange the Informal Settlement Teleconference. Upon a determination that an enrollee has made a Request for Arbitration that qualifies for Arbitration, the Department shall arrange an Informal Settlement Teleconference between the parties within 30 days of notifying the enrollee that the enrollee's Request for Arbitration qualifies for Arbitration required by Section R20-6-2402(C)(1).
- B. Notice of Informal Settlement Teleconference. At least 14 days prior to the scheduled date, the Department shall send a Notice of Informal Settlement Teleconference to the enrollee, the enrollee's authorized representative, the health insurer, the health care provider and the health care provider's representative informing them of the date, time and instructions on how to participate in the Informal Settlement Teleconference.

- C. Health Insurer documentation. On or before the Informal Settlement Teleconference, the health insurer shall provide to the parties the enrollee's cost sharing requirements under the enrollee's health plan based on the qualifying surprise out-of-network bill.
- D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the Informal Settlement Teleconference, it shall be subject to the following consequences:
  - 1. If the health insurer, provider or provider's representative fails to participate in an Informal Settlement Teleconference scheduled by the Department, the participating party may notify the Department which shall promptly schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.
  - 2. If the enrollee or the enrollee's authorized representative fails to participate in the original Informal Settlement Teleconference, the original Informal Settlement Teleconference is terminated.
  - 3. If the enrollee or the enrollee's authorized representative fails to participate in a rescheduled Informal Settlement Teleconference, the enrollee's Request for Arbitration is terminated.
- E. One-time opportunity for the enrollee to reschedule the Informal Settlement Teleconference. If the enrollee or the enrollee's representative fails to participate in the Informal Settlement Teleconference originally scheduled by the Department, the enrollee may request that the Department reschedule the Informal Settlement Conference. The enrollee's request to reschedule must be received by the Department within 14 days after the originally scheduled Informal Settlement Teleconference. Failure to submit a request to the Department to reschedule the Informal Settlement Teleconference within the 14 day period terminates the enrollee's Request for Arbitration.
- F. Notification to the Department after the Informal Settlement Teleconference. Within seven days after the date of the Informal Settlement Teleconference, the health insurer shall:
  - 1. Notify the Department whether a settlement was reached between the parties; and
  - 2. If a settlement was reached, notify the Department of the terms of the settlement on a form prescribed by the Department.
- G. Failure to settle. If the parties fail to settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the Department shall arrange for the Arbitration.
- H. Settlement. If the parties settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the health insurer shall remit its portion of the payment to the health care provider within 30 days after the Informal Settlement Teleconference. A claim that is reprocessed by a health insurer as a result of informal settlement is not in violation of A.R.S. § 20-3102(L).

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

**R20-6-2404. Arbitrators**

- A. Contracted entities. The Department shall contract with one or more persons to provide Arbitrators. The Department must have a list of at least four Arbitrators to assign to Arbitrations. The Department shall publish the list of contracted entities and a list of each entity's qualified Arbitrators on its website.

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- B. Arbitrator Qualifications.** Any person contracting with the Department must be able to provide Arbitrators who possess at least three years of experience in health care services claims.
- C. Alternative Arbitrators.** A health insurer and provider may mutually agree to use an Alternative Arbitrator if either the health insurer or the health care provider objects to an Arbitrator appointed by the Department.
- D. Appointment of an Arbitrator.**
  - 1. The Department shall appoint an Arbitrator for each Arbitration.
  - 2. If the health insurer and health care provider do not agree to the Arbitrator appointed by the Department, they shall either:
    - a. Mutually agree to use an Alternative Arbitrator; or
    - b. Participate in the following procedure:
      - i. The Department shall assign three Arbitrators.
      - ii. The health insurer shall strike one Arbitrator.
      - iii. The health care provider shall strike one Arbitrator.
      - iv. If one Arbitrator remains, the Department shall appoint the remaining Arbitrator to the Arbitration.
      - v. If the health insurer and health care provider strike the same Arbitrator, the Department shall randomly assign the Arbitrator from the remaining two Arbitrators.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

**R20-6-2405. Before the Arbitration**

- A. Enrollee's duties.** Before the Arbitration, the enrollee shall:
  - 1. Pay or make arrangements in writing to pay to the health care provider the amount stated by the health insurer in the Informal Settlement Teleconference which shall be the total amount of the enrollee's cost sharing requirements due for the health care services that are the subject of the qualifying surprise out-of-network bill.
  - 2. Pay to the health care provider any amount that the enrollee has received from the health insurer as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.
- B. Health insurer's duties.** Before the Arbitration, the health insurer shall remit any amount due to the health care provider if the health care insurer pays for out-of-network services directly to health care providers and the health insurer has not remitted any amounts due.

**Historical Note**

New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

**R20-6-2406. The Arbitration**

- A. Conduct of Arbitration.** An Arbitration of a qualifying out-of-network surprise bill shall be conducted:
  - 1. Telephonically unless the parties agree otherwise;
  - 2. With or without the enrollee's participation;
  - 3. Within 120 days after the Department's Notice of Arbitration unless agreed otherwise by the parties; and
  - 4. For a maximum duration of four hours unless agreed otherwise by the parties.
- B. Arbitrator's Determination.** The Arbitrator or Alternative Arbitrator shall determine the amount the health care provider is entitled to receive as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.
- C. Allowable Evidence.** The Arbitrator or Alternative Arbitrator shall allow each party to provide relevant information for evaluating the qualifying surprise out-of-network bill including:
  - 1. The average contracted amount that the health insurer pays for the health care services at issue in the county where the health care provider performed the health care services;
  - 2. The average amount that the health care provider has contracted to accept for the health care services at issue in the county where the health care provider performed the services;
  - 3. The amount Medicare and Medicaid pay for the health care services at issue;
  - 4. The health care provider's direct pay rate for the health care services at issue, if any, under A.R.S. § 32-3216;
  - 5. Any information that would be evaluated in determining whether a fee is reasonable under title 32 and not excessive for the health care services at issue, including the usual and customary charges for the health care services at issue performed by a health care provider in the same or similar specialty and provided in the same geographic area; and
  - 6. Any other reliable sources of information, including databases, that provide the amount paid for the health care services at issue in the county where the health care provider performed the services.
- D. Final Written Decision.** Within 10 business days following the Arbitration, the Arbitrator or Alternative Arbitrator shall issue a Final Written Decision and provide a copy to the enrollee, the health insurer, the health care provider, the health care provider's billing company (if applicable) and the health care provider's authorized representative (if applicable).
- E. Payment of the claim.** The health insurer shall remit its portion of the payment awarded by the Arbitrator or Alternative Arbitrator to the health care provider within 30 days of the date of the Final Written Decision. A claim that is reprocessed by a health insurer as a result of the Arbitration is not in violation of A.R.S. § 20-3102(L).
- F. Payment of the Costs of Arbitration.** The health insurer and health care provider shall make payment arrangements with the Arbitrator or Alternative Arbitrator to pay their respective shares of the costs of the Arbitration within 30 days after the date of the Final Written Decision. The respective shares of the costs of Arbitration are determined as follows:
  - 1. The enrollee is not responsible for any portion of the cost of the Arbitration.
  - 2. The health insurer and the health care provider shall share the costs of the Arbitration equally unless one of the following exceptions applies:
    - a. The health insurer and health care provider agree to share the costs of the Arbitration in non-equal portions.
    - b. The health insurer pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.
    - c. The health care provider or the health care provider's representative pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.

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- G.** Confidentiality. In connection with the Arbitration of a qualifying surprise out-of-network bill, all of the following apply:
1. All pricing information provided by a health insurer or health care provider is confidential.
  2. Pricing information provided by a health insurer or health care provider may not be disclosed by the Arbitrator, Alternative Arbitrator or any other party participating in the Arbitration.
  3. Pricing information provided by a health insurer or health care provider may not be used by anyone, except the party providing the information, for any purpose other than to resolve the qualifying surprise out-of-network bill.
  4. All information received by the Department in connection with the Arbitration is confidential and may not be disclosed to any person except the Arbitrator or Alternative Arbitrator.
- H.** Arbitrator's Report. At the conclusion of each Arbitration, the Arbitrator shall produce a report to the Department that contains the following information:
1. Date of Arbitration;
  2. Date the Arbitrator issued the Final Written Decision;
  3. Whether the parties settled the qualifying surprise out-of-network bill during the Arbitration;
  4. The initial amount billed by the health care provider;
  5. The payment amount awarded to the health care provider; and
  6. Any other information the Department may request an Arbitrator to report prior to an Arbitration.
- Historical Note**
- New Section made by exempt rulemaking at 25 A.A.R. 155, effective January 2, 2019 (Supp. 19-1).

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