



Arizona Administrative REGISTER

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From the Publisher

ABOUT THIS PUBLICATION

The paper copy of the *Administrative Register* (A.A.R.) is the official publication for rules and rulemaking activity in the state of Arizona.

Rulemaking is defined in Arizona Revised Statutes known as the Arizona Administrative Procedure Act (APA), A.R.S. Title 41, Chapter 6, Articles 1 through 10.

The Office of the Secretary of State does not interpret or enforce rules published in the *Arizona Administrative Register* or *Code*. Questions should be directed to the state agency responsible for the promulgation of the rule as provided in its published filing.

The *Register* is cited by volume and page number. Volumes are published by calendar year with issues published weekly. Page numbering continues in each weekly issue.

In addition, the *Register* contains the full text of the Governor's Executive Orders and Proclamations of general applicability, summaries of Attorney General opinions, notices of rules terminated by the agency, and the Governor's appointments of state officials and members of state boards and commissions.

ABOUT RULES

Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number). Rules activity published in the *Register* includes: proposed, final, emergency, expedited, and exempt rules as defined in the APA.

Rulemakings initiated under the APA as effective on and after January 1, 1995, include the full text of the rule in the *Register*. New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.

WHERE IS A "CLEAN" COPY OF THE FINAL OR EXEMPT RULE PUBLISHED IN THE REGISTER?

The *Arizona Administrative Code* (A.A.C.) contains the codified text of rules. The A.A.C. contains rules promulgated and filed by state agencies that have been approved by the Attorney General or the Governor's Regulatory Review Council. The *Code* also contains rules exempt from the rulemaking process.

The printed *Code* is the official publication of a rule in the A.A.C., and is prima facie evidence of the making, amendment, or repeal of that rule as provided by A.R.S. § 41-1012. Paper copies of rules are available by full Chapter or by subscription. The *Code* is posted online for free.

LEGAL CITATIONS AND FILING NUMBERS

On the cover: Each agency is assigned a Chapter in the *Arizona Administrative Code* under a specific Title. Titles represent broad subject areas. The Title number is listed first; with the acronym A.A.C., which stands for the *Arizona Administrative Code*; following the Chapter number and Agency name, then program name. For example, the Secretary of State has rules on rulemaking in Title 1, Chapter 1 of the *Arizona Administrative Code*. The citation for this chapter is 1 A.A.C. 1, Secretary of State, Rules and Rulemaking

Every document filed in the office is assigned a file number. This number, enclosed in brackets, is located at the top right of the published documents in the *Register*. The original filed document is available for 10 cents a page.

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This publication is available online for
free at www.azsos.gov.

ADMINISTRATIVE CODE
A price list for the *Arizona
Administrative Code* is available
online. You may also request a paper
price list by mail. To purchase a paper
Chapter, contact us at
(602) 364-3223.

PUBLICATION DEADLINES
Publication dates are published in the
back of the *Register*. These dates
include file submittal dates with a
three-week turnaround from filing to
published document.

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Participate in the Process

Look for the Agency Notice

Review (inspect) notices published in the *Arizona Administrative Register*. Many agencies maintain stakeholder lists and would be glad to inform you when they proposed changes to rules. Check an agency's website and its newsletters for news about notices and meetings.

Feel like a change should be made to a rule and an agency has not proposed changes? You can petition an agency to make, amend, or repeal a rule. The agency must respond to the petition. (See A.R.S. § 41-1033)

Attend a public hearing/meeting

Attend a public meeting that is being conducted by the agency on a Notice of Proposed Rulemaking. Public meetings may be listed in the Preamble of a Notice of Proposed Rulemaking or they may be published separately in the *Register*. Be prepared to speak, attend the meeting, and make an oral comment.

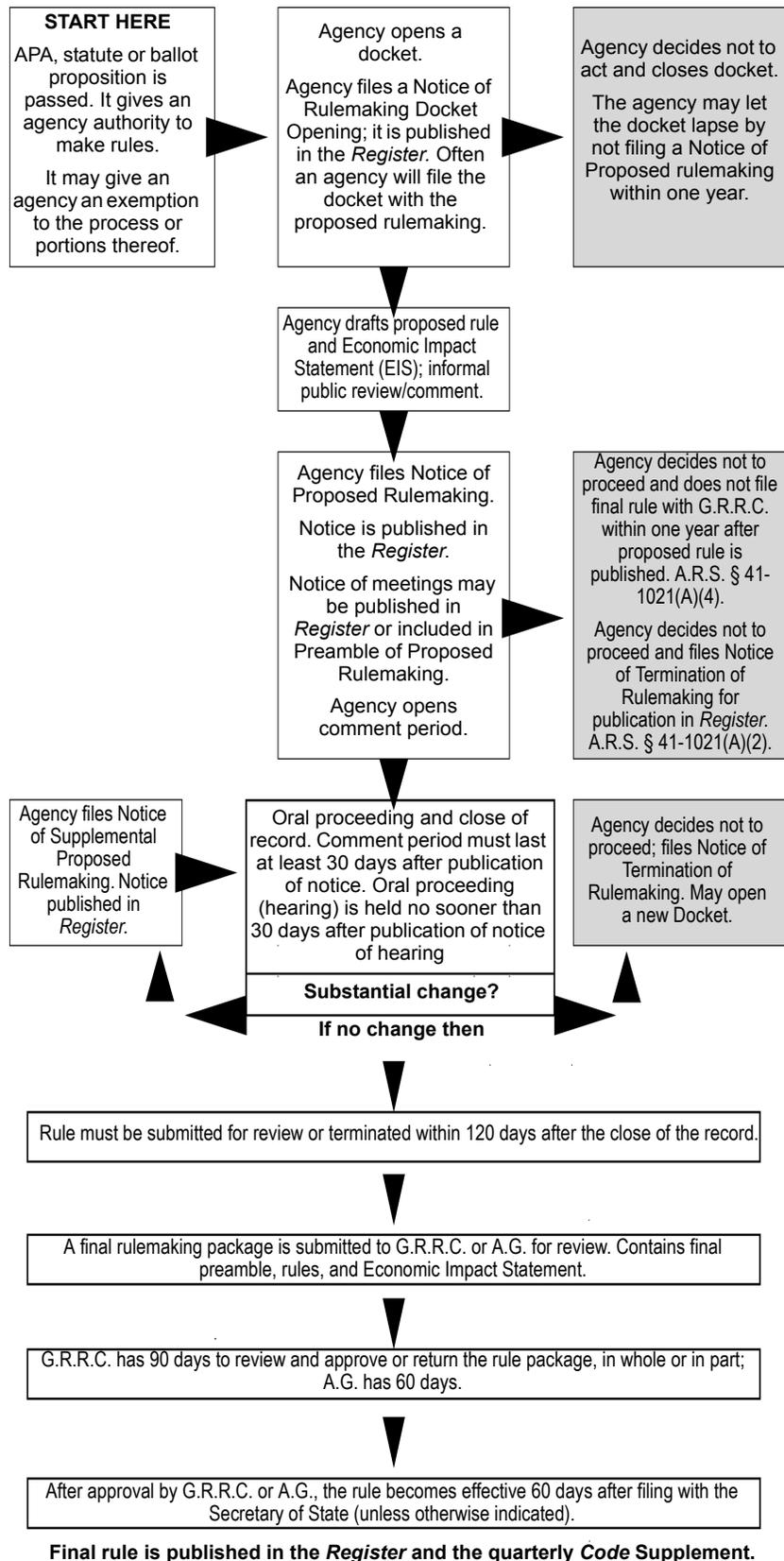
An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

Write the agency

Put your comments in writing to the agency. In order for the agency to consider your comments, the agency must receive them by the close of record. The comment must be received within the 30-day comment timeframe following the *Register* publication of the Notice of Proposed Rulemaking.

You can also submit to the Governor's Regulatory Review Council written comments that are relevant to the Council's power to review a given rule (A.R.S. § 41-1052). The Council reviews the rule at the end of the rulemaking process and before the rules are filed with the Secretary of State.

Arizona Regular Rulemaking Process



Definitions

Arizona Administrative Code (A.A.C.): Official rules codified and published by the Secretary of State's Office. Available online at www.azsos.gov.

Arizona Administrative Register (A.A.R.): The official publication that includes filed documents pertaining to Arizona rulemaking. Available online at www.azsos.gov.

Administrative Procedure Act (APA): A.R.S. Title 41, Chapter 6, Articles 1 through 10. Available online at www.azleg.gov.

Arizona Revised Statutes (A.R.S.): The statutes are made by the Arizona State Legislature during a legislative session. They are compiled by Legislative Council, with the official publication codified by Thomson West. Citations to statutes include Titles which represent broad subject areas. The Title number is followed by the Section number. For example, A.R.S. § 41-1001 is the definitions Section of Title 41 of the Arizona Administrative Procedures Act. The "§" symbol simply means "section." Available online at www.azleg.gov.

Chapter: A division in the codification of the *Code* designating a state agency or, for a large agency, a major program.

Close of Record: The close of the public record for a proposed rulemaking is the date an agency chooses as the last date it will accept public comments, either written or oral.

Code of Federal Regulations (CFR): The *Code of Federal Regulations* is a codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government.

Docket: A public file for each rulemaking containing materials related to the proceedings of that rulemaking. The docket file is established and maintained by an agency from the time it begins to consider making a rule until the rulemaking is finished. The agency provides public notice of the docket by filing a Notice of Rulemaking Docket Opening with the Office for publication in the *Register*.

Economic, Small Business, and Consumer Impact Statement (EIS): The EIS identifies the impact of the rule on private and public employment, on small businesses, and on consumers. It includes an analysis of the probable costs and benefits of the rule. An agency includes a brief summary of the EIS in its preamble. The EIS is not published in the *Register* but is available from the agency promulgating the rule. The EIS is also filed with the rulemaking package.

Governor's Regulatory Review (G.R.R.C.): Reviews and approves rules to ensure that they are necessary and to avoid unnecessary duplication and adverse impact on the public. G.R.R.C. also assesses whether the rules are clear, concise, understandable, legal, consistent with legislative intent, and whether the benefits of a rule outweigh the cost.

Incorporated by Reference: An agency may incorporate by reference standards or other publications. These standards are available from the state agency with references on where to order the standard or review it online.

Federal Register (FR): The *Federal Register* is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

Session Laws or "Laws": When an agency references a law that has not yet been codified into the Arizona Revised Statutes, use the word "Laws" is followed by the year the law was passed by the Legislature, followed by the Chapter number using the abbreviation "Ch.," and the specific Section number using the Section symbol (§). For example, Laws 1995, Ch. 6, § 2. Session laws are available at www.azleg.gov.

United States Code (U.S.C.): The Code is a consolidation and codification by subject matter of the general and permanent laws of the United States. The Code does not include regulations issued by executive branch agencies, decisions of the federal courts, treaties, or laws enacted by state or local governments.

Acronyms

A.A.C. – *Arizona Administrative Code*

A.A.R. – *Arizona Administrative Register*

APA – *Administrative Procedure Act*

A.R.S. – *Arizona Revised Statutes*

CFR – *Code of Federal Regulations*

EIS – *Economic, Small Business, and Consumer Impact Statement*

FR – *Federal Register*

G.R.R.C. – *Governor's Regulatory Review Council*

U.S.C. – *United States Code*

About Preambles

The Preamble is the part of a rulemaking package that contains information about the rulemaking and provides agency justification and regulatory intent.

It includes reference to the specific statutes authorizing the agency to make the rule, an explanation of the rule, reasons for proposing the rule, and the preliminary Economic Impact Statement.

The information in the Preamble differs between rulemaking notices used and the stage of the rulemaking.

NOTICES OF FINAL RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Final Rulemaking. Final rules have been through the regular rulemaking process as defined in the Administrative Procedures Act. These rules were either approved by the Governor’s Regulatory Review Council or the Attorney General’s Office. Certificates of Approval are on file with the Office.

The final published notice includes a preamble and

text of the rules as filed by the agency. Economic Impact Statements are not published.

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the final rules should be addressed to the agency that promulgated them. Refer to Item #5 to contact the person charged with the rulemaking. The codified version of these rules will be published in the Arizona Administrative Code.

**NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 6. DEPARTMENT OF HEALTH SERVICES
COMMUNICABLE DISEASES AND INFESTATIONS**

[R17-167]

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action</u>
R9-6-101	Amend
R9-6-201	Amend
R9-6-202	Amend
Table 1	Repeal
Table 2.1	New Section
R9-6-203	Amend
Table 2	Renumber
Table 2.2	New Section
Table 2.2	Amend
R9-6-204	Amend
Table 3	Repeal
Table 2.3	New Section
R9-6-205	Amend
R9-6-206	Amend
Table 4	Repeal
Table 2.4	New Section
R9-6-207	Amend
R9-6-301	Amend
R9-6-302	Amend
R9-6-303	Amend
R9-6-304	Amend
R9-6-305	Renumber
R9-6-305	New Section
R9-6-306	Renumber
R9-6-306	Amend
R9-6-307	Repeal
R9-6-307	New Section
R9-6-308	Renumber
R9-6-308	Amend
R9-6-309	Renumber
R9-6-309	New Section
R9-6-310	Renumber
R9-6-310	New Section
R9-6-311	Renumber
R9-6-311	Amend
R9-6-312	Renumber
R9-6-312	Amend
R9-6-313	Renumber
R9-6-313	Amend
R9-6-314	Renumber
R9-6-314	Amend
R9-6-315	Renumber
R9-6-315	New Section
R9-6-316	Renumber



R9-6-316	Amend
R9-6-317	Renumber
R9-6-317	Amend
R9-6-318	Renumber
R9-6-318	New Section
R9-6-319	Renumber
R9-6-319	Amend
R9-6-320	Renumber
R9-6-320	Amend
R9-6-321	Renumber
R9-6-321	New Section
R9-6-322	Renumber
R9-6-322	Amend
R9-6-323	Renumber
R9-6-323	Amend
R9-6-324	Renumber
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R9-6-336	Amend
R9-6-337	Renumber
R9-6-337	New Section
R9-6-338	Renumber
R9-6-338	Amend
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R9-6-356	Amend
R9-6-357	Renumber
R9-6-357	Amend
R9-6-358	Renumber
R9-6-358	New Section
R9-6-359	Renumber
R9-6-359	Amend
R9-6-360	Renumber
R9-6-360	Amend
R9-6-361	Renumber
R9-6-361	New Section
R9-6-362	Renumber
R9-6-362	Amend
R9-6-363	Renumber
R9-6-363	Amend
R9-6-364	Repeal
R9-6-364	Renumber
R9-6-364	Amend
R9-6-365	Renumber
R9-6-365	Amend
R9-6-366	Renumber
R9-6-366	Amend
R9-6-367	Renumber
R9-6-367	Amend
R9-6-368	Renumber
R9-6-368	Amend
R9-6-369	Repeal
R9-6-369	Renumber
R9-6-369	Amend
R9-6-370	Renumber
R9-6-370	New Section
R9-6-371	Renumber
R9-6-371	Amend
R9-6-372	Renumber
R9-6-372	Amend
R9-6-373	Renumber
R9-6-373	Amend
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R9-6-374	Amend
R9-6-375	Renumber
R9-6-375	Amend
R9-6-376	Renumber
R9-6-376	Amend
R9-6-377	Renumber
R9-6-377	New Section
R9-6-378	Renumber
R9-6-378	Amend
R9-6-379	Renumber
R9-6-379	Amend
R9-6-380	Renumber
R9-6-380	Amend
R9-6-381	Renumber



R9-6-381	Amend
R9-6-382	Renumber
R9-6-382	Amend
R9-6-383	Renumber
R9-6-383	Amend
R9-6-384	Renumber
R9-6-384	Amend
R9-6-385	Renumber
R9-6-385	Amend
R9-6-386	Renumber
R9-6-386	Amend
R9-6-387	Repeal
R9-6-387	Renumber
R9-6-387	Amend
R9-6-388	Renumber
R9-6-388	Amend
R9-6-389	Renumber
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R9-6-394	Renumber
R9-6-394	Amend
R9-6-395	Renumber
R9-6-395	Amend
R9-6-396	Renumber
R9-6-396	Amend
R9-6-397	Renumber
R9-6-397	Amend
R9-6-398	New Section
R9-6-1002	Amend
R9-6-1102	Amend
R9-6-1103	Amend
R9-6-1202	Amend

2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statutes: A.R.S. §§ 36-132(A)(1), 36-136(F)

Implementing statutes: A.R.S. § 36-136(H)(1)

3. The effective date of the rules:

January 1, 2018

The Arizona Department of Health Services (Department) requests an effective date of January 1, 2018, to provide sufficient time for the Department and stakeholders to implement the new rules.

4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 22 A.A.R. 1954, July 29, 2016

Notice of Proposed Rulemaking: 23 A.A.R. 1067, June 9, 2017

5. The agency’s contact person who can answer questions about the rulemaking:

Name: Ken Komatsu, State Epidemiologist
Address: Arizona Department of Health Services
Bureau of Epidemiology and Disease Control
150 N. 18th Ave., Suite 100
Phoenix, AZ 85007-3248
Telephone: (602) 364-3587
Fax: (602) 364-3199
E-mail: Ken.Komatsu@azdhs.gov
or
Name: Robert Lane, Chief
Address: Arizona Department of Health Services



Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 200
Phoenix, AZ 85007

Telephone: (602) 542-1020
Fax: (602) 364-1150
E-mail: Robert.Lane@azdhs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Revised Statutes (A.R.S.) § 36-136(H)(1) requires the Arizona Department of Health Services (Department) to make rules defining and prescribing "reasonably necessary measures for detecting, reporting, preventing, and controlling communicable and preventable diseases." The Department has adopted rules to implement this statute in Arizona Administrative Code (A.A.C.) Title 9, Chapter 6. The rules specifying reporting requirements for communicable diseases are in 9 A.A.C. 6, Article 2. The rules covering control measures for communicable diseases are in 9 A.A.C. 6, Article 3. The rules in 9 A.A.C. 6, Articles 2 and 3 contain requirements for the reporting of several conditions that no longer need to be included as reportable conditions and do not contain reporting requirements for other conditions that should be reportable to protect public health. The rules need to be revised to update reportable conditions and their control measures, ensure more accurate tracking and better reporting, and improve the effectiveness of the rules in preventing a significant threat to public health. After receiving an exception from the Governor's rulemaking moratorium established by Executive Order 2016-03, the Department is revising the rules to address these concerns, account for changes in laboratory methodologies, allow for electronic reporting, and reduce the regulatory burden of the rules. In addition, the Department is changing cross-references in other Articles in the Chapter that are being made incorrect by renumbering in Article 3. The amendments will conform to rulemaking format and style requirements of the Governor's Regulatory Review Council and the Office of the Secretary of State.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review or rely on any study for this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

This analysis covers costs and benefits associated with the rule changes and does not describe effects imposed by statutes. No new FTEs will be required due to this rulemaking. Annual cost/revenue changes are designated as minimal when more than \$0 and \$5,000 or less, moderate when between \$5,000 and \$30,000, and substantial when \$30,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification. The Department anticipates that persons affected by the rulemaking include the Department; local health agencies; local agencies responsible for vector control; health care providers; health care institutions; correctional facilities, including both public and private; schools, child care establishments, and shelters; clinical laboratories; businesses employing individuals infected with a communicable disease, including owners or operators of restaurants or other food establishments; owners or operators of aquatic venues; pharmacists and pharmacies; health insurance providers, including the Arizona Health Care Cost Containment System (AHCCCS); cases or suspect cases of a communicable disease; contacts of individuals infected with a communicable disease; other patients or residents in a health care institution; other prisoners or detainees in a correctional facility; and the general public.

The Department believes that having rules that are clearer and easier to understand may provide a significant benefit to the Department since staff could then spend less time on following up on incomplete or inadequate reports or answering questions about the communicable disease rules and more time analyzing the data received. The new rules specify that reports are required to be submitted in a Department-provided format, allowing for electronic submission. The Department anticipates receiving a significant benefit from this change. Adding communicable diseases to those reported by clinical laboratories will make reporting more uniform across reporting entities and may detect additional cases, providing a significant benefit to the Department while imposing no more than a minimal burden on the Department from reviewing the additional reports and taking required action based on the reports. The Department believes that requiring the results of all CD4-T-lymphocyte counts and the results of all HIV tests except negative screening tests may provide a substantial benefit to the Department by providing better information about individuals infected with HIV, which the Department may use to develop better public health responses. This change will also make the Department eligible for grant funding from the Centers for Disease Control and Prevention (CDC), to which Arizona is currently ineligible. Since testing methodologies in clinical laboratories have changed since the current rules were adopted, with many tests not requiring a clinical laboratory to obtain an isolate from a specimen as part of the confirmation of a communicable disease, the new rules specify that a clinical laboratory is required for some communicable diseases to submit to the Arizona State Laboratory an isolate of the organism for each positive culture, if one is available, or a specimen for each positive test result. This change may cause the Department a minimal increase in costs if the Arizona State Laboratory, a component of the Department, must develop additional isolates from submitted specimens if necessary for identification and confirmation of disease status, to establish relationships between cases of the disease, to determine the drugs that may be used to treat an individual infected with the agent, and to identify trends in the agent's antigen content that may affect vaccine effectiveness or public health control measures. A change to require an isolate or specimen for other communicable diseases only by request may reduce the number of unnecessary isolates/specimens received and provide a moderate benefit to the Department when receiving, cataloging, and storing these isolates/specimens. The Department believes that decreasing the time period for reporting may provide a significant benefit to the Department by allowing the Department to respond to individual cases more quickly to reduce the chance of an outbreak, as well as to detect



outbreaks more quickly to reduce the number of new cases. Changes that clarify the Department’s role in the control of communicable diseases may provide a significant benefit to the Department in improving public health in Arizona.

Local health agencies may receive a significant benefit from the clarified requirements related to communicable disease reporting or control measures, since local health agencies may receive more complete and accurate reports and be able to complete epidemiologic investigations more efficiently. The Department anticipates that a local health agency may incur a minimal-to-moderate burden from the addition of new reportable communicable diseases, depending on the county and the number of cases in the county, and may receive a minimal-to-substantial benefit from the removal of some reportable communicable diseases from the new rules, depending on the number that had previously been received and acted upon. The Department believes that changes that add requirements for epidemiologic investigations may impose a minimal-to-moderate burden on a local health agency and that a local health agency may receive a minimal-to-substantial benefit from the removal of requirements for epidemiologic investigations for other communicable diseases. The new rules also clarify that a local health agency may conduct an epidemiologic or other investigation, even if not specifically required by this Chapter, in cooperation with the Department. The Department believes this clarification may provide a significant benefit to a local health agency. A local health agency may also incur a minimal-to-moderate burden from the decrease in time to report to the Department for some communicable diseases and may receive a minimal-to-moderate benefit from changes increasing the reporting time, with smaller local health agencies with fewer staff perhaps receiving a significant benefit from the increased time since reports about these communicable diseases would no longer need to be reported over weekends or holidays. Based on the estimates of the numbers of cases or suspect cases for which a local health agency may now be required to ensure submission of an isolate or specimen compared with the estimated number for which a local health agency will no longer be required to ensure submission, the Department anticipates that these changes may cause at most a minimal additional cost to a local health agency. The Department believes that changes related to isolation, quarantine, or exclusion may provide a significant benefit to a local health agency, while other changes to control measures may provide a minimal-to-moderate benefit to a local health agency due to the net decrease in the number of instances in which a local health agency is required under the new rules to take action. The addition of some responsibilities for local health agencies in the new rules is anticipated to cause a minimal-to-substantial increase in cost to a local health agency, depending on the number of cases or outbreaks. If a local health agency is not responsible for conducting environmental assessments for vector control within a jurisdiction, a local agency responsible for vector control in the jurisdiction may incur a minimal-to-moderate burden for performing additional assessments if the local agency responsible for vector control were not already performing these assessments.

Some of the added communicable diseases should already have been reported under the current rules in R9-6-202 and Table 1 as “emerging or exotic disease.” Because of the low incidence of the added communicable diseases, the Department expects that a health care provider required to report who had not reported the added communicable diseases under this category may incur up to a minimal additional burden for reporting them. A health care provider required to report might also incur minimal additional costs due to the added information being required in a report and from the reduced time to report certain communicable diseases. The removal of other diseases as reportable may provide a health care provider required to report with a minimal-to-moderate benefit, depending on the number of cases the health care provider encounters. The Department believes that notification to a receiving facility that an individual known to be infected with certain antibiotic-resistant agents is being transferred to the facility is a standard of practice and is adding this requirement to the new rules. This notification may cause a minimal-to-moderate cost to a health care provider, depending on the number of cases for which notification by the health care provider would need to be made, but provide an offsetting minimal-to-substantial benefit to the receiving health care provider by reducing the chance the infection would spread. New requirements for a diagnosing health care provider to institute isolation precautions for certain diseases, including tuberculosis, and for a health care provider for a pregnant syphilis case to order serologic testing for syphilis at 28 to 32 weeks gestation and at delivery to reduce the risk of the baby being born with congenital syphilis are being added to the new rules and are expected to impose a minimal-to-moderate cost on a health care provider who diagnoses one of these diseases or is treating a pregnant syphilis case and provide a significant benefit in reducing the threat of transmission, including transmission to the fetus or newborn, thereby avoiding stillbirth, premature birth and/or potential deformities in the newborn.

An administrator of a health care institution that had not reported cases or suspect cases of added communicable diseases under the current rules may be expected to incur a minimal-to-moderate burden for reporting them. An administrator of a health care institution might also incur minimal additional costs due to the added information being required in a report and from the reduced time to report certain communicable diseases, with some of this cost mitigated through electronic reporting, especially for larger facilities. The Department anticipates that reporting outbreaks of respiratory disease in a health care institution may impose a minimal burden on an administrator of a health care institution and may result in significant cost savings if earlier reporting and institution of appropriate precautions and other responses results in less transmission and fewer cases. The Department estimates that removing the reporting requirements for certain communicable diseases may provide a minimal-to-substantial benefit to a health care institution, depending on the number of cases the health care institution encounters. The addition of requirements for isolation precautions for certain diseases may cause a health care institution to incur minimal-to-moderate costs to institute control measures for these communicable diseases and to receive minimal-to-substantial benefits from having the control measures in place. Additional requirements related to tuberculosis may provide a significant benefit to a health care institution by making requirements clearer and consistent with standards of care, but could cause a health care institution to incur minimal increased cost for providing additional information as part of a report and moderate additional costs if approval of release from isolation and airborne precautions of a tuberculosis suspect case takes longer than before. Notification requirements upon transfer may cause a minimal additional cost to a health care institution as a sending facility, depending on the number of cases for which notification would need to be made, and provide as much as a substantial benefit as a receiving health care institution by reducing the chance the infection would spread.

An administrator of a correctional facility might incur minimal additional costs due to the added information being required in a report and from the reduced time to report certain communicable diseases. The Department also anticipates that reporting outbreaks of respiratory disease in a correctional facility would impose a minimal burden on an administrator of a correctional facility,



but that the correctional facility may receive a minimal-to-moderate benefit from the earlier detection of cases and the institution of isolation precautions to reduce the number of new cases and a minimal-to-substantial benefit from the removal of requirements to report certain communicable diseases. The Department anticipates that a correctional facility may incur minimal-to-moderate costs to institute control measures for added communicable diseases, but receive minimal-to-substantial benefits from having the control measures in place, thus reducing the chance of an outbreak occurring. Similarly, a correctional facility may receive a moderate-to-substantial benefit from notification upon transfer by a health care provider or health care institution of a prisoner's or detainee's diagnosis with an antibiotic-resistant organism so precautions can be taken to prevent transmission. Requirements related to tuberculosis may cause a correctional facility to incur a minimal increased cost from providing the additional information when reporting a case of tuberculosis and to receive a minimal-to-substantial benefit from the changes related to removal from isolation precautions.

The Department believes that the addition of a few new items of information to a report may cause a school, child care establishment, or shelter to incur minimal additional costs for the added information and that a school, child care establishment, or shelter may receive a significant benefit from clarity and the reduced time spent finding and giving the additional information to a local health agency once it is requested separate from the report. In addition, the Department anticipates that a shelter could incur minimal-to-moderate costs for implementing additional control measures for measles, mumps, pertussis, and rubella recommended by a local health agency but receive a significant benefit from not having a case of one of these communicable diseases infect other individuals on the premises.

The new rules require the reporting by clinical laboratories of results from tests for several additional communicable diseases. Because the communicable diseases being added are already being reported or are rare, the Department believes that these changes will result in at most a minimal-to-moderate cost to a clinical laboratory. Changes in the requirements for reporting of HIV-related tests are expected to result in a significant benefit to a clinical laboratory through having reporting requirements consistent with the rest of the country, and may result in at most a minimal-to-moderate cost to a clinical laboratory that had not already been reporting viral load and CD4 count values for all HIV-related tests. Many clinical laboratories already report results within the new time periods in the new rules. For clinical laboratories not reporting according to the time periods in the new rules, the Department believes a clinical laboratory may incur minimal-to-moderate costs to send the report out more quickly, depending on the number of reports, and may receive a significant benefit if the new rules encourage electronic reporting. Changes requiring a clinical laboratory to send isolates/specimens on the request of the Department may result in fewer isolates/specimens being submitted and a significant benefit to a clinical laboratory, while sending specimens for other communicable diseases may cause the clinical laboratory to incur minimal additional costs, which may be reduced by the clinical laboratory using the courier service provided by the Arizona State Laboratory. A new requirement to submit a drug sensitivity pattern determined when testing for the agent causing gonorrhea may cause a minimal-to-moderate cost increase to clinical laboratories, depending on the number of reports including a drug sensitivity pattern.

Workers in sensitive occupations who are infected with certain communicable diseases are excluded from working until specific criteria are met to reduce the chance for wide-spread transmission of the disease. The Department anticipates that the owner of a business employing one of these infected workers may incur a minimal-to-moderate cost due to more stringent exclusion criteria for some diseases and may receive a minimal-to-moderate benefit from less stringent exclusion criteria for other diseases and from the potential reduction in the number of new cases or an outbreak arising from an infected worker employed at the business. The environmental control and health education requirements added in the new rules may also provide a significant benefit to a business employing an individual infected with a communicable disease if an environmental assessment includes the business as a possible source of infection and any issues are identified so the owner or operator of the business can take steps to resolve the issues.

The new rules affect other businesses as well. They add an exclusion from an individual using an aquatic venue for specific periods after diarrhea has resolved for certain water-borne diseases. The Department believes that an owner or operator of an aquatic venue may incur minimal decreased revenue from fewer individuals with one of these diseases using the aquatic venue during the time period specified in rule for exclusion and may receive up to a substantial benefit from not having the aquatic venue contaminated and having to shut down operations until the area is no longer contaminated. Clarifying reporting requirements for pharmacists and administrators of pharmacies may provide a significant benefit to these persons. The Department also anticipates that a health insurance company or health plan, including AHCCCS or Medicare, may receive up to a substantial benefit from the rule change requiring notification upon transfer through the reduction in the number of new cases for which the health insurance company or health plan would be required to pay for care.

Individuals infected with a communicable disease are expected to receive a minimal benefit from the clarification of reporting requirements and control measures for communicable diseases and a significant benefit from the reduced time to report for some of the reportable communicable, allowing individuals with expertise in the disease to provide faster assistance. Notification requirements upon transfer may provide a significant benefit to an individual infected with one of these diseases since the receiving health care provider, health care institution, or correctional facility may be able to provide better care to the individual. The environmental control and health education requirements added in the new rules may provide a significant indirect benefit to a case or suspect case by helping to protect the family members of the case or suspect case from becoming infected. Additional control measures in R9-6-303 may reduce the time of or avoid the need for isolation or exclusion in some instances, providing a significant benefit to an individual who would otherwise have been isolated or excluded. The new rules also allow local health agencies to determine when a case or suspect case should be excluded for certain diseases and when they may be removed from exclusion, which may provide a significant benefit to an infected individual who may be removed from isolation or exclusion earlier and may impose a significant cost on an individual who is excluded longer to protect public health.

The removal of contact control measures for certain diseases and changes requiring the notification of a parent or guardian of a child who is a contact of a pediculosis case may provide a significant benefit to a contact of an individual infected with a commu-



nicable disease. Other changes affecting when and for how long a contact is to be quarantined or excluded or adding additional control measures that may be used may provide a significant benefit to a contact. Requirements for environmental control measures and health education may also provide a significant benefit to the household or neighborhood contacts of an infected individual by identifying potential sources of infection and thereby reducing the risk of infection to the contacts. Notification before transfer of an individual infected with one of certain communicable diseases may also provide a significant benefit to staff or patients of a receiving facility.

The general public may receive a significant benefit from the clarity of the new rules and the ease with which they may be followed. Earlier detection of cases or outbreaks made possible by the new rules should lead to quicker response times and less disease/less transmission, as will changes to control measures, such as education, vector control, environmental measures, exclusions, and isolation, established to prevent additional cases. Reduced transmission leads to less risk to others, which may provide a significant benefit to society in general.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

To clarify the rules, the Department added a definition of “vaccine,” corrected a statutory cross-reference, and corrected a few punctuation or rulemaking style errors. No other changes were made to the rules between the proposed rulemaking and the final rulemaking.

11. An agency’s summary of the public stakeholder comments made about the rulemaking and the agency response to the comments:

The Department received no written comments during the public comment period. The Department held an oral proceeding for the proposed rules on July 13, 2017, at which oral comments were provided by infectious disease prevention staff members from two hospital systems. A summary of the comments received and the Department’s responses follows:

Comment	Department’s Response
<p>A comment was made by a representative of Dignity Health asking that the rules:</p> <ul style="list-style-type: none"> - make the definition of carbapenem-resistant enterobacteriaceae consistent with the 2013 CDC definition; 	<p>Carbapenem-resistant enterobacteriaceae is not defined in the rule, consistent with all other diseases included in the rule. Instead, as discussed during stakeholder meetings, the Department has on the Department’s website for communicable diseases “case definitions” of all reportable conditions. The case definition for a reportable condition can incorporate the criteria for when a condition is considered reportable and what constitutes a case or suspect case. These case definitions are usually based on national guidance reflecting input from infectious disease and laboratory personnel. It is in a case definition that the genus and species names of organisms considered to be included under carbapenem-resistant enterobacteriaceae would be included. The Department plans to involve Arizona infectious disease and laboratory personnel in discussions of the carbapenem-resistant enterobacteriaceae case definition. The CDC definitions change periodically, and the 2013 version of the CDC reference cited is not the most current. No change will be made to the rule.</p>
<ul style="list-style-type: none"> - remove vancomycin intermediate <i>Staphylococcus aureus</i> from the list of reportable conditions since the CDC does not list it as a serious, urgent, or concerning threat; 	<p>Vancomycin-intermediate <i>Staphylococcus aureus</i> is listed in the most recent CDC report as a concerning threat to public health. No change will be made to the rule.</p>
<ul style="list-style-type: none"> - make the criteria for removal of isolation precautions for tuberculosis two negative sputum smears, rather than three as long as one is through a bronchial wash or other kind of invasive technique. 	<p>As discussed during stakeholder meetings, there is insufficient evidence that testing of other specimens, such as through bronchoalveolar lavage, can be used to discontinue infection control precautions. Because of the significant public health risk associated with a false-negative result and the consensus of multiple expert guidelines (Infectious Diseases Society of America, CDC, American Thoracic Society, and Heartland Regional Training and Medical Consultation Center) to use only sputum nucleic acid amplification tests in making decisions whether to discontinue isolation and airborne precautions for a suspect case, no change will be made to the rules.</p>



<p>A comment was made by a representative of Honor Health: - echoing the need for more clarity in the genus/species of agents that constitute carbapenem-resistant enterobacteriaceae, but stating an understanding that this would be developed as part of a case definition;</p>	<p>The Department recognizes the need for more specificity in what constitutes a carbapenem-resistant enterobacteriaceae case or suspect case. As discussed during stakeholder meetings, the Department plans to develop the case definition with input from infectious disease and laboratory personnel throughout the state before their effective date. No change will be made to the rule.</p>
<p>- echoing a desire to reduce reportable diseases, such as vancomycin intermediate <i>Staphylococcus aureus</i>, if another mechanism could be found for providing isolates that would work;</p>	<p>The Department, as part of this rulemaking, has removed the reporting of a number of communicable diseases that had been reportable under the current rules, including aseptic meningitis and vancomycin-resistant <i>Staphylococcus epidermidis</i>. Because vancomycin-intermediate <i>Staphylococcus aureus</i> is listed in the most recent CDC report as a concerning threat to public health and there have been only four cases reported since January 2016, the Department does not consider it prudent to remove reporting for vancomycin-intermediate <i>Staphylococcus aureus</i> at this time. No change will be made to the rule.</p>
<p>- expressing support for the Department's removal of reporting of aseptic meningitis;</p>	<p>The Department thanks the commenter for the support.</p>
<p>- expressing support for changes in several Sections to specify that the control measures are for cases with active infection.</p>	<p>The Department thanks the commenter for the support.</p>

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rules do not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No business competitiveness analysis was received by the Department.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

Not applicable

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:

**TITLE 9. HEALTH SERVICES
 CHAPTER 6. DEPARTMENT OF HEALTH SERVICES
 COMMUNICABLE DISEASES AND INFESTATIONS**

ARTICLE 1. GENERAL

Section
 R9-6-101. Definitions

ARTICLE 2. COMMUNICABLE DISEASE AND INFESTATION REPORTING

Section
 R9-6-201. Definitions
 R9-6-202. Reporting Requirements for a Health Care Provider Required to Report or an Administrator of a Health Care Institution or Correctional Facility
 Table 1. ~~Reporting Requirements for a Health Care Provider Required to Report or an Administrator of a Health Care Institution or Correctional Facility~~ Repealed
 Table 2.1. Reporting Requirements for a Health Care Provider Required to Report or an Administrator of a Health Care Institution or Correctional Facility
 R9-6-203. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter
 Table 2-2.2. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter



- R9-6-204. Clinical Laboratory Director Reporting Requirements
Table 3. ~~Clinical Laboratory Director Reporting Requirements Repealed~~
Table 2.3. Clinical Laboratory Director Reporting Requirements
- R9-6-205. Reporting Requirements for a Pharmacist or an Administrator of a Pharmacy
- R9-6-206. Local Health Agency Responsibilities Regarding Communicable Disease Reports
Table 4. ~~Local Health Agency Reporting Requirements Repealed~~
Table 2.4. Local Health Agency Reporting Requirements
- R9-6-207. Federal or Tribal Entity Reporting

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE DISEASES AND INFESTATIONS

Section

- R9-6-301. Definitions
- R9-6-302. Local Health Agency Control Measures
- R9-6-303. Isolation, ~~and~~ Quarantine, ~~Exclusion, and~~ Other Control Measures
- R9-6-304. Food Establishment Control Measures
- R9-6-305. Control Measures for Multi-drug-resistant Organisms
- ~~R9-6-305-R9-6-306~~ Amebiasis
- ~~R9-6-307~~. ~~Aseptic Meningitis~~
- R9-6-307. Anaplasmosis
- ~~R9-6-306-R9-6-308~~ Anthrax
- R9-6-309. Arboviral Infection
- R9-6-310. Babesiosis
- ~~R9-6-308-R9-6-311~~ Basidiobolomycosis
- ~~R9-6-309-R9-6-312~~ Botulism
- ~~R9-6-310-R9-6-313~~ Brucellosis
- ~~R9-6-311-R9-6-314~~ Campylobacteriosis
- R9-6-315. Carbapenem-resistant Enterobacteriaceae
- ~~R9-6-312-R9-6-316~~ Chagas Infection and Related Disease (American Trypanosomiasis)
- ~~R9-6-313-R9-6-317~~ Chancroid (*Haemophilus ducreyi*)
- R9-6-318. Chikungunya
- ~~R9-6-314-R9-6-319~~ Chlamydia *Chlamydia trachomatis* Infection, Sexually Transmitted
- ~~R9-6-315-R9-6-320~~ Cholera
- R9-6-321. Clostridium difficile
- ~~R9-6-316-R9-6-322~~ Coccidioidomycosis (Valley Fever)
- ~~R9-6-317-R9-6-323~~ Colorado Tick Fever
- ~~R9-6-318-R9-6-324~~ Conjunctivitis: Acute
- ~~R9-6-319-R9-6-325~~ Creutzfeldt-Jakob Disease
- ~~R9-6-320-R9-6-326~~ Cryptosporidiosis
- ~~R9-6-321-R9-6-327~~ Cyclospora Infection
- ~~R9-6-322-R9-6-328~~ Cysticercosis
- ~~R9-6-323-R9-6-329~~ Dengue
- ~~R9-6-330~~. ~~Expired~~
- ~~R9-6-324-R9-6-330~~ Diarrhea, Nausea, or Vomiting
- ~~R9-6-325-R9-6-331~~ Diphtheria
- ~~R9-6-326-R9-6-332~~ ~~Ehrlichioses (Ehrlichiosis and Anaplasmosis)~~
- ~~R9-6-327-R9-6-333~~ Emerging or Exotic Disease
- ~~R9-6-328-R9-6-334~~ Encephalitis: Viral or Parasitic
- ~~R9-6-329-R9-6-335~~ Enterohemorrhagic *Escherichia coli*, Shiga Toxin-producing
- ~~R9-6-331-R9-6-336~~ Giardiasis
- R9-6-337. Glanders
- ~~R9-6-332-R9-6-338~~ Gonorrhea
- ~~R9-6-333-R9-6-339~~ *Haemophilus influenzae*: Invasive Disease
- ~~R9-6-334-R9-6-340~~ Hansen's Disease (Leprosy)
- ~~R9-6-335-R9-6-341~~ Hantavirus Infection
- ~~R9-6-336-R9-6-342~~ Hemolytic Uremic Syndrome
- ~~R9-6-343~~. ~~Expired~~
- ~~R9-6-337-R9-6-343~~ Hepatitis A
- ~~R9-6-338-R9-6-344~~ Hepatitis B and Hepatitis D
- ~~R9-6-339-R9-6-345~~ Hepatitis C
- ~~R9-6-340-R9-6-346~~ Hepatitis E
- ~~R9-6-341-R9-6-347~~ Human Immunodeficiency Virus (HIV) Infection and Related Disease
- ~~R9-6-342-R9-6-348~~ Influenza-Associated Mortality in a Child
- ~~R9-6-344-R9-6-349~~ Legionellosis (Legionnaires' Disease)
- ~~R9-6-345-R9-6-350~~ Leptospirosis
- ~~R9-6-346-R9-6-351~~ Listeriosis
- ~~R9-6-347-R9-6-352~~ Lyme Disease



~~R9-6-348-R9-6-353~~, Lymphocytic Choriomeningitis
~~R9-6-349-R9-6-354~~, Malaria
~~R9-6-350-R9-6-355~~, Measles (Rubeola)
~~R9-6-351-R9-6-356~~, Melioidosis
~~R9-6-352-R9-6-357~~, Meningococcal Invasive Disease
~~R9-6-358~~, Methicillin-resistant *Staphylococcus aureus* (MRSA)
~~R9-6-353-R9-6-359~~, Mumps
~~R9-6-354-R9-6-360~~, Norovirus
~~R9-6-361~~, Novel Coronavirus (e.g., SARS or MERS)
~~R9-6-355-R9-6-362~~, Pediculosis (Lice Infestation)
~~R9-6-363~~, Expired
~~R9-6-356-R9-6-363~~, Pertussis (Whooping Cough)
~~R9-6-364~~, ~~Rocky Mountain Spotted Fever~~
~~R9-6-357-R9-6-364~~, Plague
~~R9-6-358-R9-6-365~~, Poliomyelitis (Paralytic or Non-paralytic)
~~R9-6-359-R9-6-366~~, Psittacosis (Ornithosis)
~~R9-6-360-R9-6-367~~, Q Fever
~~R9-6-361-R9-6-368~~, Rabies in a Human
~~R9-6-369~~, ~~Severe Acute Respiratory Syndrome~~
~~R9-6-362-R9-6-369~~, Relapsing Fever (Borreliosis)
~~R9-6-370~~, Respiratory Disease in a Health Care Institution or Correctional Facility
~~R9-6-365-R9-6-371~~, Rubella (German Measles)
~~R9-6-366-R9-6-372~~, Rubella Syndrome, Congenital
~~R9-6-367-R9-6-373~~, Salmonellosis
~~R9-6-368-R9-6-374~~, Scabies
~~R9-6-370-R9-6-375~~, Shigellosis
~~R9-6-371-R9-6-376~~, Smallpox
~~R9-6-377~~, Spotted Fever Rickettsiosis (e.g., Rocky Mountain Spotted Fever)
~~R9-6-372-R9-6-378~~, Streptococcal Group A Infection
~~R9-6-373-R9-6-379~~, Streptococcal Group B Infection in an Infant Younger Than 90 Days of Age
~~R9-6-374-R9-6-380~~, *Streptococcus pneumoniae* Invasive Infection
~~R9-6-375-R9-6-381~~, Syphilis
~~R9-6-376-R9-6-382~~, Taeniasis
~~R9-6-377-R9-6-383~~, Tetanus
~~R9-6-384~~, Expired
~~R9-6-378-R9-6-384~~, Toxic Shock Syndrome
~~R9-6-379-R9-6-385~~, Trichinosis
~~R9-6-380-R9-6-386~~, Tuberculosis
~~R9-6-387~~, Vancomycin-Resistant *Staphylococcus epidermidis*
~~R9-6-381-R9-6-387~~, Tularemia
~~R9-6-382-R9-6-388~~, Typhoid Fever
~~R9-6-383-R9-6-389~~, Typhus Fever
~~R9-6-385-R9-6-390~~, Vaccinia-related Adverse Event
~~R9-6-386-R9-6-391~~, Vancomycin-Resistant or Vancomycin-Intermediate *Staphylococcus aureus*
~~R9-6-388-R9-6-392~~, Varicella (Chickenpox)
~~R9-6-389-R9-6-393~~, *Vibrio* Infection
~~R9-6-394~~, Expired
~~R9-6-390-R9-6-394~~, Viral Hemorrhagic Fever
~~R9-6-391-R9-6-395~~, ~~West Nile Virus-related Syndromes~~ Virus Infection
~~R9-6-392-R9-6-396~~, Yellow Fever
~~R9-6-393-R9-6-397~~, Yersiniosis (Enteropathogenic *Yersinia*)
~~R9-6-398~~, Zika Virus Infection

ARTICLE 10. HIV-RELATED TESTING AND NOTIFICATION

Section
 R9-6-1002. Local Health Agency Requirements

ARTICLE 11. STD-RELATED TESTING AND NOTIFICATION

Section
 R9-6-1102. Health Care Provider Requirements
 R9-6-1103. Local Health Agency Requirements

ARTICLE 12. TUBERCULOSIS CONTROL

Section
 R9-6-1202. Local Health Agency Reporting Requirements



ARTICLE 1. GENERAL

R9-6-101. Definitions

In this Chapter, unless otherwise specified:

1. "Active tuberculosis" means the same as in A.R.S. § 36-711.
2. "Administrator" means the individual who is the senior leader at a child care establishment, health care institution, correctional facility, school, pharmacy, or shelter.
3. "Agency" means any board, commission, department, office, or other administrative unit of the federal government, the state, or a political subdivision of the state.
4. "Agent" means an organism that may cause a disease, either directly or indirectly.
5. "AIDS" means Acquired Immunodeficiency Syndrome.
6. "Airborne precautions" means, in addition to use of standard precautions:
 - a. Either:
 - i. Placing an individual in a private room with negative air-pressure ventilation, at least six air exchanges per hour, and air either:
 - (1) Exhausted directly to the outside of the building containing the room, or
 - (2) Recirculated through a HEPA filtration system before being returned to the interior of the building containing the room; or
 - ii. If the building in which an individual is located does not have an unoccupied room meeting the specifications in subsection (6)(a)(i):
 - (1) Placing the individual in a private room, with the door to the room kept closed when not being used for entering or leaving the room, until the individual is transferred to a health care institution that has a room meeting the specifications in subsection (6)(a)(i) or to the individual's residence, as medically appropriate; and
 - (2) Ensuring that the individual is wearing a mask covering the individual's nose and mouth; and
 - b. Ensuring the use by other individuals, when entering the room in which the individual is located, of a device that is:
 - i. Designed to protect the wearer against inhalation of an atmosphere that may be harmful to the health of the wearer, and
 - ii. At least as protective as a National Institute for Occupational Safety and Health-approved N-95 respirator.
7. "Approved test for tuberculosis" means a Mantoux skin test or other test for tuberculosis recommended by the Centers for Disease Control and Prevention or the Tuberculosis Control Officer appointed under A.R.S. § 36-714.
8. "Arizona State Laboratory" means the part of the Department authorized by A.R.S. Title 36, Chapter 2, Article 2, and A.R.S. § 36-132(A)(11) that performs serological, microbiological, entomological, and chemical analyses.
9. "Average window period" means the typical time between exposure to an agent and the ability to detect infection with the agent in human blood.
10. "Barrier" means a mask, gown, glove, face shield, face mask, or other membrane or filter to prevent the transmission of infectious agents and protect an individual from exposure to body fluids.
11. "Body fluid" means semen, vaginal secretion, tissue, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, urine, blood, lymph, or saliva.
12. "Carrier" means an infected individual without symptoms who can spread the infection to a susceptible individual.
13. "Case" means an individual:
 - a. With a communicable disease whose condition is documented:
 - i. By laboratory results that support the presence of the agent that causes the disease;
 - ii. By a health care provider's diagnosis based on clinical observation; or
 - iii. By epidemiologic associations with the communicable disease, the agent that causes the disease, or toxic products of the agent;
 - b. Who has experienced diarrhea, nausea, or vomiting as part of an outbreak;
 - ~~c. Who has died without apparent cause within 48 hours after experiencing a fever; or~~
 - ~~d. Who has experienced a vaccinia-related adverse event.~~
14. "Case definition" means the disease-specific criteria that must be met for an individual to be classified as a case.
15. "Chief medical officer" means the senior health care provider in a correctional facility or that individual's designee who is also a health care provider.
16. "Child" means an individual younger than 18 years of age.
17. "Child care establishment" means:
 - a. A "child care facility," as defined in A.R.S. § 36-881;
 - b. A "child care group home," as defined in A.R.S. § 36-897;
 - c. A child care home registered with the Arizona Department of Education under A.R.S. § 46-321; or
 - d. A child care home certified by the Arizona Department of Economic Security under A.R.S. Title 46, Chapter 7, Article 1.
18. "Clinical signs and symptoms" means evidence of disease or injury that can be observed by a health care provider or can be inferred by the health care provider from a patient's description of subjective complaints.
19. "Cohort room" means a room housing only individuals infected with the same agent and no other agent.
20. "Communicable disease" means an illness caused by an agent or its toxic products that arises through the transmission of that agent or its products to a susceptible host, either directly or indirectly.
21. "Communicable period" means the time during which an agent may be transmitted directly or indirectly:
 - a. From an infected individual to another individual;
 - b. From an infected animal, arthropod, or vehicle to an individual; or
 - c. From an infected individual to an animal.
22. "Confirmatory test" means a laboratory analysis, such as a Western blot analysis approved by the U.S. Food and Drug Administration to be used after a screening test to diagnose or monitor the progression of HIV infection.



23. “Contact” means an individual who has been exposed to an infectious agent in a manner that may have allowed transmission of the infectious agent to the individual during the communicable period.
24. “Correctional facility” means any place used for the confinement or control of an individual:
 - a. Charged with or convicted of an offense,
 - b. Held for extradition, or
 - c. Pursuant to a court order for law enforcement purposes.
25. “Court-ordered subject” means a subject who is required by a court of competent jurisdiction to provide one or more specimens of blood or other body fluids for testing.
26. “Dentist” means an individual licensed under A.R.S. Title 32, Chapter 11, Article 2.
27. “Department” means the Arizona Department of Health Services.
28. “Designated service area” means the same as in R9-18-101.
29. “Diagnosis” means an identification of a disease by an individual authorized by law to make the identification.
30. “Disease” means a condition or disorder that causes the human body to deviate from its normal or healthy state.
31. “Emerging or exotic disease” means:
 - a. A new disease resulting from change in an existing organism;
 - b. A known disease not usually found in the geographic area or population in which it is found;
 - c. A previously unrecognized disease appearing in an area undergoing ecologic transformation; or
 - d. A disease reemerging as a result of a situation such as antimicrobial resistance in a known infectious agent, a breakdown in public health measures, or deliberate release.
32. “Entity” has the same meaning as “person” in A.R.S. § 1-215.
33. “Epidemiologic investigation” means the application of scientific methods to ascertain a diagnosis; identify risk factors for a disease; determine the potential for spreading a disease; institute control measures; and complete forms and reports such as communicable disease, case investigation, and outbreak reports.
34. “Fever” means a temperature of ~~101°~~ 100.4° F or higher.
35. “Food establishment” has the same meaning as in the document incorporated by reference in A.A.C. R9-8-107.
36. “Food handler” means:
 - a. A paid or volunteer full-time or part-time worker who prepares or serves food or who otherwise touches food in a food establishment; or
 - b. An individual who prepares food for or serves food to a group of two or more individuals in a setting other than a food establishment.
37. “Foodborne” means that food serves as a mode of transmission of an infectious agent.
38. “Guardian” means an individual who is invested with the authority and charged with the duty of caring for an individual by a court of competent jurisdiction.
39. “HBsAg” means hepatitis B surface antigen.
40. “Health care institution” has the same meaning as in A.R.S. § 36-401.
41. “Health care provider” means the same as in A.R.S. § 36-661.
42. “Health education” means supplying to an individual or a group of individuals:
 - a. Information about a communicable disease or options for treatment of a communicable disease, and
 - b. Guidance about methods to reduce the risk that the individual or group of individuals will become infected or infect other individuals.
43. “HIV” means Human Immunodeficiency Virus.
44. “HIV-related test” has the same meaning as in A.R.S. § 36-661.
45. “Infected” or “infection” means when an individual has an agent for a disease in a part of the individual’s body where the agent may cause a disease.
46. “Infectious active tuberculosis” means pulmonary or laryngeal active tuberculosis in an individual, which can be transmitted from the infected individual to another individual.
47. “Infectious agent” means an agent that can be transmitted to an individual.
48. “Infant” means a child younger than 12 months of age.
49. “Isolate” means:
 - a. To separate an infected individual or animal from others to limit the transmission of infectious agents, or
 - b. A pure strain of an agent obtained from a specimen.
50. “Isolation” means separation, during the communicable period, of an infected individual or animal from others to limit the transmission of infectious agents.
51. “Laboratory report” means a document that:
 - a. Is produced by a laboratory that conducts a test or tests on a subject’s specimen; and
 - b. Shows the outcome of each test, including personal identifying information about the subject.
52. “Local health agency” means a county health department, a public health services district, a tribal health unit, or a U.S. Public Health Service Indian Health Service Unit.
53. “Local health officer” means an individual who has daily control and supervision of a local health agency or the individual’s designee.
54. “Medical evaluation” means an assessment of an individual’s health by a physician, physician assistant, or registered nurse practitioner.
55. “Medical examiner” means an individual:
 - a. Appointed as a county medical examiner by a county board of supervisors under A.R.S. § 11-592, or
 - b. Employed by a county board of supervisors under A.R.S. § 11-592 to perform the duties of a county medical examiner.



- 56. "Multi-drug resistant tuberculosis" means active tuberculosis that is caused by bacteria that are not susceptible to the antibiotics isoniazid and rifampin.
- 57. "Officer in charge" means the individual in the senior leadership position in a correctional facility or that individual's designee.
- 58. "Outbreak" means an unexpected increase in incidence of a disease, infestation, or sign or symptom of illness.
- 59. "Parent" means a biological or adoptive mother or father.
- 60. "Person" has the same meaning as in A.R.S. § 1-215.
- ~~60-61.~~ "Petition" means a formal written application to a court requesting judicial action on a matter.
- ~~61-62.~~ "Pharmacy" has the same meaning as in A.R.S. § 32-1901.
- ~~62-63.~~ "Physician" means an individual licensed as a doctor of:
 - a. Allopathic medicine under A.R.S. Title 32, Chapter 13;
 - b. Naturopathic medicine under A.R.S. Title 32, Chapter 14;
 - c. Osteopathic medicine under A.R.S. Title 32, Chapter 17; or
 - d. Homeopathic medicine under A.R.S. Title 32, Chapter 29.
- ~~63-64.~~ "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
- ~~64-65.~~ "Pupil" means a student attending a school.
- ~~65-66.~~ "Quarantine" means the restriction of activities of an individual or animal that has been exposed to a case or carrier of a communicable disease during the communicable period, to prevent transmission of the disease if infection occurs.
- ~~66-67.~~ "Registered nurse practitioner" has the same meaning as in A.R.S. § 32-1601.
- 68. "Respiratory disease" means a communicable disease with acute onset of fever and symptoms such as cough, sore throat, or shortness of breath.
- ~~67-69.~~ "Risk factor" means an activity or circumstance that increases the chances that an individual will become infected with or develop a communicable disease.
- ~~68-70.~~ "School" means:
 - a. An "accommodation school," as defined in A.R.S. § 15-101;
 - b. A "charter school," as defined in A.R.S. § 15-101;
 - c. A "private school," as defined in A.R.S. § 15-101;
 - d. A "school," as defined in A.R.S. § 15-101;
 - e. A college or university;
 - f. An institution that offers a "private vocational program," as defined in A.R.S. § 32-3001; or
 - g. An institution that grants a "degree," as defined in A.R.S. § 32-3001, for completion of an educational program of study.
- ~~69-71.~~ "Screening test" means a laboratory analysis approved by the U.S. Food and Drug Administration as an initial test to indicate the possibility that an individual is infected with a communicable disease.
- ~~70-72.~~ "Sexual contact" means vaginal intercourse, anal intercourse, fellatio, ~~or~~ cunnilingus, or other deliberate interaction with another individual's genital area for a non-medical or non-hygienic reason.
- ~~71-73.~~ "Shelter" means:
 - a. A facility or home that provides "shelter care," as defined in A.R.S. § 8-201;
 - b. A "homeless shelter," as defined in A.R.S. § 16-121; or
 - c. A "shelter for victims of domestic violence," as defined in A.R.S. § 36-3001.
- ~~72-74.~~ "Significant exposure" means the same as in A.R.S. § 32-3207.
- ~~73-75.~~ "Standard precautions" means the use of barriers by an individual to prevent parenteral, mucous membrane, and nonintact skin exposure to body fluids and secretions other than sweat.
- ~~74-76.~~ "Subject" means an individual whose blood or other body fluid has been tested or is to be tested.
- ~~75-77.~~ "Submitting entity" means the same as in A.R.S. § 13-1415.
- ~~76-78.~~ "Suspect case" means an individual whose medical history, signs, or symptoms indicate that the individual:
 - a. May have or is developing a communicable disease;
 - b. May have experienced diarrhea, nausea, or vomiting as part of an outbreak;
 - e. ~~May have died without apparent cause within 48 hours after experiencing a fever; or~~
 - ~~d.c.~~ May have experienced a vaccinia-related adverse event.
- ~~77-79.~~ "Syndrome" means a pattern of signs and symptoms characteristic of a disease.
- ~~78-80.~~ "Test" means an analysis performed on blood or other body fluid to evaluate for the presence or absence of a disease.
- ~~79-81.~~ "Test result" means information about the outcome of a laboratory analysis of a subject's specimen and does not include personal identifying information about the subject.
- ~~80-82.~~ "Treatment" means a procedure or method to cure, improve, or palliate an illness or a disease.
- ~~81-83.~~ "Tuberculosis control officer" means the same as in A.R.S. § 36-711.
- ~~82.~~ "Unexplained death with a history of fever" means the demise of an individual who has had a fever within 48 hours before death and whose illness has not been diagnosed at the time of death.
- 84. "Vaccine" means a preparation of a weakened or killed agent, a portion of the agent's structure, or a synthetic substitute for a portion of the agent's structure that, upon administration into the body of an individual or animal, stimulates a response in the body to produce or increase immunity to a particular disease.
- ~~83-85.~~ "Vaccinia-related adverse event" means a reaction to the administration of a vaccine against smallpox that requires medical evaluation of the reaction.
- ~~84-86.~~ "Victim" means an individual on whom another individual is alleged to have committed a sexual offense, as defined in A.R.S. § 13-1415.
- ~~85-87.~~ "Viral hemorrhagic fever" means disease characterized by fever and hemorrhaging and caused by a virus.
- ~~86-88.~~ "Waterborne" means that water serves as a mode of transmission of an infectious agent.



87-89. "Working day" means the period from 8:00 a.m. to 5:00 p.m. on a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday.

ARTICLE 2. COMMUNICABLE DISEASE AND INFESTATION REPORTING

R9-6-201. Definitions

In this Article, unless otherwise specified:

1. "Clinical laboratory" has the same meaning as in A.R.S. § 36-451.
2. "Drug" has the same meaning as in A.R.S. § 32-1901.
3. "Epidemiologic curve" means a graphic display of the number of cases over time.
4. "Normally sterile site" means an anatomic location, or tissue or body fluid from an anatomic location, in which microorganisms are not found in the absence of disease and includes:
 - a. The lower respiratory tract;
 - b. Blood;
 - c. Bone marrow;
 - d. Cerebrospinal fluid;
 - e. Pleural fluid;
 - f. Peritoneal fluid;
 - g. Synovial fluid;
 - h. Pericardial fluid;
 - i. Amniotic fluid;
 - j. Lymph;
 - k. A closed abscess; or
 - l. Another anatomic location other than the skin, mouth, eyes, upper respiratory tract, middle ear, urogenital tract, or gastrointestinal tract.
5. "Health care provider required to report" means a physician, physician assistant, registered nurse practitioner, or dentist who diagnoses, treats, or detects a case or suspect case of a communicable disease listed in Table ~~4~~ 2.1 or detects an occurrence listed in Table ~~4~~ 2.1.
6. "Pharmacist" has the same meaning as in A.R.S. § 32-1901.
7. "Point of contact" means an individual through whom the Department or a local health agency can obtain information upon request.
8. "Whole blood" means human blood from which plasma, erythrocytes, leukocytes, and thrombocytes have not been separated.

R9-6-202. Reporting Requirements for a Health Care Provider Required to Report or an Administrator of a Health Care Institution or Correctional Facility

- A. A health care provider required to report shall, either personally or through a representative, submit a report in a Department-provided format to the local health agency within the time limitation in Table ~~4~~ 2.1 and as specified in subsection (C), ~~(D)~~, or ~~(E)~~ or (D).
- B. An administrator of a health care institution or correctional facility in which a case or suspect case of a communicable disease listed in Table ~~4~~ 2.1 is diagnosed, treated, or detected or an occurrence listed in Table ~~4~~ 2.1 is detected shall, either personally or through a representative, submit a report in a Department-provided format to the local health agency within the time limitation in Table ~~4~~ 2.1 and as specified in subsection (C), ~~(D)~~, or ~~(E)~~ or (D).
- C. Except as described in ~~subsections (D) and (E)~~ subsection (D), for each case, suspect case, or occurrence for which a report on an individual is required by subsection (A) or (B) and Table ~~4~~ 2.1, a health care provider required to report or an administrator of a health care institution or correctional facility shall submit a report that includes:
 1. The following information about the case or suspect case:
 - a. Name;
 - b. Residential and mailing addresses;
 - c. County of residence;
 - d. ~~If Whether~~ the individual is living on a reservation and, if so, the name of the reservation;
 - e. ~~Whether the individual is a member of a tribe and, if so, the name of the tribe;~~
 - ~~e-f.~~ Telephone number and, if available, email address;
 - ~~f-g.~~ Date of birth;
 - ~~g-h.~~ Race and ethnicity;
 - ~~h-i.~~ Gender;
 - ~~i-j.~~ If known, whether the individual is pregnant;
 - ~~j-k.~~ If known, whether the individual is alive or dead;
 - ~~k-l.~~ If known, the individual's occupation;
 - ~~l-m.~~ If the individual is attending or working in a school or child care establishment or working in a health care institution or food establishment, the name and address of the school, child care establishment, health care institution, or food establishment; and
 - ~~m-n.~~ For a case or suspect case who is a child requiring parental consent for treatment, the name, residential address, ~~and~~ telephone number, and, if available, email address of the child's parent or guardian, if known;
 2. The following information about the disease:
 - a. The name of the disease;
 - b. The date of onset of symptoms;
 - c. The date of diagnosis;
 - d. The date of specimen collection;
 - e. Each type of specimen collected;



- f. Each type of laboratory test completed;
- g. The date of the result of each laboratory test; and
- h. A description of the laboratory test results, including quantitative values if available;
- 3. If reporting a case or suspect case of tuberculosis:
 - a. The site of infection; ~~and~~
 - b. A description of the treatment prescribed, if any, including:
 - i. The name of each drug prescribed,
 - ii. The dosage prescribed for each drug, and
 - iii. The date of prescription for each drug; ~~and~~
 - c. Whether the diagnosis was confirmed by a laboratory and, if so, the name, address, and phone number of the laboratory;
- 4. If reporting a case or suspect case of chancroid, gonorrhea, ~~genital herpes infection,~~ or ~~genital chlamydia~~ Chlamydia trachomatis infection:
 - a. The gender of the individuals with whom the case or suspect case had sexual contact;
 - b. A description of the treatment prescribed, if any, including:
 - i. The name of each drug prescribed,
 - ii. The dosage prescribed for each drug, and
 - iii. The date of prescription for each drug;
 - c. The site of infection; and
 - d. Whether the diagnosis was confirmed by a laboratory and, if so, the name, address, and phone number of the laboratory;
- 5. If reporting a case or suspect case of syphilis:
 - a. The information required under subsection (C)(4); and
 - b. Identification of:
 - i. The stage of the disease, or
 - ii. Whether the syphilis is congenital;
- 6. If reporting a case of congenital syphilis in an infant, and in addition to the information required under subsection (C)(5) and A.R.S. § 36-694(A), the following information:
 - a. The name and date of birth of the infant's mother;
 - b. The residential address, mailing address, ~~and~~ telephone number, and, if available, email address of the infant's mother;
 - c. The date and test results for the infant's mother of the prenatal syphilis test required in A.R.S. § 36-693; and
 - d. If the prenatal syphilis test of the infant's mother indicated that the infant's mother was infected with syphilis:
 - i. Whether the infant's mother received treatment for syphilis,
 - ii. The name and dosage of each drug prescribed to the infant's mother for treatment of syphilis and the date each drug was prescribed, and
 - iii. The name and phone number of the health care provider required to report who treated the infant's mother for syphilis;
- 7. The name, address, ~~and~~ telephone number, and, if available, email address of the individual making the report; and
- 8. The name, ~~and~~ address, telephone number, and, if available, email address of the:
 - a. Health care provider, if reporting under subsection (A) and different from the individual specified in subsection (C)(7); or
 - b. Health care institution or correctional facility, if reporting under subsection (B).
- ~~**D.** For each unexplained death with a history of fever, a health care provider required to report or an administrator of a health care institution or correctional facility shall submit a report that includes:~~
 - 1. ~~The following information about the deceased individual:~~
 - a. ~~Name;~~
 - b. ~~Residential address;~~
 - c. ~~Date of birth;~~
 - d. ~~Telephone number; and~~
 - e. ~~If known, medical history;~~
 - 2. ~~A description of the clinical course of the illness that resulted in death;~~
 - 3. ~~A list of the laboratory tests completed on the deceased individual and, if available, the laboratory test results, including quantitative values;~~
 - 4. ~~The suspected cause or causes of death;~~
 - 5. ~~If known, the status of the autopsy;~~
 - 6. ~~The name, residential address, and telephone number of a family member of the deceased individual who can serve as a point of contact;~~
 - 7. ~~The name, address, and telephone number of the individual making the report; and~~
 - 8. ~~The name and address of the:~~
 - a. ~~Health care provider, if reporting under subsection (A) and different from the individual specified in subsection (D)(7); or~~
 - b. ~~Health care institution or correctional facility, if reporting under subsection (B).~~
- E.D.** For each outbreak for which a report is required by subsection (A) or (B) and Table 2.1, a health care provider required to report or an administrator of a health care institution or correctional facility shall submit a report that includes:
 - 1. A description of the signs and symptoms;
 - 2. If possible, a diagnosis and identification of suspected sources;
 - 3. The number of known cases and suspect cases;
 - 4. A description of the location and setting of the outbreak;
 - 5. The name, address, ~~and~~ telephone number, and, if available, email address of the individual making the report; and
 - 6. The name, ~~and~~ address, telephone number, and, if available, email address of the:



- a. Health care provider, if reporting under subsection (A) and different from the individual specified in subsection (E)(5)(D)(5); or
 - b. Health care institution or correctional facility, if reporting under subsection (B).
- F.E.** When an HIV-related test is ordered for an infant who was perinatally exposed to HIV to determine whether the infant is infected with HIV, the health care provider who orders the HIV-related test or the administrator of the health care institution in which the HIV-related test is ordered shall:
1. Report the results of the infant's HIV-related test to the Department, either personally or through a representative, within five working days after receiving the results of the HIV-related test;
 2. Include the following information in the report specified in subsection (F)(1)(E)(1):
 - a. The name and date of birth of the infant;
 - b. The residential address, mailing address, and telephone number of the infant;
 - c. The name and date of birth of the infant's mother;
 - d. The date of the last medical evaluation of the infant;
 - e. The types of HIV-related tests ordered for the infant;
 - f. The dates of the infant's HIV-related tests;
 - g. The results of the infant's HIV-related tests; and
 - h. The ordering health care provider's name, address, and telephone number; and
 3. Include with the report specified in subsection (F)(1)(E)(1) a report for the infant's mother including the following information:
 - a. The name and date of birth of the infant's mother;
 - b. The residential address, mailing address, and telephone number of the infant's mother;
 - c. The date of the last medical evaluation of the infant's mother;
 - d. The types of HIV-related tests ordered for the infant's mother;
 - e. The dates of the HIV-related tests for the infant's mother;
 - f. The results of the HIV-related tests for the infant's mother;
 - g. What HIV-related risk factors the infant's mother has;
 - h. Whether the infant's mother delivered the infant vaginally or by C-section;
 - i. Whether the infant's mother was receiving HIV-related drugs prior to the infant's birth to reduce the risk of perinatal transmission of HIV; and
 - j. The name, address, and telephone number of the health care provider who ordered the HIV-related tests for the infant's mother.
- G.** Except as provided in Table 1, a health care provider required to report or an administrator of a health care institution or correctional facility shall, either personally or through a representative, submit a report required under this Section:
1. By telephone;
 2. In a document sent by fax, delivery service, or mail; or
 3. Through an electronic reporting system authorized by the Department.

Table 1. Reporting Requirements for a Health Care Provider Required to Report or an Administrator of a Health Care Institution or Correctional Repealed

☒*☐	Amebiasis	☒	Hantavirus infection	⊕	Rubella syndrome, congenital
☒	Anthrax	☒	Hemolytic uremic syndrome	☒*☐	Salmonellosis
☒	Aseptic meningitis: viral	☒*☐	Hepatitis A	☐	Scabies
☒	Basidiobolomyeosis	☒	Hepatitis B and D	☒	Severe acute respiratory syndrome
☒	Botulism	☒	Hepatitis C	☒*☐	Shigellosis
⊕	Brucellosis	☒*☐	Hepatitis E	☒	Smallpox
☒*☐	Campylobacteriosis	☒	Herpes genitalis	☒	Streptococcal Group A: Invasive disease
☒	Chagas disease (American trypanosomiasis)	☒	HIV infection and related disease	☒	Streptococcal Group B: Invasive disease in infants younger than 90 days of age
☒	Chaneroid	⊕	Influenza-associated mortality in a child	☒	<i>Streptococcus pneumoniae</i> (pneumococcal invasive disease)
☒	<i>Chlamydia</i> infection, sexually transmitted	☒	Kawasaki syndrome	☒	Syphilis
⊕*	Cholera	☒	Legionellosis (Legionnaires' disease)	☒*☐	Taeniasis
☒	Coccidioidomycosis (valley fever)	☒	Leptospirosis	☒	Tetanus
☒	Colorado tick fever	☒	Listeriosis	☒	Toxic shock syndrome
☐	Conjunctivitis: acute	☒	Lyme disease	☒	Trichinosis
☒	Creutzfeldt-Jakob disease	☒	Lymphocytic choriomeningitis	⊕	Tuberculosis, active disease
☒*☐	Cryptosporidiosis	☒	Malaria	⊕	Tuberculosis-latent infection in a child 5 years of age or younger (positive screening test result)
☒	<i>Cyclospora</i> infection	☒	Measles (rubeola)	☒	Tularemia
☒	Cysticercosis	☒	Meningococcal invasive disease	☒	Typhoid fever
☒	Dengue	⊕	Mumps	⊕	Typhus fever



⊖	Diarrhea, nausea, or vomiting	☎	Pertussis (whooping cough)	☎	Unexplained death with a history of fever
☎	Diphtheria	☎	Plague	⊕	Vaccinia-related adverse event
☎	Ehrlichiosis and Anaplasmosis	☎	Poliomyelitis		
☎	Emerging or exotic disease	☎	Psittacosis (ornithosis)	☎	Vancomycin-resistant or Vancomycin-intermediate <i>Staphylococcus aureus</i>
⊕	Encephalitis, viral or parasitic	⊕	Q fever	☎	Vancomycin-resistant <i>Staphylococcus epidermidis</i>
☎	Enterohemorrhagic <i>Escherichia coli</i>	☎	Rabies in a human	☎	Varicella (chickenpox)
☎	Enterotoxigenic <i>Escherichia coli</i>	☎	Relapsing fever (borreliosis)	☎*	<i>Vibrio</i> infection
☎*, ⊖	Giardiasis	☎	Reye syndrome	☎	Viral hemorrhagic fever
☎	Gonorrhea	☎	Rocky Mountain spotted fever	☎	West Nile virus infection
☎	<i>Haemophilus influenzae</i> -invasive disease	⊕*	Rubella (German measles)	☎	Yellow fever
☎	Hansen's disease (Leprosy)			☎*, ⊖	Yersiniosis

Key:

- ☎ Submit a report by telephone or through an electronic reporting system authorized by the Department within 24 hours after a case or suspect case is diagnosed, treated, or detected or an occurrence is detected.
- * If a case or suspect case is a food handler or works in a child care establishment or a health care institution, instead of reporting within the general reporting deadline, submit a report within 24 hours after the case or suspect case is diagnosed, treated, or detected.
- ⊕ Submit a report within one working day after a case or suspect case is diagnosed, treated, or detected.
- ☎ Submit a report within five working days after a case or suspect case is diagnosed, treated, or detected.
- ⊖ Submit a report within 24 hours after detecting an outbreak.

Table 2.1. Reporting Requirements for a Health Care Provider Required to Report or an Administrator of a Health Care Institution or Correctional Facility

☎*, ⊖	Amebiasis	☎	Glanders	⊖	Respiratory disease in a health care institution or correctional facility
☎	Anaplasmosis	☎	Gonorrhea	⊕*	Rubella (German measles)
☎	Anthrax	⊕	<i>Haemophilus influenzae</i> , invasive disease	⊕	Rubella syndrome, congenital
☎	Arboviral infection	☎	Hansen's disease (Leprosy)	⊕*, ⊖	Salmonellosis
☎	Babesiosis	⊕	Hantavirus infection	⊖	Scabies
☎	Basidiobolomycosis	⊕	Hemolytic uremic syndrome	⊕*, ⊖	Shigellosis
☎	Botulism	⊕*, ⊖	Hepatitis A	☎	Smallpox
⊕	Brucellosis	☎	Hepatitis B and Hepatitis D	⊕	Spotted fever rickettsiosis (e.g., Rocky Mountain spotted fever)
☎*, ⊖	Campylobacteriosis	☎	Hepatitis C	☎	Streptococcal group A infection, invasive disease
☎	Chagas infection and related disease (American trypanosomiasis)	☎*, ⊖	Hepatitis E	☎	Streptococcal group B infection in an infant younger than 90 days of age, invasive disease
☎	Chancroid	☎	HIV infection and related disease	☎	<i>Streptococcus pneumoniae</i> infection (pneumococcal invasive disease)
⊕	Chikungunya	⊕	Influenza-associated mortality in a child	☎ ^L	Syphilis
☎	<i>Chlamydia trachomatis</i> infection	⊕	Legionellosis (Legionnaires' disease)	☎*, ⊖	Taeniasis
⊕*	Cholera	⊕	Leptospirosis	☎	Tetanus
☎	Coccidioidomycosis (Valley Fever)	⊕	Listeriosis	☎	Toxic shock syndrome
☎	Colorado tick fever	☎	Lyme disease	⊕	Trichinosis
⊖	Conjunctivitis, acute	⊕	Lymphocytic choriomeningitis	⊕	Tuberculosis, active disease
☎	Creutzfeldt-Jakob disease	☎	Malaria	⊕	Tuberculosis latent infection in a child 5 years of age or younger (positive screening test result)
⊕*, ⊖	Cryptosporidiosis	☎	Measles (rubeola)	☎	Tularemia
⊕	<i>Cyclospora</i> infection	⊕	Melioidosis	⊕	Typhoid fever
☎	Cysticercosis	☎	Meningococcal invasive disease	⊕	Typhus fever
⊕	Dengue	⊕	Mumps	⊕	Vaccinia-related adverse event



<u>O</u>	<u>Diarrhea, nausea, or vomiting</u>		<u>Novel coronavirus infection (e.g., SARS or MERS)</u>		<u>Vancomycin-resistant or Vancomycin-intermediate <i>Staphylococcus aureus</i></u>
	<u>Diphtheria</u>	<u>1</u>	<u>Pertussis (whooping cough)</u>		<u>Varicella (chickenpox)</u>
	<u>Ehrlichiosis</u>		<u>Plague</u>	<u>1*,O</u>	<u><i>Vibrio</i> infection</u>
	<u>Emerging or exotic disease</u>		<u>Poliomyelitis (paralytic or non-paralytic)</u>		<u>Viral hemorrhagic fever</u>
	<u>Encephalitis, parasitic</u>		<u>Psittacosis (ornithosis)</u>		<u>West Nile virus infection</u>
<u>1</u>	<u>Encephalitis, viral</u>	<u>1</u>	<u>Q fever</u>		<u>Yellow fever</u>
<u>1</u>	<u><i>Escherichia coli</i>, Shiga toxin-producing</u>		<u>Rabies in a human</u>	<u>1*,O</u>	<u>Yersiniosis (enteropathogenic <i>Yersinia</i>)</u>
*, <u>O</u>	<u>Giardiasis</u>	<u>1</u>	<u>Relapsing fever (borreliosis)</u>	<u>1</u>	<u>Zika virus infection</u>

Key:

- Submit a report by telephone or through an electronic reporting system authorized by the Department within 24 hours after a case or suspect case is diagnosed, treated, or detected, or an occurrence is detected.
- * Submit a report within 24 hours after a case or suspect case is diagnosed, treated, or detected, instead of reporting within the general reporting deadline, if the case or suspect case is a food handler or works in a child care establishment or a health care institution.
- 1 Submit a report within one working day if the case or suspect case is a pregnant woman.
- 1 Submit a report within one working day after a case or suspect case is diagnosed, treated, or detected.
- Submit a report within five working days after a case or suspect case is diagnosed, treated, or detected.
- O Submit a report within 24 hours after detecting an outbreak.

R9-6-203. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter

- A. An administrator of a school, child care establishment, or shelter shall, either personally or through a representative, submit a report, in a Department-provided format, a case, suspect case, or outbreak listed in Table 2 to the local health agency within the time limitation and as specified in Table 2.2 and as specified in subsection (B).
- B. For each individual with a disease, infestation, or symptoms of a communicable disease or infestation listed in Table 2.2, or an outbreak of the communicable disease or infestation, an administrator of a school, child care establishment, or shelter shall submit a report by telephone that includes:
 1. The name and address of the school, child care establishment, or shelter;
 2. The number of individuals with the disease, infestation, or symptoms;
 3. The date and time that the disease or infestation was detected or that the symptoms began;
 4. The number of rooms, grades, or classes affected and the name of each;
 5. The following information about each affected individual with the disease, infestation, or symptoms:
 - a. Name;
 - b. Date of birth or age;
 - c. If the individual is a child, name and contact information for the individual’s parent or guardian;
 - ~~e-d.~~ Residential address and telephone number; and
 - ~~e-c.~~ Whether the individual is a staff member, a student, a child in care, or a resident;
 6. The number of individuals attending or residing at the school, child care establishment, or shelter; and
 7. The name, address, ~~and~~ telephone number, and, if available, email address of the individual making the report.

Table 2.2.2. Reporting Requirements for an Administrator of a School, Child Care Establishment, or Shelter

	<u>Campylobacteriosis</u>		<u>Mumps</u>
<u>O</u>	<u>Conjunctivitis, acute</u>		<u>Pertussis (whooping cough)</u>
	<u>Cryptosporidiosis</u>		<u>Rubella (German measles)</u>
<u>O</u>	<u>Diarrhea, nausea, or vomiting</u>		<u>Salmonellosis</u>
	<u>Enterohemorrhagic <i>Escherichia coli</i>, Shiga toxin-producing</u>	<u>O</u>	<u>Scabies</u>
	<u><i>Haemophilus influenzae</i>, invasive disease</u>		<u>Shigellosis</u>
	<u>Hepatitis A</u>	<u>O</u>	<u>Streptococcal Group A infection</u>
	<u>Measles</u>		<u>Varicella (chickenpox)</u>
	<u>Meningococcal invasive disease</u>		

Key:

- Submit a report within 24 hours after detecting a case or suspect case.
- Submit a report within five working days after detecting a case or suspect case.
- O Submit a report within 24 hours after detecting an outbreak.

R9-6-204. Clinical Laboratory Director Reporting Requirements

- A. Except as specified in subsection (D), a director of a clinical laboratory that obtains a test result described in Table 3 2.3 or that receives a specimen for detection of an infectious agent or toxin listed in Table 3 2.3 shall, either personally or through a representa-



tive, submit a report, in a Department-provided format, and, if applicable, an isolate or a specimen to the Department within the time limitation and as specified in Table 3 2.3 and subsection (B) or (C).

B. For each specimen for which an immediate report is required by subsection (A) and Table 2.3, a clinical laboratory director shall ensure the report includes:

- 1. The name and address of the laboratory;
2. The name and telephone number of the director of the clinical laboratory;
3. The name and, as available, the address, telephone number, and email address of the subject;
4. The date of birth of the subject;
5. The gender of the subject;
6. The laboratory identification number;
7. The specimen type;
8. The date of collection of the specimen;
9. The type of test ordered on the specimen; and
10. The ordering health care provider's name, address, telephone number, and, if available, email address.

B-C. Except as provided in Table 3 2.3 and as specified in subsection (D), for each test result for a subject for which a report is required by subsection (A) and Table 3 2.3, a clinical laboratory director shall ensure the report includes:

- 1. The name and address of the laboratory;
2. The name and telephone number of the director of the clinical laboratory;
3. The name and, if as available, the address, and telephone number, and email address of the subject;
4. The date of birth of the subject;
5. The gender of the subject;
6. The laboratory identification number;
7. The specimen type;
8. The date of collection of the specimen;
9. The date of the result of the test;
10. The type of test completed on the specimen;
11. The test result, including quantitative values and reference ranges, if available applicable; and
12. The ordering health care provider's name, address, and telephone number, and, if available, email address.

C. For each specimen for which an immediate report is required by subsection (A) and Table 3, a clinical laboratory director shall submit a report that includes:

- 1. The name and, if available, the address and telephone number of the subject;
2. The date of birth of the subject;
3. The gender of the subject;
4. The laboratory identification number;
5. The specimen type;
6. The date of collection of the specimen;
7. The type of test ordered on the specimen; and
8. The ordering health care provider's name, address, and telephone number.

D. When the Arizona State Laboratory obtains a test result from anonymous HIV testing sent to the Arizona State Laboratory as described in R9-6-1005, the director of the Arizona State Laboratory shall, either personally or through a representative:

- 1. Submit a report to the Department within five working days after obtaining a positive test result; and
2. Include in the report the following information:
a. The laboratory identification number of the subject;
b. The date of birth, gender, race, and ethnicity of the subject;
c. The date the specimen was collected;
d. The type of tests completed on the specimen;
e. The test results, including quantitative values if available; and
f. The name, address, and telephone number of the person who submitted the specimen to the Arizona State Laboratory.

E. The Department shall supply the director of each clinical laboratory with forms that may be used by the clinical laboratory when making a report required under subsection (A) or (D) and Table 3.

F. A clinical laboratory director shall submit a report by telephone; in a document sent by fax, delivery service, or mail; or through an electronic reporting system authorized by the Department. Except as provided in Table 3, each report shall contain the information required under subsection (B), (C), or (D).

Table 3. Clinical Laboratory Director Reporting Requirements Repealed

Table with 4 columns: Reporting Method, Pathogen, Reporting Method, and Pathogen. Rows include Arboviruses, Bacillus anthracis, Bordetella pertussis, Brucella spp., Burkholderia mallei and B. pseudomallei, and Campylobacter spp.



☐	CD ₄ -T lymphocyte count of fewer than 200 per microliter of whole blood or CD ₄ -T lymphocyte percentage of total lymphocytes of less than 14%	☐ ¹ ,+	Hepatitis E virus (anti-HEV-IgM serologies)	☐	<i>Streptococcus</i> Group A, isolated from a normally sterile site
☐	<i>Chlamydia trachomatis</i>	☐	HIV (by culture, antigen, antibodies to the virus, or detection of viral nucleic acid)	☐	<i>Streptococcus</i> Group B, isolated from a normally sterile site in an infant younger than 90 days of age
☐,☐	<i>Clostridium botulinum</i> toxin (botulism)	☐	HIV—any test result for an infant (by culture, antigen, antibodies to the virus, or detection of viral nucleic acid)	☐,*	<i>Streptococcus pneumoniae</i> and its drug sensitivity pattern, isolated from a normally sterile site
☐	<i>Coccidioides</i> spp., by culture or serologies	☐	Influenza virus	☐	<i>Treponema pallidum</i> (syphilis)
☐	<i>Coxiella burnetii</i>	☐,*	<i>Legionella</i> spp. (culture or DFA)	☐	<i>Trypanosoma cruzi</i> (Chagas disease)
☐	<i>Cryptosporidium</i> spp.	☐,*	<i>Listeria</i> spp., isolated from a normally sterile site	☐,*	Vancomycin-resistant or Vancomycin-intermediate <i>Staphylococcus aureus</i>
☐	<i>Cyclospora</i> spp.	☐,+	Measles virus and anti-measles-IgM serologies	☐,*	Vancomycin-resistant <i>Staphylococcus epidermidis</i>
☐	Dengue virus	☐ ²	Methicillin-resistant <i>Staphylococcus aureus</i> , isolated from a normally sterile site	☐,*	Variola virus (smallpox)
☐,☐	Emerging or exotic disease agent	☐,+	Mumps virus and anti-mumps-IgM serologies	☐,*	<i>Vibrio</i> spp.
☐	<i>Entamoeba histolytica</i>	☐,* ³	<i>Mycobacterium tuberculosis</i> complex and its drug sensitivity pattern	☐,*	Viral hemorrhagic fever agent
☐	<i>Escherichia coli</i> O157:H7	☐	<i>Neisseria gonorrhoeae</i>	☐,☐	West Nile virus
☐,*	<i>Escherichia coli</i> , Shiga-toxin producing	☐	<i>Neisseria meningitidis</i> , isolated from a normally sterile site	☐,*	<i>Yersinia</i> spp. (other than <i>Y. pestis</i>)
☐,☐,*	<i>Francisella tularensis</i>	☐,*	Norovirus	☐,*	<i>Yersinia pestis</i> (plague)
☐,*	<i>Haemophilus influenzae</i> , type b, isolated from a normally sterile site	☐			

Keys:

- ☐ Submit a report immediately after receiving one specimen for detection of the agent. Report receipt of subsequent specimens within five working days after receipt.
- ☐ Submit a report within 24 hours after obtaining a positive test result.
- ☐ Submit a report within one working day after obtaining a positive test result.
- ☐ Submit a report within five working days after obtaining a positive test result or a test result specified in Table 3.
- * Submit an isolate of the organism for each positive culture to the Arizona State Laboratory at least once each week, as applicable.
- + For each positive test result, submit a specimen to the Arizona State Laboratory within 24 hours after obtaining the positive test result.
- ¹ When reporting a positive result for any of the specified tests, report the results of all other tests performed for the subject as part of the disease panel.
- ² Submit a report only when an initial positive result is obtained for an individual.
- ³ Submit an isolate of the organism only when an initial positive result is obtained for an individual, when a change in resistance pattern is detected, or when a positive result is obtained > 12 months after the initial positive result is obtained for an individual.

Table 2.3. Clinical Laboratory Director Reporting Requirements

☐	<i>Anaplasma</i> spp.	☐,☐,*	<i>Francisella tularensis</i>	☐	<i>Plasmodium</i> spp.
☐,* ⁴	Arboviruses	☐,* ^{4,5}	<i>Haemophilus influenzae</i> , from a normally sterile site	☐,*	Rabies virus from a human
☐	<i>Babesia</i> spp.	☐	Hantavirus	☐,* ⁴	Rabies virus from an animal
☐,☐,*	<i>Bacillus anthracis</i>	☐ ¹	Hepatitis A virus (anti-HAV-IgM serologies, detection of viral nucleic acid, or genetic sequencing)	☐	Respiratory syncytial virus
☐,* ⁴	<i>Bordetella pertussis</i>	☐ ¹	Hepatitis B virus (anti-Hepatitis B core-IgM serologies, Hepatitis B surface or envelope antigen serologies, detection of viral nucleic acid, or genetic sequencing)	☐,* ⁴	<i>Rickettsia</i> spp. – any test result
☐,*	<i>Brucella</i> spp.	☐ ¹	Hepatitis C virus	☐ ¹ ,*	Rubella virus and anti-rubella-IgM serologies
☐,*	<i>Burkholderia mallei</i> and <i>B. pseudomallei</i>	☐ ¹	Hepatitis D virus	☐,*	<i>Salmonella</i> spp.
☐,* ⁴	<i>Campylobacter</i> spp.	☐ ¹ ,* ⁴	Hepatitis E virus	☐,* ⁴	<i>Shigella</i> spp.
☐,* ⁴	Carbapenem-resistant Enterobacteriaceae (CRE)	☐	HIV—any test result (by culture, antigen, antibodies to the virus, detection of viral nucleic acid, or genetic sequencing), except from a negative screening test	☐,* ⁴	<i>Streptococcus</i> group A, from a normally sterile site



☒	CD ₄ -T-lymphocyte count	☒	HIV—any test result for an infant (by culture, antigen, antibodies to the virus, detection of viral nucleic acid, or genetic sequencing)	☒	Streptococcus group B, from a normally sterile site in an infant younger than 90 days of age
④,* ⁴	Chikungunya virus	☒,* ⁴	Influenza virus	☒,* ⁴	<i>Streptococcus pneumoniae</i> and its drug sensitivity pattern, from a normally sterile site
☒	<i>Chlamydia trachomatis</i>	④,+	<i>Legionella</i> spp. (excluding single serological results)	☒ ¹	<i>Treponema pallidum</i> (syphilis) or rapid plasma reagin
☒	<i>Chlamydia psittaci</i> / <i>Chlamydia psittaci</i>	④	<i>Leptospira</i> spp.	☒	<i>Trypanosoma cruzi</i> (Chagas disease)
☒,☒	<i>Clostridium botulinum</i> toxin (botulism)	④	<i>Lymphocytic choriomeningitis</i> virus	④,*	Vancomycin-resistant or Vancomycin-intermediate <i>Staphylococcus aureus</i>
☒,* ⁴	<i>Coccidioides</i> spp.	④,*	<i>Listeria</i> spp., from a normally sterile site	☒,☒,*	Variola virus (smallpox)
④	<i>Coxiella burnetii</i>	☒, ¹ * ²	Measles virus and anti-measles-IgM serologies	④,*	<i>Vibrio</i> spp.
④	<i>Cryptosporidium</i> spp.	☒, ²	Methicillin-resistant <i>Staphylococcus aureus</i> , from a normally sterile site	☒,☒,*	Viral hemorrhagic fever agent
④	<i>Cyclospora</i> spp.	④, ¹ * ²	Mumps virus and anti-mumps-IgM serologies	☒	West Nile virus
④,* ⁴	Dengue virus	④,* ³	<i>Mycobacterium tuberculosis</i> complex and its drug sensitivity pattern	☒,*	Yellow fever virus
☒	<i>Ehrlichia</i> spp.	☒,* ⁴	<i>Neisseria gonorrhoeae</i> and, if performed, the drug sensitivity pattern	☒,☒,*	<i>Yersinia pestis</i> (plague)
☒,☒	Emerging or exotic disease agent	☒,*	<i>Neisseria meningitidis</i> , from a normally sterile site	④,*	<i>Yersinia</i> spp. (other than <i>Y. pestis</i>)
☒	<i>Entamoeba histolytica</i>	④	Norovirus	④,*	Zika virus
④,*	<i>Escherichia coli</i> , <i>Shiga</i> toxin-producing	☒	Novel coronavirus infection (e.g., SARS or MERS)		

Key:

- ☒ Submit a report immediately after receiving one specimen for detection of the agent. Report the receipt of subsequent specimens within five working days after receipt.
 - ☒ Submit a report within 24 hours after obtaining a positive test result.
 - ④ Submit a report within one working day after obtaining a positive test result.
 - ☒ Submit a report within five working days after obtaining a positive test result or a test result specified in Table 2.3.
 - * Submit an isolate of the organism for each positive culture, if available, or a specimen for each positive test result to the Arizona State Laboratory within one working day.
 - + Submit an isolate of the organism for each positive culture to the Arizona State Laboratory within one working day.
- When appearing after one of the symbols above, the following modify the requirement:
- ¹ When reporting a positive result for any of the specified tests, report the results of all other tests performed for the subject as part of the disease panel or as a reflex test.
 - ² Submit a report only when an initial positive result is obtained for an individual.
 - ² Submit an isolate or specimen of the organism, as applicable, only when an initial positive result is obtained for an individual, when a change in resistance pattern is detected, or when a positive result is obtained > 12 months after the initial positive result is obtained for an individual.
 - ⁴ Submit an isolate or specimen, as applicable, only by request.
 - ⁵ Submit an isolate of the organism, if available, or a specimen when a positive result is obtained for an individual < 5 years of age.

R9-6-205. Reporting Requirements for a Pharmacist or an Administrator of a Pharmacy

- A. A pharmacist who fills an individual's initial prescription for two or more of the drugs listed in subsection (B) or an administrator of a pharmacy in which an individual's initial prescription for two or more of the drugs listed in subsection (B) is filled shall, either personally or through a representative, submit a report, in a Department-provided format, that complies with subsection (C) to the Department within five working days after the prescription is filled.
- B. Any combination of two or more of the following drugs when initially prescribed for an individual triggers the reporting requirement of subsection (A):
 1. Isoniazid,
 2. Streptomycin,
 3. Any rifamycin,
 4. Pyrazinamide, or
 5. Ethambutol.
- C. A pharmacist or an administrator of a pharmacy shall submit a report required under subsection (A) ~~by telephone; in a document sent by fax, delivery service, or mail; or through an electronic reporting system authorized by the Department and shall include in the report that includes:~~
 1. The following information about the individual for whom the drugs are prescribed:
 - a. Name,
 - b. Address,
 - c. Telephone number, and
 - d. Date of birth; and
 2. The following information about the prescription:



- a. The name of the drugs prescribed,
- b. The date of prescription, and
- c. The name and telephone number of the prescribing health care provider.

R9-6-206. Local Health Agency Responsibilities Regarding Communicable Disease Reports

- A. The Department shall ~~supply~~ notify each local health agency ~~with forms of the format~~ to be used by:
1. A health care provider required to report when making a ~~written~~ report required under R9-6-202(A) and Table ~~4 2.1~~;
 2. An administrator of a health care institution or correctional facility when making a ~~written~~ report required under R9-6-202(B) and Table ~~4 2.1~~; and
 3. An administrator of a school, child care establishment, or shelter when making a ~~written~~ report required under R9-6-203(A) and Table ~~4 2.2~~.
- B. A local health agency shall ~~distribute copies of the Department-provided forms specified in subsection (A) as needed to inform~~ health care providers required to report and administrators of health care institutions, correctional facilities, schools, child care establishments, and shelters ~~of the format to use when making a report, as specified in subsection (A)~~.
- C. Except as specified in Table ~~4 2.4~~ and Article 3, a local health agency shall provide to the Department the information contained in each report of a case, suspect case, or occurrence received by the local health agency under R9-6-202 or R9-6-203, including any report of disease in a nonresident of the jurisdiction who is or has been diagnosed or treated in the jurisdiction, within five working days after receipt and shall specify:
1. Which of the following best describes the individual identified in each report:
 - a. The individual meets the case definition for a case of the specific disease,
 - b. The individual is a suspect case,
 - c. The individual does not meet the case definition for a case or suspect case of the specific disease, or
 - d. The local health agency has not yet determined the status of the disease in the individual; and
 2. The status of the epidemiologic investigation for each report.
- D. Except as specified in Table ~~4 2.4~~ and Article 3, a local health agency shall submit to the Department a ~~written or electronic~~ report, in a ~~format specified by the Department~~ Department-provided format, of an epidemiologic investigation conducted by the local health agency:
1. In response to a report of a case, suspect case, or occurrence:
 - a. Submitted under R9-6-202 or R9-6-203, or
 - b. About which the local health agency was notified by the Department;
 2. Within 30 calendar days after receiving the report submitted under R9-6-202 or R9-6-203 or notification by the Department;
 3. If an epidemiologic investigation is required for the reported disease under Article 3; and
 4. Including in the report of the epidemiologic investigation:
 - a. The information described in:
 - i. R9-6-202(C) for a report submitted under R9-6-202,
 - ii. R9-6-203(B) for a report submitted under R9-6-203, or
 - iii. R9-6-202(C) for a report about which the Department notified the local health agency;
 - b. A description of all laboratory or other test results, performed in addition to the laboratory tests described in R9-6-202(C) and contributing to the diagnosis;
 - c. A description of the case's symptoms of the disease and other signs that may be observed that indicate that the individual may have the disease, if applicable;
 - d. A classification of the case according to the case definition;
 - e. A description of the condition or status of the case at the end of the epidemiologic investigation;
 - f. A description of the case's specific risk factors for acquiring the disease or other epidemiologic evidence of how the case acquired the infection that resulted in the disease;
 - g. A description of how the local health agency provided or arranged for the case to receive health education about the nature of the disease and how to prevent transmission or limit disease progression;
 - h. A description of the case's specific risk factors for transmitting the disease considered by the local health agency when conducting an assessment of contacts;
 - i. A description of the control measures used by the local health agency to reduce the spread of the disease; and
 - j. The date the report of the case, suspect case, or occurrence was submitted or the Department notified the local health agency.
- E. ~~For each reported case or suspect case of unexplained death with a history of fever, the local health agency for the jurisdiction in which the death occurred shall:~~
- ~~1. Within one working day after receiving a report of unexplained death with a history of fever, submit to the Department in a format specified by the Department:~~
 - ~~a. The following information about the deceased individual:~~
 - ~~i. Name;~~
 - ~~ii. Residential address;~~
 - ~~iii. Date of birth;~~
 - ~~iv. Race and ethnicity;~~
 - ~~v. County of residence;~~
 - ~~vi. If the individual was living on a reservation at the time of the individual's death, the name of the reservation;~~
 - ~~vii. Gender;~~
 - ~~viii. Whether the individual was pregnant and, if so, the result of the pregnancy; and~~
 - ~~ix. Occupation;~~
 - ~~b. The date of onset of symptoms;~~



- e. The approximate date and time of death;
 - d. A description of the setting where the death occurred and of the circumstances leading up to the time of death;
 - e. The name, residential address, and telephone number of a family member of the deceased individual who may be contacted;
 - f. The name, address, and telephone number of the individual making the report to the local health agency; and
 - g. The name and address of the:
 - i. Health care provider required to report, if:
 - (1) The unexplained death with a history of fever was reported to the local health agency under R9-6-202(A), and
 - (2) The health care provider is different from the individual specified in subsection (E)(1)(f); or
 - ii. Health care institution or correctional facility, if the unexplained death with a history of fever was reported to the local health agency under R9-6-202(B); and
2. Within 30 calendar days after receiving the report of unexplained death with a history of fever, submit to the Department a written or electronic report of the epidemiologic investigation required under Article 3, in a format provided by the Department, including:
- a. The name and date of birth of the deceased individual;
 - b. The date of each specimen collection;
 - c. Identification of each type of specimen collected;
 - d. Identification of each type of laboratory test completed;
 - e. A description of the laboratory test results, including quantitative results if available;
 - f. If an autopsy was completed, the autopsy results;
 - g. A hypothesis or conclusion as to the cause of death; and
 - h. Specific recommendations for preventing future deaths, if applicable.

F. E. Except as specified in Table 4 and Article 3, for ~~For~~ each instance when the local health agency receives a report or reports indicating an outbreak or possible outbreak, the local health agency shall:

1. Within ~~one working day~~ 24 hours after receiving the report or reports, provide to the Department, in a Department-provided format, the following information:
 - a. The location of the outbreak or possible outbreak;
 - b. If known, the number of cases and suspect cases;
 - c. The date that the outbreak was reported or the dates that cases suggestive of an outbreak were reported;
 - d. The setting of the outbreak or possible outbreak;
 - e. The name of the disease suspected or known to be the cause of the outbreak or possible outbreak; and
 - f. The name and telephone number of an individual at the local health agency who can serve as a point of contact regarding the outbreak or possible outbreak; and
2. Within 30 calendar days after receiving the last report or reports associated with the outbreak, submit to the Department a ~~written or electronic~~ report, in a Department-provided format, specified by the Department, of the epidemiologic investigation conducted by the local health agency in response to the outbreak or possible outbreak, including:
 - a. A description of the outbreak location and setting;
 - b. The date that the local health agency was notified of the outbreak;
 - c. A description of how the local health agency verified the outbreak;
 - d. The number of individuals reported to be ill during the outbreak;
 - e. The number of individuals estimated to be at risk for illness as a result of the outbreak;
 - f. The specific case definition used;
 - g. A summary profile of the signs and symptoms;
 - h. An epidemiologic curve;
 - i. A copy of the laboratory evidence collected, including all laboratory test results, for all specimens submitted for testing to a laboratory other than the Arizona State Laboratory;
 - j. Hypotheses of how the outbreak occurred;
 - k. A description of the control measures used and the dates the control measures were implemented;
 - l. The conclusions drawn based upon the results of the epidemiologic investigation;
 - m. Recommendations for preventing future outbreaks; and
 - n. The name, address, and telephone number of the individual making the report to the Department.

Table 4. Local Health Agency Reporting Requirements Repealed

HH	Amebiasis	HH	Hantavirus infection	HH	Rocky Mountain spotted fever
☎,HH,*	Anthrax	HH	Hemolytic uremic syndrome	☎,HH,S	Rubella (German measles)
⊖-HH	Aseptic meningitis, viral	HH	Hepatitis A	☎,HH,S	Rubella syndrome, congenital
☎	Basidiobolomyces	HH	Hepatitis B and Hepatitis D	HH	Salmonellosis
☎,HH,S	Botulism	HH	Hepatitis C	⊖-☎	Scabies
HH,*	Brucellosis	HH	Hepatitis E	☎,HH	Severe acute respiratory syndrome
HH	Campylobacteriosis	None	Herpes genitalis	HH	Shigellosis
HH	Chagas infection and related disease (American Trypanosomiasis)	HH	Human Immunodeficiency Virus (HIV) infection and related disease	☎,HH	Smallpox
HH	Chancroid (<i>Haemophilus ducreyi</i>)	HH	Influenza-associated mortality in a child	⊖-HH	Streptococcal Group A infection



5-day-only	Chlamydia infection, sexually transmitted	☐	Kawasaki syndrome	HH	Streptococcal Group B infection in an infant younger than 90 days of age
Ⓢ, HH	Cholera	HH	Legionellosis (Legionnaires' disease)	☐	<i>Streptococcus pneumoniae</i> infection
Ⓢ, HH	Coccidioidomycosis (Valley Fever)	HH	Leptospirosis	HH, Ⓢ, HH	Syphilis
HH	Colorado tick fever	HH, *	Listeriosis	HH	Taeniasis
Ⓢ, ☐	Conjunctivitis: acute	HH	Lyme disease	HH	Tetanus
☐	Creutzfeldt-Jakob disease	HH	Lymphocytic choriomeningitis	HH	Toxic shock syndrome
HH	Cryptosporidiosis	HH	Malaria	HH	Trichinosis
HH	<i>Cyclospora</i> infection	☐, HH, S	Measles (rubeola)	HH, *	Tuberculosis
☐	Cysticercosis	HH, *	Melioidosis	☐, HH, *	Tularemia
HH	Dengue	☐, HH, *	Meningococcal invasive disease	HH	Typhoid fever
Ⓢ, HH	Diarrhea, nausea, or vomiting	☐, HH, S	Mumps	HH	Typhus fever
☐, HH	Diphtheria	Ⓢ, HH	Norovirus	Ⓢ, HH	Unexplained death with a history of fever
HH	Ehrlichiosis (Ehrlichiosis and Anaplasmosis)	5-day-only	Pediculosis (lice infestation)	HH	Vaccinia-related adverse event
☐, HH	Emerging or exotic disease	HH	Pertussis (whooping cough)	☐, HH, *	Vancomycin-resistant or Vancomycin-intermediate <i>Staphylococcus aureus</i>
Ⓢ, HH	Encephalitis: viral or parasitic	☐, HH, *	Plague	Ⓢ, HH, *	Vancomycin-resistant <i>Staphylococcus epidermidis</i>
HH	Enterohemorrhagic <i>Escherichia coli</i>	☐, HH, S	Poliomyelitis	☐	Varicella (chickenpox)
HH	Enterotoxigenic <i>Escherichia coli</i>	HH	Psittacosis (ornithosis)	HH	<i>Vibrio</i> infection
Ⓢ, HH	Giardiasis	Ⓢ, HH	Q Fever	☐, HH, S	Viral hemorrhagic fever
5-day-only	Gonorrhea	☐, HH	Rabies in a human	HH	West Nile virus-related syndromes
HH	<i>Haemophilus influenzae</i> : invasive disease	HH	Relapsing fever (borreliosis)	Ⓢ, HH	Yellow fever
☐	Hansen's disease (Leprosy)	☐	Reye syndrome	Ⓢ, HH, *	Yersiniosis (enteropathogenic <i>Yersinia</i>)

Unless otherwise specified, notify the Department within five working days after receiving a report under R9-6-202 or R9-6-203.

Key:

- ☐ Notify the Department within 24 hours after receiving a report under R9-6-202 or R9-6-203.
- Ⓢ Notify the Department within one working day after receiving a report under R9-6-202 or R9-6-203.
- HH Submit an epidemiologic investigation report within 30 calendar days after receiving a report under R9-6-202 or R9-6-203 or notification by the Department.
- ☐ Submit an epidemiologic investigation report within 60 calendar days after receiving a report under R9-6-202 or R9-6-203 or notification by the Department.
- * Ensure that an isolate from a case is submitted to the Arizona State Laboratory.
- S Ensure that specimens from a case, as specified by the Department, are submitted to the Arizona State Laboratory.
- Ⓢ Submit a report after conducting an epidemiological investigation of an outbreak.

Table 2.4. Local Health Agency Reporting Requirements

☐, →	Amebiasis	☐	Gonorrhea	Ⓢ, →, *	Rubella (German measles)
☐, →	Anaplasmosis	Ⓢ, →	<i>Haemophilus influenzae</i> , invasive disease	☐, →, *	Rubella syndrome, congenital
☐, →, *	Anthrax	☐, →	Hansen's disease (Leprosy)	Ⓢ, →	Salmonellosis
☐, →	Arboviral infection	Ⓢ, →	Hantavirus infection	Ⓢ, →	Shigellosis
☐, →	Babesiosis	Ⓢ, →	Hemolytic uremic syndrome	☐, →, *	Smallpox
☐, →	Basidiobolomycosis	Ⓢ, →	Hepatitis A	Ⓢ, →	Spotted fever rickettsiosis (e.g., Rocky Mountain spotted fever)
☐, →, *	Botulism	☐, →	Hepatitis B and Hepatitis D	☐	Streptococcal group A infection, invasive disease
☐, →, *	Brucellosis	☐, →	Hepatitis E	☐	Streptococcal group B infection in an infant younger than 90 days of age, invasive disease
☐, →	Campylobacteriosis	☐, →	HIV infection and related disease	☐	<i>Streptococcus pneumoniae</i> infection, (pneumococcal invasive disease)



☒ →	<u>Chagas infection and related disease (American Trypanosomiasis)</u>	① →	<u>Influenza-associated mortality in a child</u>	☒ →	<u>Syphilis</u>
☒ →	<u>Chancroid (<i>Haemophilus ducreyi</i>)</u>	① →	<u>Legionellosis (Legionnaires' disease)</u>	☒ →	<u>Taeniasis</u>
☒ →	<u>Chikungunya</u>	① →	<u>Leptospirosis</u>	☒ →	<u>Tetanus</u>
☒	<u><i>Chlamydia trachomatis</i> infection</u>	① → *	<u>Listeriosis</u>	☒ →	<u>Toxic shock syndrome</u>
① →	<u>Cholera</u>	☒ →	<u>Lyme disease</u>	① →	<u>Trichinosis</u>
☒	<u>Coccidioidomycosis (Valley Fever)</u>	① →	<u>Lymphocytic choriomeningitis</u>	① → *	<u>Tuberculosis, active disease</u>
☒ →	<u>Colorado tick fever</u>	☒ →	<u>Malaria</u>	① →	<u>Tuberculosis latent infection in a child five years of age or younger (positive screening test result)</u>
☒ →	<u>Creutzfeldt-Jakob disease</u>	☒ → *	<u>Measles (rubeola)</u>	☒ → *	<u>Tularemia</u>
☒ →	<u>Cryptosporidiosis</u>	① → *	<u>Melioidosis</u>	☒ → *	<u>Typhoid fever</u>
☒ →	<u><i>Cyclospora</i> infection</u>	☒ → *	<u>Meningococcal invasive disease</u>	① →	<u>Typhus fever</u>
☒ →	<u>Cysticercosis</u>	① → *	<u>Mumps</u>	① →	<u>Vaccinia-related adverse event</u>
① →	<u>Dengue</u>	☒ →	<u>Novel coronavirus (e.g., SARS or MERS)</u>	① →	<u>Vancomycin-resistant or Vancomycin-intermediate <i>Staphylococcus aureus</i></u>
☒ →	<u>Diphtheria</u>	① →	<u>Pertussis (whooping cough)</u>	① → *	<u>Varicella (chickenpox)</u>
☒ →	<u>Ehrlichiosis</u>	☒ → *	<u>Plague</u>	☒ → 1	<u><i>Vibrio</i> infection</u>
☒ →	<u>Emerging or exotic disease</u>	☒ → *	<u>Poliomyelitis (paralytic or non-paralytic)</u>	① →	<u>Viral hemorrhagic fever</u>
☒ →	<u>Encephalitis, parasitic</u>	☒ →	<u>Psittacosis (ornithosis)</u>	☒ → *	<u>West Nile virus infection</u>
① →	<u>Encephalitis, viral</u>	① →	<u>Q Fever</u>	☒ → *	<u>Yellow fever</u>
① →	<u><i>Escherichia coli</i>, Shiga toxin-producing</u>	☒ → *	<u>Rabies in a human</u>	☒ → *	<u>Yersiniosis (enteropathogenic <i>Yersinia</i>)</u>
☒ →	<u>Giardiasis</u>	① →	<u>Relapsing fever (borreliosis)</u>	① → *	<u>Zika virus infection</u>
① → *	<u>Glanders</u>				

Key:

- ☒ Notify the Department within 24 hours after receiving a report under R9-6-202 or R9-6-203.
- ① Notify the Department within one working day after receiving a report under R9-6-202 or R9-6-203.
- ☒ Notify the Department within five working days after receiving a report under R9-6-202 or R9-6-203.
- Submit an epidemiologic investigation report within 30 calendar days after receiving a report under R9-6-202 or R9-6-203 or notification by the Department.
- * Ensure that an isolate of the organism for each positive culture, if available, or a specimen for each positive test result is submitted to the Arizona State Laboratory within one working day.
- 1 Submit an epidemiologic investigation report only if a case or suspect case has died as a result of the communicable disease.

R9-6-207. Federal or Tribal Entity Reporting

- A. To the extent permitted by law, a federal or tribal entity shall comply with the reporting requirements in this Article as follows:
1. If the federal or tribal entity is participating in the diagnosis or treatment of an individual, the federal or tribal entity shall comply with the reporting requirements in R9-6-202 and Table 2.1 for a health care provider;
 2. If the federal or tribal entity is operating a facility that provides health care services, the federal or tribal entity shall comply with the reporting requirements in R9-6-202 and Table 2.1 for an administrator of a health care institution;
 3. If the federal or tribal entity is operating a correctional facility, the federal or tribal entity shall comply with the reporting requirements in R9-6-202 and Table 2.1 for an administrator of a correctional facility;
 4. If the federal or tribal entity is operating a facility that provides child care services, the federal or tribal entity shall comply with the reporting requirements in R9-6-203 and Table 2.2 for an administrator of a child care establishment;
 5. If the federal or tribal entity is operating a facility that offers instruction to students in a grade level from kindergarten through grade 12, a college or university, a “private vocational program” as defined in A.R.S. § 32-3001, or an institution that grants a “degree” as defined in A.R.S. § 32-3001, the federal or tribal entity shall comply with the reporting requirements in R9-6-203 and Table 2.2 for an administrator of a school;
 - 4-6. If the federal or tribal entity is operating a clinical laboratory, the federal or tribal entity shall comply with the reporting requirements in R9-6-204 and Table 2.3 for a clinical laboratory director; and
 - 5-7. If the federal or tribal entity is operating a facility that provides pharmacy services, the federal or tribal entity shall comply with the reporting requirements in R9-6-205 for an administrator of a pharmacy; and
 6. If the federal or tribal entity is operating a facility that provides child care services, the federal or tribal entity shall comply with the reporting requirements for an administrator of a child care establishment; and
 7. If the federal or tribal entity is operating a facility that offers instruction to students in a grade level from kindergarten through grade 12, a college or university, a “private vocational program” as defined in A.R.S. § 32-3001, or an institution that grants a “degree” as defined in A.R.S. § 32-3001, the federal or tribal entity shall comply with the reporting requirements for an administrator of a school.



- B. For the purposes of this Section, “federal or tribal entity” means a person operating within this state, whether on federal or tribal land or otherwise, under the authority of an agency or other administrative subdivision of the federal government or a tribal nation and who is:
1. Licensed as a doctor of allopathic, naturopathic, osteopathic, or homeopathic medicine under the laws of this or another state;
 2. Licensed as a physician assistant under the laws of this or another state;
 3. Licensed as a registered nurse practitioner under the laws of this or another state;
 4. Licensed as a dentist under the laws of this or another state;
 5. Operating a facility that provides health care services;
 6. Operating a correctional facility;
 7. Operating a facility that provides child care services;
 8. Operating a facility that offers instruction to students in a grade level from kindergarten through grade 12, a college or university, a “private vocational program” as defined in A.R.S. § 32-3001, or an institution that grants a “degree” as defined in A.R.S. § 32-3001;
 - ~~7-9. Operating a clinical laboratory; or~~
 - ~~8-10. Operating a facility that provides pharmacy services;~~
 9. Operating a facility that provides child care services; or
 10. Operating a facility that offers instruction to students in a grade level from kindergarten through grade 12, a college or university, a “private vocational program” as defined in A.R.S. § 32-3001, or an institution that grants a “degree” as defined in A.R.S. § 32-3001.

ARTICLE 3. CONTROL MEASURES FOR COMMUNICABLE DISEASES AND INFESTATIONS

R9-6-301. Definitions

In this Article, unless otherwise specified:

1. “Aquatic venue” means an artificially constructed structure or modified natural structure that:
 - a. Is used:
 - i. For water contact recreation, as defined in A.A.C. R9-8-801; or
 - ii. To treat a diagnosed injury, illness, or medical condition under the supervision of a health professional, as defined in A.R.S. § 32-3201;
 - b. Is open to all individuals or to all residents of a community, members of a club or camp, individuals being treated by a specific health professional, or patrons of other such establishments; and
 - c. Includes a:
 - i. Natural bathing place as defined in A.A.C. R18-5-201,
 - ii. Public spa as defined in A.A.C. R18-5-201,
 - iii. Public swimming pool as defined in A.A.C. R18-5-201,
 - iv. Semi-artificial bathing place as defined in A.A.C. R18-5-201,
 - v. Semi-public spa as defined in A.A.C. R18-5-201,
 - vi. Semi-public swimming pool as defined in A.A.C. R18-5-201, and
 - vii. Water-play area, an artificially constructed depression in which water issues from showers or other nozzles and drains away to leave little or no standing water.
- ~~1-2.~~ “Blood bank” means a facility where human whole blood or a blood component is collected, prepared, tested, processed, or stored, or from which human whole blood or a blood component is distributed.
- ~~2-3.~~ “Blood center” means a mobile or stationary facility that procures human whole blood or a blood component that is transported to a blood bank.
- ~~3-4.~~ “Contact precautions” means, in addition to use of standard precautions:
 - a. Placing an individual in a private room or a cohort room with a distance of three or more feet separating the individual’s bed from the bed of another individual; and
 - b. Ensuring the use of a gown and gloves by other individuals when entering the room in which the individual is located.
- ~~4-5.~~ “Contaminated” means to have come in contact with a disease-causing agent or toxin.
- ~~5-6.~~ “Disinfection” means killing or inactivating communicable-disease-causing agents on inanimate objects by directly applied chemical or physical means.
- ~~6-7.~~ “Disinfestation” means any physical, biological, or chemical process to reduce or eliminate undesired arthropod or rodent populations.
- ~~7-8.~~ “Droplet precautions” means, in addition to use of standard precautions:
 - a. Placing an individual in a private room or a cohort room with a distance of three or more feet and a curtain separating the individual’s bed from the bed of another individual;
 - b. Ensuring that the individual wears a mask covering the individual’s mouth and nose, if medically appropriate, when not in the room described in subsection ~~(7)(a)~~ (8)(a); and
 - c. Ensuring the use of a mask covering the mouth and nose by other individuals when entering the room in which the individual is located.
- ~~8-9.~~ “Follow-up” means the practice of investigating and monitoring cases, carriers, contacts, or suspect cases to detect, treat, or prevent disease.
- ~~9-10.~~ “Incapacitated adult” means an individual older than 18 years of age for whom a guardian has been appointed by a court of competent jurisdiction.
11. “Isolation precautions” means methods to limit the transmission of an infectious agent, based on the infectious agent and the location of infection in or on the infected individual or animal, that includes isolation of the infected individual or animal and may include any one or combination of the following:



- a. Standard precautions.
 - b. Contact precautions.
 - c. Droplet precautions, or
 - d. Airborne precautions.
- 10-12. "Midwife" has the same meaning as in A.R.S. § 36-751.
13. "Multi-drug-resistant organism" means a bacterial agent on a Department-provided list that is known to not be killed or whose growth is not slowed by specific classes of antibiotics.
- 14-14. "Pediculocide" means a shampoo or cream rinse manufactured and labeled for controlling head lice.
- 12-15. "Person in charge" means the individual present at a food establishment who is responsible for the food establishment's operation at the time in question.
- 13-16. "Plasma center" means a facility where the process of plasmapheresis or another form of apheresis is conducted.
- 14-17. "State health officer" means the Director of the Department or the Director's designee.
18. "Vector" means a living animal, usually a mosquito, tick, flea, or other arthropod, that may transmit an infectious agent to an individual.

R9-6-302. Local Health Agency Control Measures

A local health agency shall:

- 1. Review each report received under Article 2 for completeness and accuracy;
- 2. Confirm each diagnosis;
- 3. Conduct epidemiologic and other investigations required by this Chapter or in cooperation with the Department;
- 4. Facilitate notification of known contacts;
- 5. Conduct surveillance;
- 6. Determine trends;
- 7. Implement control measures, quarantines, isolations, and exclusions as required by the Arizona Revised Statutes and this Chapter;
- 8. Disseminate surveillance information to health care providers;
- 9. Provide health education to a disease case or contact to reduce the risk of transmission of the respective disease; and
- 10. Report to the Department, as specified in R9-6-206 and this Article.

R9-6-303. Isolation, and Quarantine, Exclusion, and Other Control Measures

A. When a local health agency is required by this Article to isolate or quarantine an individual or group of individuals, the local health agency:

- 1. Shall issue a written order:
 - a. For isolation or quarantine and other control measures;
 - b. To each individual or group of individuals and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian, except as provided in subsection (A)(2);
 - c. That specifies:
 - i. The isolation or quarantine and other control measure requirements being imposed, including, if applicable, requirements for physical examinations and medical testing to ascertain and monitor each individual's health status;
 - ii. The identity of each individual or group of individuals subject to the order;
 - iii. The premises at which each individual or group of individuals is to be isolated or quarantined;
 - iv. The date and time at which isolation or quarantine and other control measure requirements begin; and
 - v. The justification for isolation or quarantine and other control measure requirements, including, if known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
 - d. That may provide information about existing medical treatment, if available and necessary to render an individual less infectious, and the consequences of an individual's failure to obtain the medical treatment; and
- 2. May post the written order in a conspicuous place at the premises at which a group of individuals is to be isolated or quarantined if:
 - a. The written order applies to the group of individuals, and
 - b. It would be impractical to provide a copy to each individual in the group.

B. A local health agency may issue a written order for additional control measures:

- 1. Except as provided in subsection (A)(2), to each affected individual, group of individuals, or person and, for each individual who is a minor or incapacitated adult, the individual's parent or guardian;
- 2. That specifies:
 - a. The control measure requirements being imposed, including, if applicable, requirements for:
 - i. Being excluded from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a school or child care establishment;
 - ii. Avoiding other locations where the individual or an individual in the group of individuals may pose a health risk to other individuals;
 - iii. Observing airborne precautions, droplet precautions, or contact precautions and the methods by which the individual shall comply with the requirement;
 - iv. Prophylaxis or immunization, as applicable, as an alternative to or to reduce the length of exclusion;
 - v. Physical examinations and medical testing to ascertain and monitor the individual's health status; or
 - vi. Not creating a situation where additional individuals may be exposed to the communicable disease;
 - b. The identity of each individual, group of individuals, or person subject to the order;
 - c. The date and time at which the control measure requirements begin; and
 - d. The justification for the control measure requirements, including:



- i. ~~If known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and~~
 - ii. ~~If applicable, the possible consequences of the individual, group of individuals, or person failing to follow the recommendations of the Department or the local health agency to control the spread of the communicable disease; and~~
3. ~~That may provide information about the disease, existing medical treatment, if applicable, and the consequences of an individual's failure to comply with the order.~~
- B-C.** Within 10 calendar days after ~~the~~ issuing of a written order described in subsection (A) ~~or~~ (B), if a local health agency determines that isolation, ~~or~~ quarantine, ~~or~~ ~~and~~ other control measure requirements need to continue for more than 10 calendar days after the date of the order, the local health agency shall file a petition for a court order that:
- 1. Authorizes the continuation of isolation, ~~or~~ quarantine, ~~or~~ ~~and~~ other control measure requirements pertaining to an individual, ~~or~~ a group of individuals, ~~or~~ a person;
 - 2. Includes the following:
 - a. The isolation, ~~or~~ quarantine, ~~or~~ ~~and~~ other control measure requirements being imposed, including, if applicable, requirements for physical examinations and medical testing to ascertain and monitor an individual's health status;
 - b. The identity of each individual, ~~or~~ group of individuals, ~~or~~ person subject to isolation, ~~or~~ quarantine, ~~or~~ ~~and~~ other control measure requirements;
 - c. ~~If applicable, the~~ premises at which each individual or group of individuals is isolated or quarantined;
 - d. The date and time at which isolation, ~~or~~ quarantine, ~~or~~ ~~and~~ other control measure requirements began; and
 - e. The justification for isolation, ~~or~~ quarantine, ~~or~~ ~~and~~ other control measure requirements, including, if applicable and known, the disease for which the individual or individuals are believed to be cases, suspect cases, or contacts; and
 - 3. Is accompanied by the sworn affidavit of a representative of the local health agency or the Department attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.
- C-D.** A local health agency that files a petition for a court order under subsection ~~(B)~~ (C) shall provide notice to each individual, ~~or~~ group of individuals, ~~or~~ person identified in the petition according to the Arizona Rules of Civil Procedure, except that notice shall be provided within 24 hours after the petition is filed.
- D-E.** In the event of noncompliance with a written order issued under subsection (A) ~~or~~ (B), a local health agency may contact law enforcement to request assistance in enforcing the order.
- E.** ~~If the Department determines that isolation, quarantine, or other control measure requirements are necessary, the Department, under A.R.S. § 36-136(G), may take any of the actions specified in subsections (A) through (E).~~

R9-6-304. Food Establishment Control Measures

The person in charge of a food establishment shall ensure compliance with all food handler exclusion requirements in this Article or as ordered by a local health agency ~~or the Department~~.

R9-6-305. Control Measures for Multi-drug-resistant Organisms

Case control measures:

- 1. ~~A diagnosing health care provider or an administrator of a health care institution transferring a case with active infection of a bacterial disease, for which the agent is known to be a multi-drug-resistant organism, to another health care provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the patient is infected with a multi-drug-resistant organism.~~
- 2. ~~An administrator of the correctional facility transferring a case with active infection of a bacterial disease, for which the agent is known to be a multi-drug-resistant organism, to another correctional facility or to a health care institution shall, either personally or through a representative, ensure that the receiving correctional facility or health care institution is informed that the individual is infected with a multi-drug-resistant organism.~~

R9-6-305, R9-6-306. Amebiasis

Case control measures: A local health agency shall:

- 1. Exclude an amebiasis case or suspect case ~~with diarrhea~~ from:
 - a. ~~working~~ Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
 - i. ~~Either:~~
 - a. ~~(1) Treatment with an amebicide is initiated, and~~
 - b. ~~(2) Two successive stool specimens A stool specimen negative for amoebae are is obtained from specimens collected at least 24 hours apart the amebiasis case or suspect case; or~~
 - ii. ~~The local health agency has determined that the amebiasis case or suspect case is unlikely to infect other individuals; and~~
 - b. ~~Using an aquatic venue for two weeks after diarrhea has resolved;~~
- 2. Conduct an epidemiologic investigation of each reported amebiasis case or suspect case; and
- 3. For each amebiasis case, submit to the Department, as specified in ~~Article 2, Table 4 2.4,~~ the information required under R9-6-206(D).

R9-6-307. Aseptic Meningitis

Outbreak control measures: A local health agency shall:

- 1. ~~Conduct an epidemiologic investigation of each reported outbreak of aseptic meningitis; and~~
- 2. For each outbreak of aseptic meningitis, submit to the Department, as specified in ~~Article 2, Table 4,~~ the information required under R9-6-202(E).

R9-6-307. Anaplasmosis



Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported anaplasmosis case or suspect case; and
2. For each anaplasmosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

~~R9-6-306~~, R9-6-308. Anthrax

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of an anthrax case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported anthrax case or suspect case;
3. For each anthrax case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each anthrax case or suspect case is submitted to the Arizona State Laboratory.

B. Environmental control measures: A local health agency shall, in conjunction with the Department and applicable federal agencies, provide or arrange for disinfection of areas or objects sterilization by dry heating or incineration of objects contaminated by *Bacillus anthracis* through sterilization by dry heating, incineration of objects, or other appropriate means.

R9-6-309. Arboviral Infection

A. Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported arboviral infection case or suspect case;
2. For each arboviral infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
3. Ensure that each arboviral infection case is provided with health education that includes measures to:
 - a. Avoid mosquito bites, and
 - b. Reduce mosquito breeding sites.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each arboviral infection case or suspect case and implement vector control measures as necessary.

R9-6-310. Babesiosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported babesiosis case or suspect case; and
2. For each babesiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

~~R9-6-308~~, R9-6-311. Basidiobolomycosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported basidiobolomycosis case or suspect case; and
2. For each basidiobolomycosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-309~~, R9-6-312. Botulism

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a botulism case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported botulism case or suspect case; and
3. For each botulism case or suspect case:
 - a. Submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
 - b. Ensure that a specimen one or more specimens from each botulism case or suspect case is are submitted to the Arizona State Laboratory; and
 - e. In consultation with the Department, determine if treatment of the botulism case is required.

B. Environmental control measures: An individual in possession of:

1. Food known to be contaminated by *Clostridium botulinum* or Clostridium botulinum toxin shall boil the contaminated food for 10 minutes and then discard it, and
2. Utensils known to be contaminated by *Clostridium botulinum* or Clostridium botulinum toxin shall boil the contaminated utensils for 10 minutes before reuse or disposal.

~~R9-6-310~~, R9-6-313. Brucellosis

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported brucellosis case or suspect case;
2. For each brucellosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
3. Ensure that an isolate or a specimen, as available, from each brucellosis case is submitted to the Arizona State Laboratory.

~~R9-6-311~~, R9-6-314. Campylobacteriosis

Case control measures: A local health agency shall:

1. Exclude a campylobacteriosis case or suspect case with diarrhea from:
 - a. working Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
 - i. Diarrhea has resolved.



- A. Case control measures:
 - ~~1. The Department shall review each chlamydia infection case report for completeness, accuracy, and need for follow-up.~~
 2. A local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for a chlamydia *Chlamydia trachomatis* infection case that seeks treatment from the local health agency.
- B. Contact control measures: If an individual who may have been exposed to chlamydia through sexual contact with a chlamydia *Chlamydia trachomatis* infection case seeks treatment for symptoms of chlamydia infection from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

~~R9-6-315~~**R9-6-320. Cholera**

- A. Case control measures: A local health agency shall:
 1. Upon receiving a report under R9-6-202 of a cholera case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
 2. Exclude a cholera case or suspect case from:
 - a. ~~working~~ Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until ~~two successive cultures a stool specimen~~ negative for *Vibrio cholerae* toxigenic *Vibrio cholerae* are is obtained from stool specimens collected at least 24 hours apart and the cholera case or suspect case at least 48 hours after discontinuing antibiotics; and
 - b. Using an aquatic venue until diarrhea has resolved;
 3. Conduct an epidemiologic investigation of each reported cholera case or suspect case; and
 4. For each cholera case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).
- B. Contact control measures: A local health agency shall provide follow-up for each cholera contact for five calendar days after exposure.

~~R9-6-321~~ **Clostridium difficile**

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution transferring a known *Clostridium difficile* case with active infection and diarrhea to another health care provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the patient is a known *Clostridium difficile* case.
2. If a known *Clostridium difficile* case with active infection and diarrhea is being transferred from a correctional facility to another correctional facility or to a health care institution, an administrator of the correctional facility, either personally or through a representative, shall ensure that the receiving correctional facility or health care institution is informed that the individual is a known *Clostridium difficile* case.

~~R9-6-316~~**R9-6-322. Coccidioidomycosis (Valley Fever)**

Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of coccidioidomycosis; and
2. For each outbreak of coccidioidomycosis, submit to the Department, ~~as specified in Article 2, Table 4,~~ the information required under ~~R9-6-202(E)~~ R9-6-206(E).

~~R9-6-317~~**R9-6-323. Colorado Tick Fever**

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Colorado tick fever case or suspect case; and
2. For each Colorado tick fever case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-318~~**R9-6-324. Conjunctivitis: Acute**

- A. Case control measures: An administrator of a school or child care establishment, either personally or through a representative, shall exclude an acute conjunctivitis case from attending the school or child care establishment until the symptoms of acute conjunctivitis subside or treatment for acute conjunctivitis is initiated and maintained for 24 hours.
- B. Outbreak control measures: A local health agency shall:
 1. Conduct an epidemiologic investigation of each reported conjunctivitis outbreak; and
 2. For each conjunctivitis outbreak, submit to the Department, ~~as specified in Article 2, Table 4,~~ the information required under ~~R9-6-206(F)~~ R9-6-206(E).

~~R9-6-319~~**R9-6-325. Creutzfeldt-Jakob Disease**

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Creutzfeldt-Jakob disease case or suspect case; and
2. For each Creutzfeldt-Jakob disease case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-320~~**R9-6-326. Cryptosporidiosis**

A. Case control measures: A local health agency shall:

1. Exclude a cryptosporidiosis case or suspect case with diarrhea from:
 - a. ~~working~~ Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until diarrhea has resolved; and
 - b. Using an aquatic venue for two weeks after diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported cryptosporidiosis case or suspect case; and



3. For each cryptosporidiosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of cryptosporidiosis.

~~R9-6-324~~, ~~R9-6-327~~, **Cyclospora Infection**

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported *Cyclospora* infection case or suspect case; and
2. For each *Cyclospora* infection case submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-322~~, ~~R9-6-328~~, **Cysticercosis**

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported cysticercosis case or suspect case; and
2. For each cysticercosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-323~~, ~~R9-6-329~~, **Dengue**

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a dengue case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported dengue case or suspect case; ~~and~~
- ~~2-3.~~ For each dengue case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); ~~and~~
4. Ensure that each dengue case is provided with health education that includes measures to:
 - a. Avoid mosquito bites, and
 - b. Reduce mosquito breeding sites.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each dengue case or suspect case and implement vector control measures as necessary.

~~R9-6-330.~~ **Expired**

~~R9-6-324~~, ~~R9-6-330~~, **Diarrhea, Nausea, or Vomiting**

~~A.~~ Environmental control measures: A local health agency shall conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each water, sewage, or food preparation facility associated with an outbreak of diarrhea, nausea, or vomiting.

~~B.~~ **A.** Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of diarrhea, nausea, or vomiting;
2. Submit to the Department, as specified in ~~Article 2~~, Table 4, the information required under ~~R9-6-206(F)~~ R9-6-206(E) ~~for:~~
 - a. ~~Each suspected foodborne illness outbreak,~~
 - b. ~~Each suspected waterborne illness outbreak, and~~
 - e. ~~Each outbreak of viral gastroenteritis; and~~
3. Exclude each case that is part of an outbreak of diarrhea, nausea, or vomiting from:
 - a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
 - i. Diarrhea and vomiting have resolved, or
 - ii. The local health agency has determined that the case is unlikely to infect other individuals; and
 - b. Using an aquatic venue for two weeks after diarrhea has resolved.

B. Environmental control measures: A local health agency shall conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each facility or location regulated under 9 A.A.C. 8 that is associated with an outbreak of diarrhea, nausea, or vomiting.

~~R9-6-325~~, ~~R9-6-331~~, **Diphtheria**

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall:
 - a. Isolate and institute droplet precautions for a pharyngeal diphtheria case or suspect case until:
 - i. ~~Two two~~ successive sets of cultures negative for *Corynebacterium diphtheriae* are obtained from nose and throat specimens collected from the case or suspect case at least 24 hours apart and at least 24 hours after cessation of treatment; ~~or~~
 - ii. ~~Fourteen calendar days after initiation of treatment;~~ and
 - b. Isolate and institute contact precautions for a cutaneous diphtheria case or suspect case until:
 - i. ~~Two two~~ successive sets of cultures negative for *Corynebacterium diphtheriae* are obtained from skin specimens collected from the case or suspect case at least 24 hours apart and at least 24 hours after cessation of treatment; ~~or~~
 - ii. ~~Fourteen calendar days after initiation of treatment.~~
2. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 of a diphtheria case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
 - b. Conduct an epidemiologic investigation of each reported diphtheria case or suspect case; and



c. For each diphtheria case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall:

1. Exclude each diphtheria contact from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a school or child care establishment until a set of cultures negative for *Corynebacterium diphtheriae* is obtained from the contact's nose and throat specimens;
2. In consultation with the Department, quarantine a contact of a diphtheria case, if indicated, until two successive sets of cultures negative for *Corynebacterium diphtheriae* are obtained from nose and throat specimens collected from the contact at least 24 hours apart;
3. Offer each previously immunized diphtheria contact prophylaxis and a vaccine containing diphtheria toxoid; and
4. Offer each unimmunized diphtheria contact prophylaxis and the primary vaccine series ~~and treatment~~.

~~R9-6-326~~**R9-6-332. Ehrlichioses (Ehrlichiosis and Anaplasmosis)**

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported ehrlichiosis ~~or anaplasmosis~~ case or suspect case; and
2. For each ehrlichiosis ~~or anaplasmosis~~ case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-327~~**R9-6-333. Emerging or Exotic Disease**

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of an emerging or exotic disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
2. In consultation with the Department, isolate an emerging or exotic disease case or suspect case as necessary to prevent transmission;
3. Conduct an epidemiologic investigation of each reported emerging or exotic disease case or suspect case; and
4. For each emerging or exotic disease case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine or exclude an emerging or exotic disease contact as necessary, according to R9-6-303, to prevent transmission.

~~R9-6-328~~**R9-6-334. Encephalitis, Viral or Parasitic**

Case control measures: A local health agency shall:

- ~~1. Upon receiving a report under R9-6-202 of a viral or parasitic encephalitis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;~~
1. Upon receiving a report of encephalitis under R9-6-202, notify the Department:
 - a. For a case or suspect case of parasitic encephalitis, within 24 hours after receiving the report and provide to the Department the information contained in the report; and
 - b. For a case or suspect case of viral encephalitis, within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported viral or parasitic encephalitis case or suspect case; and
3. For each encephalitis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-329~~**R9-6-335. Enterohemorrhagic *Escherichia coli*, Shiga Toxin-producing**

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a Shiga toxin-producing *Escherichia coli* case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Exclude ~~an enterohemorrhagic a Shiga toxin-producing *Escherichia coli* case or suspect case with diarrhea from:~~
 - a. working Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
 - ~~a-i.~~ Two successive cultures stool specimens, collected from the Shiga toxin-producing *Escherichia coli* case or suspect case at least 24 hours apart, are negative for enterohemorrhagic Shiga toxin-producing *Escherichia coli* are obtained from stool specimens collected from the case at least 24 hours apart and at least 48 hours after discontinuing antibiotics; or
 - ~~b-ii.~~ Diarrhea has resolved; or
 - ~~iii.~~ The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
 - b. Using an aquatic venue for two weeks after diarrhea has resolved;
- ~~2-3.~~ Conduct an epidemiologic investigation of each reported enterohemorrhagic Shiga toxin-producing *Escherichia coli* case or suspect case; and
- ~~3-4.~~ For each enterohemorrhagic Shiga toxin-producing *Escherichia coli* case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~**B.** Contact control measures: A local health agency shall exclude an enterohemorrhagic *Escherichia coli* contact with diarrhea of unknown cause from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until diarrhea has resolved.~~

~~**C-B.** Environmental control measures: A local health agency shall:~~

1. ~~If an animal located in a private residence is suspected to be the source of infection for an enterohemorrhagic a Shiga toxin-producing *Escherichia coli* case or outbreak, provide health education for the animal's owner about enterohemorrhagic Shiga toxin-~~



producing *Escherichia coli* and the risks of becoming infected with ~~enterohemorrhagic~~ Shiga toxin-producing *Escherichia coli*; and

2. If an animal located in a setting other than a private residence is suspected to be the source of infection for ~~an enterohemorrhagic~~ a Shiga toxin-producing *Escherichia coli* case or outbreak:
 - a. Provide health education for the animal's owner about ~~enterohemorrhagic~~ Shiga toxin-producing *Escherichia coli* and the risks of becoming infected with ~~enterohemorrhagic~~ Shiga toxin-producing *Escherichia coli*, and
 - b. Require the animal's owner to provide information to individuals with whom the animal may come into contact about ~~enterohemorrhagic~~ Shiga toxin-producing *Escherichia coli* and methods to reduce the risk of transmission.

~~R9-6-331~~R9-6-336. **Giardiasis**

- A.** Case control measures: A local health agency shall exclude a giardiasis case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
1. Two successive stool specimens negative for *Giardia lamblia* are obtained from specimens collected from the case at least 24 hours apart; or
 2. Treatment for giardiasis is initiated and diarrhea has resolved.
- B.** Contact control measures: A local health agency shall exclude a giardiasis contact with diarrhea of unknown cause from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until diarrhea has resolved.
- C.** Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported giardiasis outbreak;
 2. For each giardiasis case involved in an outbreak, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(D); and
 3. For each giardiasis outbreak, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(F).

Case control measures: A local health agency shall:

1. Exclude a giardiasis case or suspect case with diarrhea from:
 - a. Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
 - i. Treatment for giardiasis is initiated and diarrhea has resolved, or
 - ii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
 - b. Using an aquatic venue for two weeks after diarrhea has resolved;
2. Conduct an epidemiologic investigation of each reported giardiasis case or suspect case; and
3. For each giardiasis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

~~R9-6-337~~. **Glanders**

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a glanders case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported glanders case or suspect case;
3. For each glanders case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D); and
4. Ensure that an isolate or a specimen, as available, from each glanders case or suspect case is submitted to the Arizona State Laboratory.

~~R9-6-332~~R9-6-338. **Gonorrhea**

A. Case control measures:

1. ~~The Department shall review each gonorrhea case report for completeness, accuracy, and need for follow-up.~~
- 2.1. For the prevention of gonorrheal ophthalmia, a physician, physician assistant, registered nurse practitioner, or midwife attending the birth of an infant in this state shall treat the eyes of the infant immediately after the birth with one of the following, unless treatment is refused by the parent or guardian:
 - a. Erythromycin ophthalmic ointment 0.5%, or
 - b. Tetracycline ophthalmic ointment 1%.
- 3.2. A local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for a gonorrhea case that seeks treatment from the local health agency.

B. Contact control measures: If an individual who may have been exposed to gonorrhea through sexual contact with a gonorrhea case seeks treatment for symptoms of gonorrhea from a local health agency, the local health agency shall comply with the requirements specified in R9-6-1103 concerning treatment and health education for the individual.

~~R9-6-333~~R9-6-339. ***Haemophilus influenzae*: Invasive Disease**

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a *Haemophilus influenzae* meningitis or epiglottitis case or suspect case for 24 hours after the initiation of treatment.
2. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 or R9-6-203 of a *Haemophilus influenzae* invasive disease case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
 - a-b. Conduct an epidemiologic investigation of each reported *Haemophilus influenzae* invasive disease case or suspect case; and



b.c. For each *Haemophilus influenzae* invasive disease case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall evaluate the level of risk of transmission from each contact’s exposure to a *Haemophilus influenzae* invasive disease case and, if indicated, shall provide or arrange for each contact to receive immunization or treatment.

~~R9-6-334~~**R9-6-340. Hansen’s Disease (Leprosy)**

A. Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Hansen’s disease case or suspect case; and
2. For each Hansen’s disease case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Contact control measures: In consultation with the Department, a local health agency shall examine contacts of a Hansen’s disease case, if indicated, for signs and symptoms of leprosy at six-to-twelve month intervals for five years after the last exposure to an infectious case.

~~R9-6-335~~**R9-6-341. Hantavirus Infection**

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a hantavirus infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2. Provide or arrange for~~ Ensure that a hantavirus infection case or, if the case is a child or incapacitated adult, the parent or guardian of the case ~~to receive~~ receives health education about reducing the risks of becoming reinfected with or of having others become infected with hantavirus;
- ~~2-3.~~ Conduct an epidemiologic investigation of each reported hantavirus infection case or suspect case; and
- ~~3-4.~~ For each hantavirus infection case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall conduct an environmental assessment for each hantavirus infection case or suspect case.

~~R9-6-336~~**R9-6-342. Hemolytic Uremic Syndrome**

A. Case control measures: A local health agency shall:

- ~~1. Exclude a hemolytic uremic syndrome case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:~~
 - ~~a. Two successive cultures negative for enterohemorrhagic *Escherichia coli* and *Shigella* spp. are obtained from stool specimens collected from the case at least 24 hours apart and at least 48 hours after discontinuing antibiotics, or~~
 - ~~b. Diarrhea has resolved;~~
1. Upon receiving a report under R9-6-202 of a hemolytic uremic syndrome case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported hemolytic uremic syndrome case or suspect case; and
3. For each hemolytic uremic syndrome case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall exclude a hemolytic uremic syndrome contact with diarrhea of unknown cause from working as a food handler until diarrhea has resolved.

~~R9-6-343. Expired~~

~~R9-6-337~~**R9-6-343. Hepatitis A**

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 or R9-6-203 of a hepatitis A case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Exclude a hepatitis A case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
- ~~2-3.~~ Conduct an epidemiologic investigation of each reported hepatitis A case or suspect case; and
- ~~3-4.~~ For each hepatitis A case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency shall:

1. Exclude a hepatitis A contact with symptoms of hepatitis A from working as a food handler during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
2. For 45 calendar days after exposure, monitor a food handler who was a contact of a hepatitis A case during the infectious period for symptoms of hepatitis A; and
3. Evaluate the level of risk of transmission from each contact’s exposure to a hepatitis A case and, if indicated, provide or arrange for each contact to receive prophylaxis and immunization.

~~R9-6-338~~**R9-6-344. Hepatitis B and Hepatitis D**

A. Case control measures:

1. A local health agency shall:
 - a. Evaluate a health care provider identified as the source of hepatitis B virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated;



- b. Conduct an epidemiologic investigation of each reported case or suspect case of hepatitis B or hepatitis B co-infected with hepatitis D; and
 - c. For each acute case of hepatitis B or hepatitis B co-infected with hepatitis D or case of perinatal hepatitis B, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).
2. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of hepatitis B, as required under A.R.S. § 32-1483 and 21 CFR 630.6.
- B.** Contact control measures: A local health agency shall:
1. Refer each non-immune hepatitis B contact to a health care provider for prophylaxis and initiation of the hepatitis B vaccine series, and
 2. Provide health education related to the progression of hepatitis B disease and the prevention of transmission of hepatitis B infection to each non-immune hepatitis B contact.

~~R9-6-339~~**R9-6-345. Hepatitis C**

Case control measures:

1. A local health agency shall:
 - a. ~~Conduct an epidemiologic investigation of each reported acute hepatitis C case or suspect case; and~~
 - b. For each acute hepatitis C case, submit to the Department, as specified in ~~Article 2~~, Table 4, the information required under ~~R9-6-206(D)~~.
2. ~~The Department shall provide health education related to the progression of hepatitis C disease and the prevention of transmission of hepatitis C infection to each reported non-acute hepatitis C case or suspect case.~~

Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported hepatitis C outbreak;
2. For each hepatitis C outbreak, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(E);
3. Evaluate a health care provider identified as the source of hepatitis C virus transmission in the work place and, if indicated, ensure reassignment of the health care provider to a position where the occupational risk of transmission is eliminated; and
4. Ensure that health education related to the progression of hepatitis C disease and the prevention of transmission of hepatitis C infection is provided to each individual who may have been exposed to hepatitis C during the outbreak.

~~R9-6-340~~**R9-6-346. Hepatitis E**

Case control measures: A local health agency shall:

1. Exclude a hepatitis E case or suspect case from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment during the first 14 calendar days of illness or for seven calendar days after onset of jaundice;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported hepatitis E case or suspect case; and
- ~~2-3.~~ For each hepatitis E case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-341~~**R9-6-347. Human Immunodeficiency Virus (HIV) Infection and Related Disease**

A. Case control measures:

1. A local health agency shall:
 - a. Conduct an epidemiologic investigation, including a review of medical records, of each reported HIV-infected individual or suspect case; and
 - b. For each HIV-infected individual, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).
2. The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of HIV infection, as required under A.R.S. § 32-1483 and 21 CFR 630.6.
3. The Department and a local health agency shall offer anonymous HIV-testing to an individual as specified in R9-6-1005.

B. Contact control measures: The Department or the Department's designee shall confidentially notify an individual reported to be at risk for HIV infection under ~~A.R.S. § 36-664(J)~~A.R.S. § 36-664(I) as specified in R9-6-1006(A).

C. Environmental control measures: An employer, as defined under A.R.S. § 23-401, or health care provider shall comply with the requirements specified in A.R.S. § 23-403 and A.A.C. R20-5-602.

~~R9-6-342~~**R9-6-348. Influenza-Associated Mortality in a Child**

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a case or suspect case of an influenza-associated death of a child, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Confirm that influenza was the cause of death for Conduct an epidemiologic investigation of each reported case or suspect case of influenza-associated mortality in a child; and
- ~~2-3.~~ For each case of influenza-associated mortality in a child, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under ~~R9-6-206(C)~~ R9-6-206(D).

~~R9-6-344~~**R9-6-349. Legionellosis (Legionnaires' Disease)**

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a legionellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported legionellosis case or suspect case; and
- ~~2-3.~~ For each legionellosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).



B. Environmental control measures: The owner of a water, cooling, or ventilation system or equipment that is determined by the Department or a local health agency to have caused be associated with a case of Legionella infection shall disinfect the system before resuming its use comply with the environmental control measures recommended by the Department or local health agency to prevent the exposure of other individuals.

~~R9-6-345~~**R9-6-350. Leptospirosis**

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a leptospirosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported leptospirosis case or suspect case; and
- ~~2-3.~~ For each leptospirosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D).

~~R9-6-346~~**R9-6-351. Listeriosis**

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a listeriosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported listeriosis case or suspect case;
- ~~2-3.~~ For each listeriosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D); and
- ~~3-4.~~ Ensure that an isolate or a specimen, as available, from each listeriosis case is submitted to the Arizona State Laboratory.

~~R9-6-347~~**R9-6-352. Lyme Disease**

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported Lyme disease case or suspect case; and
2. For each Lyme disease case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D).

~~R9-6-348~~**R9-6-353. Lymphocytic Choriomeningitis**

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a lymphocytic choriomeningitis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported lymphocytic choriomeningitis case or suspect case; and
- ~~2-3.~~ For each lymphocytic choriomeningitis case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D).

~~R9-6-349~~**R9-6-354. Malaria**

A. Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported malaria case or suspect case; and
2. For each malaria case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D).

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each malaria case or suspect case and implement vector control measures as necessary.

~~R9-6-350~~**R9-6-355. Measles (Rubeola)**

A. Case control measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
 - a. Exclude a measles case from the school or child care establishment and from school- or child-care-establishment-sponsored events from the onset of illness through the fourth calendar day after the rash appears; and
 - b. Exclude a measles suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until ~~evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner~~ the local health agency has determined that the suspect case is unlikely to infect other individuals.
2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute airborne precautions for a measles case from onset of illness through the fourth calendar day after the rash appears.
3. An administrator of a health care institution, either personally or through a representative, shall exclude a measles:
 - a. Case from working at the health care institution from the onset of illness through the fourth calendar day after the rash appears; and
 - b. Suspect case from working at the health care institution until the local health agency has determined that the suspect case may return to work.
- ~~3-4.~~ A local health agency shall:
 - a. Upon receiving a report under R9-6-202 or R9-6-203 of a measles case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
 - b. Conduct an epidemiologic investigation of each reported measles case or suspect case;
 - c. For each measles case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D); and
 - d. Ensure that one or more specimens from each measles case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.



5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the measles control measures recommended by a local health agency or the Department.
- B. Contact control measures:**
1. When a measles case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
 - a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
 - b. Comply with the local health agency's recommendations for exclusion.
 2. A local health agency shall:
 - a. Determine which measles contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
 - b. ~~provide~~ Provide or arrange for immunization of each non-immune measles contact within 72 hours after last exposure, if possible.
 3. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a measles case or suspect case unless the worker is able to provide evidence of immunity to measles through one of the following:
 - a. A record of immunization against measles with two doses of live virus vaccine given on or after the first birthday and at least one month apart;
 - b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to measles; or
 - c. Documentary evidence of birth before January 1, 1957.

~~R9-6-351~~ **R9-6-356. Melioidosis**

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a melioidosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported melioidosis case or suspect case;
- ~~2-3.~~ For each melioidosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D); and
- ~~3-4.~~ Ensure that an isolate or a specimen, as available, from each melioidosis case or suspect case is submitted to the Arizona State Laboratory.

~~R9-6-352~~ **R9-6-357. Meningococcal Invasive Disease**

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a meningococcal invasive disease case for 24 hours after the initiation of treatment.
2. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 or R9-6-203 of a meningococcal invasive disease case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
 - b. Conduct an epidemiologic investigation of each reported meningococcal invasive disease case or suspect case;
 - c. For each meningococcal invasive disease case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D); and
 - d. Ensure that an isolate or a specimen, as available, from each meningococcal invasive disease case is submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency shall evaluate the level of risk of transmission from each contact's exposure to a meningococcal invasive disease case and, if indicated, provide or arrange for each contact to receive prophylaxis.

R9-6-358. Methicillin-resistant *Staphylococcus aureus* (MRSA)

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution transferring a known methicillin-resistant *Staphylococcus aureus* case with active infection to another health care provider or health care institution or to a correctional facility shall, either personally or through a representative, ensure that the receiving health care provider, health care institution, or correctional facility is informed that the patient is a known methicillin-resistant *Staphylococcus aureus* case.
2. If a known methicillin-resistant *Staphylococcus aureus* case with active infection is being transferred from a correctional facility to another correctional facility or to a health care institution, an administrator of the correctional facility, either personally or through a representative, shall ensure that the receiving correctional facility or health care institution is informed that the individual is a known methicillin-resistant *Staphylococcus aureus* case.

B. Outbreak control measures:

1. A local health agency, in consultation with the Department, shall:
 - a. Conduct an epidemiologic investigation of each reported outbreak of methicillin-resistant *Staphylococcus aureus* in a health care institution or correctional facility; and
 - b. For each outbreak of methicillin-resistant *Staphylococcus aureus* in a health care institution or correctional facility, submit to the Department the information required under R9-6-206(E).



- 2. When an outbreak of methicillin-resistant *Staphylococcus aureus* occurs in a health care institution or correctional facility, the administrator of the health care institution or correctional facility, either personally or through a representative, shall comply with the control measures recommended by a local health agency or the Department.

R9-6-353, R9-6-359, Mumps

A. Case control measures:

- 1. An administrator of a school or child care establishment, either personally or through a representative, shall:
 - a. Exclude a mumps case from the school or child care establishment for five calendar days after the onset of glandular swelling; and
 - b. Exclude a mumps suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner, or local health agency.
- 2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions with a mumps case for five calendar days after the onset of glandular swelling.
- 3. An administrator of a health care institution, either personally or through a representative, shall exclude a mumps:
 - a. Case from working at the health care institution for five calendar days after the onset of glandular swelling; and
 - b. Suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
- ~~3-4.~~ A local health agency shall:
 - a. Upon receiving a report under R9-6-202 or R9-6-203 of a mumps case or suspect case, notify the Department within ~~24 hours~~ one working day after receiving the report and provide to the Department the information contained in the report;
 - b. Conduct an epidemiologic investigation of each reported mumps case or suspect case;
 - c. For each mumps case, submit to the Department, as specified in ~~Article 2, Table 4 2.4,~~ the information required under R9-6-206(D); and
 - d. Ensure that one or more specimens from each mumps case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
- 5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the mumps control measures recommended by a local health agency or the Department.

B. Contact control measures:

- 1. When a mumps case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
 - a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
 - b. Comply with the local health agency's recommendations for exclusion.
- 2. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a mumps case or suspect case unless the worker is able to provide evidence of immunity to mumps through one of the following:
 - a. A record of immunization against mumps with two doses of live virus vaccine given on or after the first birthday and at least one month apart; or
 - b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to mumps.
- 3. A local health agency shall determine which mumps contacts will be:
 - a. ~~Excluded from a school or child care establishment~~ Quarantined or excluded, according to R9-6-303, to prevent transmission; and
 - b. Advised to obtain an immunization against mumps.

R9-6-354, R9-6-360, Norovirus

A. Outbreak control measures: A local health agency shall:

- 1. Conduct an epidemiologic investigation of each reported norovirus outbreak; ~~and~~
- 2. Submit to the Department, ~~as specified in Article 2, Table 4,~~ the information required under ~~R9-6-206(F)~~ R9-6-206(E); and
- 3. Exclude each case that is part of a norovirus outbreak from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until:
 - a. Diarrhea has resolved, or
 - b. The local health agency has determined that the case or suspect case is unlikely to infect other individuals.

B. Environmental control measures: A local health agency shall conduct a sanitary inspection or ensure that a sanitary inspection is conducted of each ~~water, sewage, or food preparation~~ facility or location regulated under 9 A.A.C. 8 that is associated with a norovirus outbreak.

R9-6-361, Novel Coronavirus (e.g., SARS or MERS)

A. Case control measures:

- 1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a novel coronavirus case or suspect case, including a case or suspect case of severe acute respiratory syndrome or Middle East respiratory syndrome, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.
- 2. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 of a novel coronavirus case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;



- b. In consultation with the Department, ensure that isolation and both airborne precautions and contact precautions have been instituted for a novel coronavirus case or suspect case to prevent transmission.
- c. Conduct an epidemiologic investigation of each reported novel coronavirus case or suspect case; and
- d. For each novel coronavirus case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).

B. Contact control measures: A local health agency, in consultation with the Department, shall determine which novel coronavirus contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission.

~~R9-6-355~~R9-6-362. Pediculosis (Lice Infestation)

A. Case control measures:

- 1. An administrator of a school or child care establishment, either personally or through a representative, shall exclude a pediculosis case from the school or child care establishment until the case is treated with a pediculocide.
- 2. An administrator of a shelter shall ensure that a pediculosis case is treated with a pediculocide and that the case's clothing and personal articles are disinfested.

B. Contact control measures: An administrator of a school or child care establishment that excludes a pediculosis case from the school or child care establishment, either personally or through a representative, shall ensure that a parent or guardian of a child who is a contact is notified that a pediculosis case was identified at the school or child care establishment.

~~R9-6-363. Expired~~

~~R9-6-356~~R9-6-363. Pertussis (Whooping Cough)

A. Case control measures:

- 1. An administrator of a school or child care establishment, either personally or through a representative, shall:
 - a. Exclude a pertussis case from the school or child care establishment for 21 calendar days after the date of onset of cough or for five calendar days after the date of initiation of antibiotic treatment for pertussis; and
 - b. Exclude a pertussis suspect case from the school or child care establishment until evaluated and determined to be noninfectious by a physician, physician assistant, ~~or~~ registered nurse practitioner, or local health agency.
- 2. An administrator of a health care institution, either personally or through a representative, shall:
 - a. Exclude a pertussis case from working at the health care institution for 21 calendar days after the date of onset of cough or for five calendar days after the date of initiation of antibiotic treatment for pertussis; and
 - b. Exclude a pertussis suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, ~~or~~ registered nurse practitioner, or local health agency.
- 3. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and initiate droplet precautions for a pertussis case for five calendar days after the date of initiation of antibiotic treatment for pertussis.
- 4. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 or R9-6-203 of a pertussis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
 - ~~a-b.~~ Conduct an epidemiologic investigation of each reported pertussis case or suspect case; and
 - ~~b-c.~~ For each pertussis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).
- 5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the pertussis control measures recommended by a local health agency or the Department.

B. Contact control measures:

- 1. When a pertussis case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
 - a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
 - b. Comply with the local health agency's recommendations for exclusion.
- 2. A local health agency shall identify contacts of a pertussis case and, ~~if indicated~~, shall:
 - a. Determine which pertussis contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
 - b. If indicated, provide or arrange for a pertussis contact to receive antibiotic prophylaxis.

~~R9-6-364. Rocky Mountain Spotted Fever~~

~~Case control measures: A local health agency shall:~~

- ~~1. Conduct an epidemiologic investigation of each reported Rocky Mountain spotted fever case or suspect case; and~~
- ~~2. For each Rocky Mountain spotted fever case, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(D).~~

~~R9-6-357~~R9-6-364. Plague

A. Case control measures:

- 1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute droplet precautions for a pneumonic plague case or suspect case until 72 hours of antibiotic therapy have been completed with favorable clinical response.
- 2. An individual handling the body of a deceased plague case shall use droplet precautions.
- 3. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 of a plague case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;



- b. Conduct an epidemiologic investigation of each reported plague case or suspect case;
- c. For each plague case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
- d. Ensure that an isolate or a specimen, as available, from each plague case or suspect case is submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency shall provide follow-up to pneumonic plague contacts for seven calendar days after last exposure to a pneumonic plague case.

~~R9-6-358~~R9-6-365. Poliomyelitis (Paralytic or Non-paralytic)

Case control measures: A local health agency shall:

- 1. Upon receiving a report under R9-6-202 of a poliomyelitis case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
- 2. Conduct an epidemiologic investigation of each reported poliomyelitis case or suspect case;
- 3. For each poliomyelitis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
- 4. Ensure that one or more specimens from each poliomyelitis case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.

~~R9-6-359~~R9-6-366. Psittacosis (Ornithosis)

A. Case control measures: A local health agency shall:

- 1. Conduct an epidemiologic investigation of each reported psittacosis case or suspect case; and
- 2. For each psittacosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

B. Environmental control measures: A local health agency shall:

- 1. If a bird infected with *Chlamydia psittaci* or *Chlamydophila psittaci* is located in a private residence:
 - a. Provide health education for the bird’s owner about psittacosis and the risks of becoming infected with psittacosis, and
 - b. Advise the bird’s owner to obtain treatment for the bird; and
- 2. If a bird infected with *Chlamydia psittaci* or *Chlamydophila psittaci* is located in a setting other than a private residence:
 - a. Provide health education for the bird’s owner about psittacosis and the risks of becoming infected with psittacosis,
 - b. Ensure that the bird is treated or destroyed and any contaminated structures are disinfected, and
 - c. Require the bird’s owner to isolate the bird from contact with members of the public and from other birds until treatment of the bird is completed or the bird is destroyed.

~~R9-6-360~~R9-6-367. Q Fever

Case control measures: A local health agency shall:

- 1. Upon receiving a report under R9-6-202 of a Q fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- 2. Conduct an epidemiologic investigation of each reported Q fever case or suspect case; and
- 3. For each Q fever case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-361~~R9-6-368. Rabies in a Human

A. Case control measures: A local health agency shall:

- 1. Upon receiving a report under R9-6-202 of a human rabies case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
- 2. Conduct an epidemiologic investigation of each reported human rabies case or suspect case; ~~and~~
- 3. For each human rabies case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); ~~and~~
- 4. Ensure that a specimen from each human rabies case or suspect case, as required by the Department, is submitted to the Arizona State Laboratory.

B. Contact control measures: A local health agency shall evaluate the level of risk of transmission from each contact’s exposure to a human rabies case and, if indicated, provide or arrange for each contact to receive prophylaxis.

~~R9-6-369~~ Severe Acute Respiratory Syndrome

~~A. Case control measures: A local health agency shall:~~

- ~~1. Upon receiving a report under R9-6-202 of a severe acute respiratory syndrome case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;~~
- ~~2. In consultation with the Department, ensure the isolation of and the institution of both airborne precautions and contact precautions for a severe acute respiratory syndrome case or suspect case to prevent transmission;~~
- ~~3. Conduct an epidemiologic investigation of each reported severe acute respiratory syndrome case or suspect case; and~~
- ~~4. For each severe acute respiratory syndrome case, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(D).~~

~~B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine a severe acute respiratory syndrome contact as necessary to prevent transmission.~~

~~R9-6-362~~R9-6-369. Relapsing Fever (Borreliosis)

Case control measures: A local health agency shall:

- 1. Upon receiving a report under R9-6-202 of a borreliosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;



- ~~1-2.~~ Conduct an epidemiologic investigation of each reported borreliosis case or suspect case; and
- ~~2-3.~~ For each borreliosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D).

R9-6-370. Respiratory Disease in a Health Care Institution or Correctional Facility

Outbreak control measures:

1. A local health agency shall:
 - a. Conduct an epidemiologic investigation of each reported outbreak of respiratory disease in a health care institution or correctional facility; and
 - b. For each outbreak of respiratory disease in a health care institution or correctional facility, submit to the Department the information required under R9-6-206(E).
2. When an outbreak of respiratory disease occurs in a health care institution or correctional facility, the administrator of the health care institution or correctional facility, either personally or through a representative, shall comply with the control measures recommended by a local health agency.

~~R9-6-365-R9-6-371. Rubella (German Measles)~~

A. Case control measures:

1. An administrator of a school or child care establishment, either personally or through a representative, shall:
 - a. Exclude a rubella case from the school or child care establishment and from school- or child-care-establishment-sponsored events from the onset of illness through the seventh calendar day after the rash appears; and
 - b. Exclude a rubella suspect case from the school or child care establishment and from school- or child-care-establishment-sponsored events until evaluated and determined to be noninfectious by a physician, physician assistant, ~~or~~ registered nurse practitioner, or local health agency.
2. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, and in consultation with the local health agency, shall isolate and institute droplet precautions for a rubella case through the seventh calendar day after the rash appears.
3. An administrator of a health care institution, either personally or through a representative, shall exclude a rubella:
 - a. Case from working at the health care institution from the onset of illness through the seventh calendar day after the rash appears; and
 - b. Suspect case from working at the health care institution until evaluated and determined to be noninfectious by a physician, physician assistant, registered nurse practitioner, or local health agency.
- ~~3-4.~~ A local health agency shall:
 - a. Upon receiving a report under R9-6-202 or R9-6-203 of a rubella case or suspect case, notify the Department within ~~24 hours~~ one working day after receiving the report and provide to the Department the information contained in the report;
 - b. Conduct an epidemiologic investigation of each reported rubella case or suspect case;
 - c. For each rubella case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D); and
 - d. Ensure that one or more specimens from each rubella case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
5. An administrator of a correctional facility or shelter, either personally or through a representative, shall comply with the rubella control measures recommended by a local health agency or the Department.

B. Contact control measures:

1. An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution does not participate in the direct care of a rubella case or suspect case or of a patient who is or may be pregnant unless the worker first provides evidence of immunity to rubella consisting of:
 - a. A record of immunization against rubella given on or after the first birthday; or
 - b. A statement signed by a physician, physician assistant, registered nurse practitioner, state health officer, or local health officer affirming serologic evidence of immunity to rubella.
2. When a rubella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
 - a. Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
 - b. Comply with the local health agency's recommendations for exclusion.
3. A local health agency shall:
 - a. Determine which rubella contacts will be quarantined or excluded, according to R9-6-303, to prevent transmission; and
 - b. ~~provide~~ Provide or arrange for immunization of each non-immune rubella contact within 72 hours after last exposure, if possible.

~~R9-6-366-R9-6-372. Rubella Syndrome, Congenital~~

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for an infant congenital rubella syndrome case until:
 - a. The infant congenital rubella syndrome case reaches one year of age; or
 - b. Two successive negative virus cultures, from specimens collected at least one month apart, are obtained from the infant congenital rubella syndrome case after the infant congenital rubella syndrome case reaches three months of age.
2. A local health agency shall:



- a. Upon receiving a report under R9-6-202 of a congenital rubella syndrome case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
 - b. Conduct an epidemiologic investigation of each reported congenital rubella syndrome case or suspect case;
 - c. For each congenital rubella syndrome case, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
 - d. Ensure that one or more specimens from each congenital rubella syndrome case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory.
- B.** Contact control measures: An administrator of a health care institution shall ensure that a paid or volunteer full-time or part-time worker at a health care institution who is known to be pregnant does not participate in the direct care of a congenital rubella syndrome case or suspect case unless the worker first provides evidence of immunity to rubella that complies with ~~R9-6-365(B)(1)~~ R9-6-371(B)(1).

~~R9-6-367~~ **R9-6-373. Salmonellosis**

- A.** Case control measures: A local health agency shall:
- 1. Upon receiving a report under R9-6-202 or R9-6-203 of a salmonellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
 - ~~1-2.~~ 2. Exclude a salmonellosis case or suspect case with diarrhea from:
 - ~~a.~~ a. working ~~Working~~ as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until either of the following occurs:
 - ~~i.~~ i. Diarrhea has resolved;
 - ~~a-ii.~~ ii. Two successive cultures A stool specimen negative for Salmonella spp. are is obtained from the salmonellosis case or suspect case stool specimens collected at least 24 hours apart, or
 - ~~iii.~~ iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
 - ~~b.~~ b. Diarrhea has resolved;
 - ~~b.~~ b. Using an aquatic venue until diarrhea has resolved;
 - ~~2-3.~~ 3. Conduct an epidemiologic investigation of each reported salmonellosis case or suspect case; and
 - ~~3-4.~~ 4. For each salmonellosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).
- ~~**B.**~~ Contact control measures: A local health agency shall exclude a salmonellosis contact with diarrhea of unknown cause from working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until either of the following occurs:
- ~~1.~~ 1. Two successive cultures negative for Salmonella spp. are obtained from stool specimens collected at least 24 hours apart, or
 - ~~2.~~ 2. Diarrhea has resolved.
- ~~**C.**~~ **B.** Environmental control measures: A local health agency shall:
- 1. If an animal infected with *Salmonella* spp. is located in a private residence, provide health education for the animal's owner about salmonellosis and the risks of becoming infected with *Salmonella* spp.; and
 - 2. If an animal infected with *Salmonella* spp. is located in a setting other than a private residence:
 - a. Provide health education for the animal's owner about salmonellosis and the risks of becoming infected with *Salmonella* spp., and
 - b. Require the animal's owner to provide information to individuals with whom the animal may come into contact about salmonellosis and methods to reduce the risk of transmission.

~~R9-6-368~~ **R9-6-374. Scabies**

- A.** Case control measures:
- 1. An administrator of a school or child care establishment, either personally or through a representative, shall exclude a scabies case from the school or child care establishment until treatment for scabies is completed.
 - 2. An administrator of a health care institution or shelter, either personally or through a representative, shall exclude a scabies case from participating in the direct care of a patient or resident until treatment for scabies is completed.
 - 3. An administrator of a shelter, either personally or through a representative, shall ensure that a scabies case receives treatment for scabies and that the case's clothing and personal articles are disinfested.
 - 4. An administrator of a correctional facility, either personally or through a representative, shall ensure that a scabies case receives treatment for scabies and that the case's clothing and personal articles are disinfested.
- B.** Contact control measures: An administrator of a school, child care establishment, health care institution, or shelter, either personally or through a representative, shall advise a scabies contact with symptoms of scabies to obtain examination and, if necessary, treatment.
- C.** Outbreak control measures: A local health agency shall:
- ~~1.~~ 1. Conduct an epidemiologic investigation of each reported scabies outbreak;
 - ~~2-1.~~ 2-1. Provide health education regarding prevention, control, and treatment of scabies to individuals affected by ~~the~~ a scabies outbreak;
 - ~~3-2.~~ 3-2. When a scabies outbreak occurs in a health care institution, notify the licensing agency of the outbreak; and
 - ~~4-3.~~ 4-3. For each scabies outbreak, submit to the Department, ~~as specified in Article 2, Table 4,~~ the information required under ~~R9-6-202(E)~~ R9-6-202(D).

~~R9-6-370~~ **R9-6-375. Shigellosis**

- ~~**A.**~~ Case control measures: A local health agency shall:
- 1. Upon receiving a report under R9-6-202 or R9-6-203 of a shigellosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;



- 1-2. Exclude a shigellosis case or suspect case with diarrhea from:
- a. ~~working~~ Working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until either of the following occurs:
 - i. Diarrhea has resolved;
 - ~~a-ii. Two successive cultures~~ A stool specimen negative for *Shigella* spp. ~~are is~~ obtained from the shigellosis case or suspect case stool specimens collected at least 24 hours apart and at least 48 hours after discontinuing antibiotics, or
 - iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
 - b. Treatment is maintained for 24 hours and diarrhea has resolved;
 - b. Using an aquatic venue for one week after diarrhea has resolved;
- 2-3. Conduct an epidemiologic investigation of each reported shigellosis case or suspect case; and
- 3-4. For each shigellosis case, submit to the Department, as specified in ~~Article 2~~; Table 4 2.4, the information required under R9-6-206(D).
- ~~B.~~ Contact control measures: A local health agency shall exclude a shigellosis contact with diarrhea of unknown cause from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
1. Two successive cultures negative for *Shigella* spp. are obtained from stool specimens collected at least 24 hours apart, or
 2. Treatment has been maintained for 24 hours and diarrhea has resolved.

~~R9-6-371~~R9-6-376. Smallpox

- A. Case control measures:
1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute both airborne precautions and contact precautions for a smallpox case or suspect case, until evaluated and determined to be noninfectious by a physician, physician assistant, or registered nurse practitioner.
 2. A local health agency shall:
 - 1-a. Upon receiving a report under R9-6-202 of a smallpox case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
 - 2-b. In consultation with the Department:
 - a-i. Ensure the that isolation of and the institution of both airborne precautions and contact precautions have been instituted for a smallpox case or suspect case to prevent transmission; and
 - b-ii. Conduct an epidemiologic investigation of each reported smallpox case or suspect case; and
 - 3-c. For each smallpox case, submit to the Department, as specified in ~~Article 2~~; Table 4 2.4, the information required under R9-6-206(D); and
 - d. Ensure that a specimen from each smallpox case or suspect case, as required by the Department, is submitted to the Arizona State Laboratory.
- B. Contact control measures: A local health agency, in consultation with the Department, shall:
1. Quarantine or exclude a smallpox contact as necessary, according to R9-6-303, to prevent transmission; and
 2. Monitor the contact for smallpox symptoms, including fever, each day for 21 calendar days after last exposure.

~~R9-6-372~~R9-6-377. Spotted Fever Rickettsiosis (e.g., Rocky Mountain Spotted Fever)

- A. Case control measures: A local health agency shall:
1. Upon receiving a report under R9-6-202 of a spotted fever rickettsiosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
 2. Ensure that a spotted fever rickettsiosis case or, if the case is a child or incapacitated adult, the parent or guardian of the case receives health education about reducing the risks of becoming reinfected with or of having others become infected with spotted fever rickettsiosis;
 3. Conduct an epidemiologic investigation of each reported spotted fever rickettsiosis case or suspect case; and
 4. For each spotted fever rickettsiosis case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D).
- B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each spotted fever rickettsiosis case or suspect case and implement vector control measures as necessary.

~~R9-6-372~~R9-6-378. Streptococcal Group A Infection

- A. ~~Non-invasive streptococcal~~ Streptococcal group A infection, invasive or non-invasive:
Case control measures: An administrator of a school, child care establishment, or health care institution or a person in charge of a food establishment, either personally or through a representative, shall exclude a streptococcal group A infection case with streptococcal lesions or streptococcal sore throat from working as a food handler, attending or working in a school, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution for 24 hours after the initiation of treatment for streptococcal group A infection.
- B. Invasive streptococcal group A infection:
Outbreak control measures: A local health agency shall:
1. Conduct an epidemiologic investigation of each reported outbreak of streptococcal group A invasive infection;
 2. For each streptococcal group A invasive infection case involved in an outbreak, submit to the Department, as specified in ~~Article 2~~; Table 4 2.4, the information required under R9-6-206(D); and
 3. For each outbreak of streptococcal group A invasive infection, submit to the Department, ~~as specified in Article 2, Table 4;~~ the information required under ~~R9-6-206(F)~~ R9-6-206(E).

~~R9-6-373~~R9-6-379. Streptococcal Group B Invasive Infection in an Infant Younger Than 90 Days of Age



Case control measures: A local health agency shall:

1. Confirm the diagnosis of streptococcal group B invasive infection for each reported case or suspect case of streptococcal group B invasive infection in an infant younger than 90 days of age; and
2. For each case of streptococcal group B infection in an infant younger than 90 days of age, submit to the Department, ~~as specified in Article 2, Table 4,~~ the information required under ~~R9-6-206(C)~~ R9-6-202(C).

~~R9-6-374~~R9-6-380. *Streptococcus pneumoniae* Invasive Infection

Case control measures: A local health agency shall:

1. ~~If a reported *Streptococcus pneumoniae* infection case or suspect case is five or more years of age:~~
 - a. ~~Confirm the diagnosis of *Streptococcus pneumoniae* infection for each reported *Streptococcus pneumoniae* infection case or suspect case who is five or more years of age; and~~
 - b. ~~For each *Streptococcus pneumoniae* infection case who is five or more years of age, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(C); and~~
2. ~~If a reported *Streptococcus pneumoniae* infection case or suspect case is under five years of age:~~
 - a. ~~Conduct an epidemiologic investigation for each reported *Streptococcus pneumoniae* infection case or suspect case who is under five years of age; and~~
 - b. ~~For each *Streptococcus pneumoniae* infection case who is under five years of age, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(D).~~

Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported outbreak of *Streptococcus pneumoniae* invasive infection; and
2. For each outbreak of *Streptococcus pneumoniae* invasive infection, submit to the Department the information required under R9-6-206(E).

~~R9-6-375~~R9-6-381. Syphilis

A. Case control measures:

1. A syphilis case shall obtain serologic testing for syphilis three months, six months, and one year after initiating treatment, unless more frequent or longer testing is recommended by a local health agency.
2. A health care provider for a pregnant syphilis case shall order serologic testing for syphilis at 28 to 32 weeks gestation and at delivery.
- 2-3. A local health agency shall:
 - a. Conduct an epidemiologic investigation, including a review of medical records, of each reported syphilis case or suspect case, confirming the stage of the disease;
 - b. For each syphilis case, submit to the Department, as specified in ~~Article 2, Table 4~~ 2.4, the information required under R9-6-206(D);
 - c. If the syphilis case is pregnant, ensure that the syphilis case obtains the serologic testing for syphilis required in subsection (A)(1) and (A)(2); and
 - d. Comply with the requirements specified in R9-6-1103 concerning treatment and health education for a syphilis case.

~~3-4.~~ The operator of a blood bank, blood center, or plasma center shall notify a donor of a test result with significant evidence suggestive of syphilis, as required under A.R.S. § 32-1483 and 21 CFR 630.6.

B. Contact control measures: When a syphilis case has named a contact, a local health agency shall comply with the requirements specified in R9-6-1103 concerning notification, testing, treatment, and health education for the contact.

C. Outbreak control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported syphilis outbreak; and
2. For each syphilis outbreak, submit to the Department, ~~as specified in Article 2, Table 4,~~ the information required under ~~R9-6-206(F)~~ R9-6-206(E).

~~R9-6-376~~R9-6-382. Taeniasis

Case control measures: A local health agency shall:

1. Exclude a taeniasis case with *Taenia* spp. from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until free of infestation;
2. Conduct an epidemiologic investigation of each reported taeniasis case; and
3. For each taeniasis case, submit to the Department, as specified in ~~Article 2, Table 4~~ 2.4, the information required under R9-6-206(D).

~~R9-6-377~~R9-6-383. Tetanus

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported tetanus case or suspect case; and
2. For each tetanus case, submit to the Department, as specified in ~~Article 2, Table 4~~ 2.4, the information required under R9-6-206(D).

~~R9-6-384~~. Expired

~~R9-6-378~~R9-6-384. Toxic Shock Syndrome

Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported toxic shock syndrome case or suspect case; and
2. For each toxic shock syndrome case, submit to the Department, as specified in ~~Article 2, Table 4~~ 2.4, the information required under R9-6-206(D).

~~R9-6-379~~R9-6-385. Trichinosis



Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a trichinosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported trichinosis case or suspect case; and
- ~~2-3.~~ For each trichinosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D).

~~R9-6-380, R9-6-386.~~ Tuberculosis

A. Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and institute airborne precautions for: ~~an individual with infectious active tuberculosis or a suspect case until:~~
 - a. An individual with infectious active tuberculosis until:
 - ~~i.~~ At least three successive sputum smears collected at least eight hours apart, at least one of which is taken first thing in the morning as soon as possible after the individual awakens from sleep, are negative for acid-fast bacilli;
 - ~~b-ii.~~ Anti-tuberculosis treatment is initiated with multiple antibiotics; and
 - ~~e-iii.~~ Clinical signs and symptoms of active tuberculosis are improved;
 - b. A suspect case of infectious active tuberculosis until:
 - ~~i.~~ At least two successive tests for tuberculosis, using a product and methodology approved by the U.S. Food and Drug Administration for use when making decisions whether to discontinue isolation and airborne precautions, for the suspect case are negative; or
 - ~~ii.~~ At least three successive sputum smears collected from the suspect case as specified in subsection (A)(1)(a)(i) are negative for acid-fast bacilli, anti-tuberculosis treatment of the suspect case is initiated with multiple antibiotics, and clinical signs and symptoms of active tuberculosis are improved; and
 - ~~d-c.~~ For a A case or suspect case of multi-drug resistant active tuberculosis, until a tuberculosis control officer has approved the release of the case or suspect case.
2. An administrator of a health care institution, either personally or through a representative, shall notify a local health agency at least one working day before discharging a tuberculosis case or suspect case.
3. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 of a tuberculosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
 - ~~a-b.~~ Exclude an individual with infectious active tuberculosis or a suspect case from working, unless the individual's work setting has been approved by a tuberculosis control officer, until the individual with infectious active tuberculosis or suspect case is released from airborne precautions according to the applicable criteria in subsection (A)(1);
 - ~~i.~~ At least three successive sputum smears collected at least eight hours apart, at least one of which is taken first thing in the morning as soon as possible after the individual awakens from sleep, are negative for acid-fast bacilli;
 - ~~ii.~~ Anti-tuberculosis treatment is initiated with multiple antibiotics;
 - ~~iii.~~ Clinical signs and symptoms of active tuberculosis are improved; and
 - ~~iv.~~ For a case of multi-drug resistant active tuberculosis, a tuberculosis control officer has approved the release of the case from airborne precautions;
 - ~~b-c.~~ Conduct an epidemiologic investigation of each reported tuberculosis case, ~~or suspect case, or latent infection in a child five years of age or younger;~~
 - ~~e-d.~~ For each tuberculosis case or suspect case, submit to the Department, as specified in ~~Article 2~~, Table 4 ~~2.4~~, the information required under R9-6-206(D);
 - ~~d-e.~~ Ensure that an isolate or a specimen, as available, from each tuberculosis case is submitted to the Arizona State Laboratory; and
 - ~~e-f.~~ Comply with the requirements specified in R9-6-1202.

B. Contact control measures:

1. A contact of an individual with infectious active tuberculosis shall allow a local health agency to evaluate the contact's tuberculosis status.
2. A local health agency shall comply with the tuberculosis contact control measures specified in R9-6-1202.

C. An individual is not a tuberculosis case if the individual has a positive result from an approved test for tuberculosis but does not have clinical signs or symptoms of disease.

~~R9-6-387.~~ Vancomycin-Resistant *Staphylococcus epidermidis*

Case control measures:

- ~~1.~~ A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for a case or suspect case of vancomycin-resistant *Staphylococcus epidermidis*.
2. A local health agency shall:
 - a. ~~Upon receiving a report under R9-6-202 of a case or suspect case of vancomycin-resistant *Staphylococcus epidermidis*, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;~~
 - b. ~~Conduct an epidemiologic investigation of each reported case or suspect case of vancomycin-resistant *Staphylococcus epidermidis*;~~
 - e. ~~For each case of vancomycin-resistant *Staphylococcus epidermidis*, submit to the Department, as specified in Article 2, Table 4, the information required under R9-6-206(D); and~~



- d. ~~Ensure that an isolate from each case of vancomycin-resistant *Staphylococcus epidermidis* is submitted to the Arizona State Laboratory.~~

~~R9-6-381~~R9-6-387. Tularemia

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate a pneumonic tularemia case until 72 hours of antibiotic therapy have been completed with favorable clinical response.
2. A local health agency shall:
 - a. Upon receiving a report under R9-6-202 of a tularemia case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
 - b. Conduct an epidemiologic investigation of each reported tularemia case or suspect case;
 - c. For each tularemia case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
 - d. Ensure that an isolate or a specimen, as available, from each tularemia case or suspect case is submitted to the Arizona State Laboratory.

~~R9-6-382~~R9-6-388. Typhoid Fever

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a typhoid fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported typhoid fever case or suspect case;
- ~~2-3.~~ For each typhoid fever case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D);
- ~~3-4.~~ Exclude a typhoid fever case or suspect case from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until:
 - a. At least one month after the date of onset of illness; and
 - b. After ~~three~~ two successive ~~cultures stool specimens, collected from the typhoid fever case at least 24 hours apart and at least 48 hours after cessation of antibiotic therapy, are negative for *Salmonella typhi* have been obtained from stool specimens collected at least 24 hours apart and at least 48 hours after cessation of antibiotic therapy;~~
- ~~4-5.~~ If a ~~culture stool specimen~~ from a typhoid fever case who has received antibiotic therapy is positive for *Salmonella typhi*, enforce the exclusions specified in subsection ~~(A)(3)~~ (A)(4) until ~~three~~ two successive ~~cultures stool specimens, collected from the typhoid fever case at least one month apart and 12 or fewer months after the date of onset of illness, are negative for *Salmonella typhi* are obtained from stool specimens collected at least one month apart and 12 or fewer months after the date of onset of illness;~~
- ~~5-6.~~ If a positive ~~culture is obtained on a stool specimen, collected at least 12 months after onset of illness, is obtained~~ from a typhoid fever case who has received antibiotic therapy, redesignate the case as a carrier; and
- ~~6-7.~~ Exclude a typhoid fever carrier from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until ~~three successive cultures stool specimens, collected from the typhoid fever carrier at least one month apart, are negative for *Salmonella typhi* have been obtained from stool specimens collected at least one month apart, at least one by purging.~~

B. Contact control measures: A local health agency shall exclude a typhoid fever contact from working as a food handler, caring for children in or attending a child care establishment, or caring for patients or residents in a health care institution until two successive ~~cultures stool specimens, collected from the typhoid fever contact at least 24 hours apart, are negative for *Salmonella typhi* are obtained from stool specimens collected at least 24 hours apart.~~

~~R9-6-383~~R9-6-389. Typhus Fever

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a typhus fever case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported typhus fever case or suspect case; and
- ~~2-3.~~ For each typhus fever case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-385~~R9-6-390. Vaccinia-related Adverse Event

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a case or suspect case of a vaccinia-related adverse event, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~1-2.~~ Conduct an epidemiologic investigation of each reported case or suspect case of a vaccinia-related adverse event; and
- ~~2-3.~~ For each case of a vaccinia-related adverse event, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-386~~R9-6-391. Vancomycin-Resistant or Vancomycin-Intermediate *Staphylococcus aureus*

Case control measures:

1. A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement contact precautions for a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*.



2. A diagnosing health care provider or an administrator of a health care institution transferring a known case with active infection or a known carrier of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* to another health care provider or health care institution shall, either personally or through a representative, comply with R9-6-305.
- 2-3. A local health agency, in consultation with the Department, shall:
- Upon receiving a report under R9-6-202 of a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, notify the Department within ~~24 hours~~ one working day after receiving the report and provide to the Department the information contained in the report;
 - ~~Isolate~~ Ensure that a case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* is isolated as necessary to prevent transmission;
 - Conduct an epidemiologic investigation of each reported case or suspect case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*;
 - For each case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus*, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
 - Ensure that an isolate or a specimen, as available, from each case of vancomycin-resistant or vancomycin-intermediate *Staphylococcus aureus* is submitted to the Arizona State Laboratory.

~~R9-6-388~~R9-6-392. Varicella (Chickenpox)

- A. Case control measures:
- An administrator of a school or child care establishment, either personally or through a representative, shall exclude a varicella case from the school or child care establishment and from school- or child-care-establishment-sponsored events until lesions are dry and crusted.
 - An administrator of a health care institution, either personally or through a representative, shall isolate and implement airborne precautions for a varicella case until the case is no longer infectious.
 - A local health agency shall:
 - Conduct an epidemiologic investigation of each reported case of death due to primary varicella infection; and
 - For each reported case of death due to varicella infection, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).
- B. Contact control measures:
- When a varicella case has been at a school or child care establishment, the administrator of the school or child care establishment, either personally or through a representative, shall:
 - Consult with the local health agency to determine who shall be excluded and how long each individual shall be excluded from the school or child care establishment, and
 - Comply with the local health agency's recommendations for exclusion.
 - A local health agency shall determine which contacts of a varicella case will be:
 - Excluded from a school or child care establishment, and
 - Advised to obtain an immunization against varicella.

~~R9-6-389~~R9-6-393. *Vibrio* Infection

Case control measures: A local health agency shall:

- Upon receiving a report under R9-6-202 of a *Vibrio* infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~2~~3. Exclude a *Vibrio* infection case or suspect case with diarrhea from:
 - ~~working~~ Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until either of the following occurs:
 - ~~Two successive cultures negative for *Vibrio* spp. are obtained from stool specimens collected at least 24 hours apart, or~~
 - ~~Diarrhea has resolved;~~ The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
 - Using an aquatic venue until diarrhea has resolved;
- ~~2-3~~3. Conduct an epidemiologic investigation of each reported *Vibrio* infection case or suspect case; and
- ~~3-4~~4. For each *Vibrio* infection case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D).

~~R9-6-394~~. **Expired**

~~R9-6-390~~R9-6-394. Viral Hemorrhagic Fever

- A. Case control measures:
- A diagnosing health care provider or an administrator of a health care institution, either personally or through a representative, shall isolate and implement both droplet precautions and contact precautions for a viral hemorrhagic fever case or suspect case for the duration of the illness.
 - A local health agency shall:
 - Upon receiving a report under R9-6-202 of a viral hemorrhagic fever case or suspect case, notify the Department within 24 hours after receiving the report and provide to the Department the information contained in the report;
 - Conduct an epidemiologic investigation of each reported viral hemorrhagic fever case or suspect case;
 - For each viral hemorrhagic fever case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
 - Ensure that one or more specimens from each viral hemorrhagic fever case or suspect case are submitted to the Arizona State Laboratory.



B. Contact control measures: A local health agency, in consultation with the Department, shall quarantine a viral hemorrhagic fever contact as necessary to prevent transmission.

~~R9-6-391~~R9-6-395. West Nile Virus-related Syndromes Virus Infection

A. Case control measures: A local health agency shall:

1. Conduct an epidemiologic investigation of each reported West Nile ~~virus-related syndrome~~ virus infection case or suspect case; ~~and~~
2. For each case of West Nile ~~virus-related syndrome~~ virus infection, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); ~~and~~
3. Ensure that each West Nile virus infection case is provided with health education that includes measures to:
 - a. Avoid mosquito bites, and
 - b. Reduce mosquito breeding sites.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each West Nile virus infection case or suspect case and implement vector control measures as necessary.

~~R9-6-392~~R9-6-396. Yellow Fever

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a yellow fever case or suspect case, notify the Department within ~~one working day~~ 24 hours after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported yellow fever case or suspect case; ~~and~~
3. For each yellow fever case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D);
4. Ensure that each yellow fever case is provided with health education that includes measures to:
 - a. Avoid mosquito bites, and
 - b. Reduce mosquito breeding sites; and
5. Ensure that an isolate or a specimen, as available, from each yellow fever case or suspect case is submitted to the Arizona State Laboratory.

B. Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each yellow fever case or suspect case and implement vector control measures as necessary.

~~R9-6-393~~R9-6-397. Yersiniosis (Enteropathogenic Yersinia)

Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a yersiniosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
- ~~2.~~ Exclude a yersiniosis case or suspect case with diarrhea from:
 - a. ~~working~~ Working as a food handler, caring for patients or residents in a health care institution, or caring for children in or attending a child care establishment until ~~either of the following occurs:~~
 - i. Diarrhea has resolved;
 - ~~a-ii. Two successive cultures~~ A stool specimen negative for enteropathogenic Yersinia ~~are is obtained from stool specimens collected the case or suspect case at least 24 hours apart and at least 48 hours after discontinuing antibiotics, or~~
 - iii. The local health agency has determined that the case or suspect case is unlikely to infect other individuals; and
 - b. ~~Diarrhea has resolved;~~
 - Using an aquatic venue for two weeks after diarrhea has resolved;
2. Upon receiving a report under R9-6-202 of a yersiniosis case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
3. Conduct an epidemiologic investigation of each reported yersiniosis case or suspect case;
4. For each yersiniosis case, submit to the Department, as specified in ~~Article 2~~, Table 4 2.4, the information required under R9-6-206(D); and
5. Ensure that an isolate or a specimen, as available, from each yersiniosis case is submitted to the Arizona State Laboratory.

R9-6-398. Zika Virus Infection

A. Case control measures: A local health agency shall:

1. Upon receiving a report under R9-6-202 of a Zika virus infection case or suspect case, notify the Department within one working day after receiving the report and provide to the Department the information contained in the report;
2. Conduct an epidemiologic investigation of each reported Zika virus infection case or suspect case;
3. For each Zika virus infection case, submit to the Department, as specified in Table 2.4, the information required under R9-6-206(D);
4. Ensure that one or more specimens from each Zika virus infection case or suspect case, as required by the Department, are submitted to the Arizona State Laboratory; and
5. Provide to the Zika virus infection case or ensure that another person provides to the Zika virus infection case health education that includes measures to:
 - a. Avoid mosquito bites,
 - b. Reduce mosquito breeding sites, and
 - c. Reduce the risk of sexual or congenital transmission of Zika virus.



- B.** Environmental control measures: In cooperation with the Department, a local health agency or another local agency responsible for vector control within a jurisdiction shall conduct an assessment of the environment surrounding each Zika virus infection case or suspect case and implement vector control measures as necessary.

ARTICLE 10. HIV-RELATED TESTING AND NOTIFICATION

R9-6-1002. Local Health Agency Requirements

For each HIV-infected individual or suspect case, a local health agency shall comply with the requirements in ~~R9-6-341~~ R9-6-347.

ARTICLE 11. STD-RELATED TESTING AND NOTIFICATION

R9-6-1102. Health Care Provider Requirements

When a laboratory report for a test ordered by a health care provider for a subject indicates that the subject is infected with an STD, the ordering health care provider or the ordering health care provider's designee shall:

1. Describe the test results to the subject;
2. Provide or arrange for the subject to receive the following information about the STD for which the subject was tested:
 - a. A description of the disease or syndrome caused by the STD, including its symptoms;
 - b. Treatment options for the STD and where treatment may be obtained;
 - c. A description of how the STD is transmitted to others;
 - d. A description of measures to reduce the likelihood of transmitting the STD to others and that it is necessary to continue the measures until the infection is eliminated;
 - e. That it is necessary for the subject to notify individuals who may have been infected by the subject that the individuals need to be tested for the STD;
 - f. The availability of assistance from local health agencies or other resources; and
 - g. The confidential nature of the subject's test results;
3. Report the information required in R9-6-202 to a local health agency; and
4. If the subject is pregnant and is a syphilis case, inform the subject of the requirement ~~in R9-6-375~~ that the subject obtain serologic testing for syphilis ~~three months, six months, and one year after initiating treatment for syphilis~~ according to R9-6-381.

R9-6-1103. Local Health Agency Requirements

- A.** For each STD case, a local health agency shall:
1. Comply with the requirements in:
 - a. ~~R9-6-313(A)(1) and (2)~~ R9-6-317(A)(1) and (2) for each chancroid case reported to the local health agency, and
 - b. ~~R9-6-375(A)(2)(a) through (c)~~ R9-6-381(A)(3)(a) through (c) for each syphilis case reported to the local health agency;
 2. Offer or arrange for treatment for each STD case that seeks treatment from the local health agency for symptoms of:
 - a. Chancroid,
 - b. Chlamydia infection,
 - c. Gonorrhea, or
 - d. Syphilis;
 3. Provide information about the following to each STD case that seeks treatment from the local health agency:
 - a. A description of the disease or syndrome caused by the applicable STD, including its symptoms;
 - b. Treatment options for the applicable STD;
 - c. A description of measures to reduce the likelihood of transmitting the STD to others and that it is necessary to continue the measures until the infection is eliminated; and
 - d. The confidential nature of the STD case's test results; and
 4. Inform the STD case that:
 - a. A chlamydia or gonorrhea case must notify each individual, with whom the chlamydia or gonorrhea case has had sexual contact within 60 days preceding the onset of chlamydia or gonorrhea symptoms up to the date the chlamydia or gonorrhea case began treatment for chlamydia or gonorrhea infection, of the need for the individual to be tested for chlamydia or gonorrhea; and
 - b. The Department or local health agency will notify, as specified in subsection (B), each contact named by a chancroid or syphilis case.
- B.** For each contact named by a chancroid or syphilis case, the Department or a local health agency shall:
1. Notify the contact named by a chancroid or syphilis case of the contact's exposure to chancroid or syphilis and of the need for the contact to be tested for:
 - a. Chancroid, if the chancroid case has had sexual contact with the contact within 10 days preceding the onset of chancroid symptoms up to the date the chancroid case began treatment for chancroid infection; or
 - b. Syphilis, if the syphilis case has had sexual contact with the contact within:
 - i. 90 days preceding the onset of symptoms of primary syphilis up to the date the syphilis case began treatment for primary syphilis infection;
 - ii. Six months preceding the onset of symptoms of secondary syphilis up to the date the syphilis case began treatment for secondary syphilis infection; or
 - iii. 12 months preceding the date the syphilis case was diagnosed with syphilis if the syphilis case cannot identify when symptoms of primary or secondary syphilis began;
 2. Offer or arrange for each contact named by a chancroid or syphilis case to receive testing and, if appropriate, treatment for chancroid or syphilis; and
 3. Provide information to each contact named by a chancroid or syphilis case about:
 - a. The characteristics of the applicable STD,
 - b. The syndrome caused by the applicable STD,



- c. Measures to reduce the likelihood of transmitting the applicable STD, and
- d. The confidential nature of the contact’s test results.
- C. For each contact of a chlamydia or gonorrhea case who seeks treatment from a local health agency for symptoms of chlamydia or gonorrhea, the local health agency shall:
 - 1. Offer or arrange for treatment for chlamydia or gonorrhea;
 - 2. Provide information to each contact of a chlamydia or gonorrhea case about:
 - a. The characteristics of the applicable STD,
 - b. The syndrome caused by the applicable STD,
 - c. Measures to reduce the likelihood of transmitting the applicable STD, and
 - d. The confidential nature of the contact’s test results.

ARTICLE 12. TUBERCULOSIS CONTROL

R9-6-1202. Local Health Agency Reporting Requirements

- A. Within 30 days after receiving information, a local health agency shall report to the Department regarding:
 - 1. Each individual in its jurisdiction who has been diagnosed with active tuberculosis,
 - 2. Each individual in its jurisdiction who is suspected of having active tuberculosis, and
 - 3. Each individual in its jurisdiction who is believed to have been exposed to an individual with infectious active tuberculosis.
- B. Each report made under subsection (A) shall consist of completed Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Form CDC 72.9A and B, “Report of Verified Case of Tuberculosis” (January 2003), which is incorporated by reference in ~~R9-6-373~~, or a completed electronic equivalent to Form CDC 72.9A and B provided by the Department.

NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 25. DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES

[R17-168]

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action</u>
Article 13	Amend
R9-25-1301	Amend
R9-25-1302	Amend
R9-25-1303	Renumber
R9-25-1303	Amend
R9-25-1303.01	New Section
R9-25-1304	Renumber
R9-25-1304	Amend
R9-25-1305	Repeal
R9-25-1305	Renumber
R9-25-1305	Amend
R9-25-1306	Repeal
R9-25-1306	Renumber
R9-25-1306	New Section
R9-25-1307	Repeal
R9-25-1307	Renumber
R9-25-1307	Amend
R9-25-1308	Renumber
R9-25-1308	Amend
Table 1	Repeal
Exhibit I	Repeal
Table 13.1	New Section
R9-25-1309	Renumber
R9-25-1309	New Section
R9-25-1310	Repeal
R9-25-1310	Renumber
R9-25-1310	Amend
R9-25-1311	Repeal
R9-25-1312	Renumber
R9-25-1313	Renumber
R9-25-1315	Repeal
Article 14	Repeal
R9-25-1401	Repeal
R9-25-1402	Repeal
Table 1	Repeal



R9-25-1403	Repeal
R9-25-1405	Repeal
R9-25-1406	Renumber

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statutes: A.R.S. §§ 36-132(A)(1), 36-136(F), and 36-2202(A)(4)
 Implementing statutes: A.R.S. §§ 36-2208(A), 36-2221, and 36-2225

3. The effective date of the rules:

January 1, 2018

The Arizona Department of Health Services (Department) requests an effective date of January 1, 2018, to provide sufficient time for the Department and stakeholders to implement the new rules.

4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 22 A.A.R. 1612, June 17, 2016

Notice of Proposed Rulemaking: 23 A.A.R. 1067, May 12, 2017

5. The agency's contact person who can answer questions about the rulemaking:

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 Bureau of Emergency Medical Services and Trauma System
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 or
 Name: Robert Lane, Chief
 Address: Arizona Department of Health Services
 Office of Administrative Counsel and Rules
 150 N. 18th Ave., Suite 200
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6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Revised Statutes (A.R.S.) § 36-2225 requires the Department to develop and administer a statewide emergency medical services and trauma system to implement the Arizona emergency medical services and trauma system plan, required under A.R.S. § 36-2208. A.R.S. § 36-2225 further requires the Department to adopt rules for the designation of trauma centers and to require trauma centers to submit data to the trauma registry established by the Department under A.R.S. § 36-2208. The Department has implemented these statutes in Arizona Administrative Code (A.A.C.) Title 9, Chapter 25, Articles 13 and 14. In 9 A.A.C. 25, Article 13, the Department specifies the processes by which a health care institution may voluntarily request designation. Any hospital in Arizona that meets applicable standards of the American College of Surgeons Committee on Trauma (ACS) or standards specified in the rule (state standards) may apply for and receive a designation as a Level I, II, or III trauma center. Any health care institution in Arizona that meets applicable state standards may apply for and receive a designation as a Level IV trauma center. A.R.S. § 36-2225 allows three methods to become a trauma center, but the rules only specify two methods. According to 9 A.A.C. 25, Article 14, all trauma centers are required to report to the trauma registry using ICD-9 codes. At the same time, all Arizona hospitals are required by the Centers for Medicare and Medicaid Services to use ICD-10 codes when billing for services. This may result in an expensive duplicate reporting system for hospitals. In addition, several issues have arisen with the current system for provisional designation as a trauma center. For example, the rules appear to limit submission to less than 12 consecutive months of data. This is problematic since the Department encourages the submission of data by hospitals that are not trauma centers to obtain a more complete view of trauma services in the state and to enable the Department to provide technical assistance to a hospital that may seek designation as a trauma center in the future. After receiving an exception from the Governor's rulemaking moratorium established by Executive Order 2016-03, the Department is revising the rules to address these concerns, update application and other requirements, remove obsolete requirements, and improve the effectiveness of the rules. The changes will conform to rulemaking format and style requirements of the Governor's Regulatory Review Council and the Office of the Secretary of State.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review or rely on any study for this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

**9. The summary of the economic, small business, and consumer impact:**

This analysis covers costs and benefits associated with the rule changes and does not describe effects imposed by statutes. No new FTEs will be required due to this rulemaking. Annual cost/revenue changes are designated as minimal when more than \$0 and \$5,000 or less, moderate when between \$5,000 and \$30,000, and substantial when \$30,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification. The Department anticipates that persons affected by the rulemaking include the Department; designated trauma centers or health care institutions that may seek designation in the future; health insurance providers, including AHCCCS; tribal or federal agencies operating a hospital or other health care institution under federal or tribal law; ambulance services and other EMS providers, as well as their emergency medical care technicians (EMCTs); physicians and other health care providers; the American College of Surgeons Committee on Trauma (ACS); trauma patients and their families, and the general public.

The Department anticipates that changes to update and make the rules clearer and easier to understand may remove the need for three substantive policy statements and provide the Department with as much as a minimal benefit through reducing the number of questions the Department receives to interpret the rules and being able to rescind the substantive policy statements. Additional information being collected as part of an application may provide the Department with a significant benefit. Clarifying and updating requirements related to inspections, requirements related to designation and dedesignation, and requirements related to trauma registry data quality and usefulness may provide a significant benefit to the Department while causing at most minimal costs to the Department. The new rules allow a health care institution to request designation as a Level III trauma center through Department assessment, with no review by a national verification organization, and add the safety-net process the Department has been providing for health care institutions that had applied for review by a national verification organization. The Department may receive a significant benefit from having a process included in rule for state assessment for more than Level IV trauma centers and incur a moderate cost for developing inspection and review criteria for Level III trauma centers and for formalizing the safety-net process for Level I and Level II trauma centers.

Since the new rules were developed to improve the trauma system within Arizona and, thus, the outcomes for patients suffering an injury due to trauma, the changes in the new rules may allow patients who would otherwise have died of their injuries to survive. The changes in the new rules may also reduce disability and lengths of stay for patients who would have survived the trauma, regardless of changes made to the rules. Therefore, the rules changes may cause a health insurance company or health plan to incur up to substantial cost increases for hospitalization and rehabilitation costs for patients who would otherwise have died and receive up to substantial cost reductions from patients who would otherwise have had poorer outcomes and required longer lengths of stay.

ACS is specified in the current rule as the only means to designation for Level I, Level II, and Level III trauma centers, either through verification or through ACS stating that the health care institution meets the standards specified in rule. Under the new rules, a health care institution seeking designation as a Level III trauma center will no longer be required to apply for review through ACS or another national verification organization. Nor is ACS specified as the only national verification organization that may provide verification for any Level. The Department anticipates that ACS may incur a moderate-to-substantial revenue loss due to the rule changes, depending on how many current trauma centers, or other health care institutions seeking initial designation, choose a route to designation other than through ACS assessment.

Of the 41 hospitals designated as trauma centers, two are publically owned. As mentioned above, currently all health care institutions wanting to be designated as a Level I trauma center, Level II trauma center, or Level III trauma center are required by rule to apply to ACS for verification and obtain either verification or documentation issued by ACS stating that the health care institution meets the state standards for the specific Level of trauma center. However, a health care institution applying for designation as a Level IV trauma center is assessed by the Department. Under the new rules, a health care institution may continue to obtain designation as a Level III trauma center based on verification by a national verification organization but may also achieve designation through a Department assessment, without ACS review. Conversely, a health care institution applying for designation as a Level IV trauma center may obtain designation as a Level IV trauma center based on assessment by a national verification organization as well as through Department assessment. The new rules also ensure that the Department may serve as a safety net for Arizona's Level I and Level II trauma centers, providing requirements for the use of this process similar to those currently being used by the Department. The Department anticipates that these changes may provide a health care institution with up to a substantial benefit, depending on the decisions made by the health care institution. In the unlikely possibility that a health care institution plans to pursue designation as a Level IV trauma center through verification, the health care institution could incur up to a substantial cost increase. The Department anticipates that a requirement that verification or assessment of compliance with state standards be dated within six months before the date of an application for designation may impose up to a substantial burden on a health care institution by requiring the health care institution to submit an application to ACS (or another national verification organization) earlier than had been the practice under the current rules. However, the requirement may also provide up to a substantial benefit to a health care institution since earlier scheduling would give the health care institution time to receive documentation of verification or denial of verification before the date of application and allow the health care institution to apply based on assessment of compliance with state standards if necessary.

At the request of stakeholders, the Department added categories and associated requirements for Level I Pediatric trauma centers and Level II Pediatric trauma centers to the rules, consistent with requirements used by ACS for verification of hospitals as these categories of trauma facilities. If a hospital were designated as a Level I Pediatric trauma center or Level II Pediatric trauma center, the hospital might expect to receive more critically injured pediatric patients, resulting in up to a substantial increase in revenue for the hospital. Although the Department believes that a health care institution would not seek designation as a Level I Pediatric trauma center or Level II Pediatric trauma center if the health care institution did not already comply with these requirements, compliance would cause a substantial cost to an unprepared health care institution. Clarifying that an outpatient treatment center authorized to provide emergency room services is eligible to become a Level IV trauma center may provide up to a substantial benefit to an outpatient treatment center that becomes designated, since it may receive more patients requiring trauma care.



Although seeking to obtain designation is at the discretion of a health care institution and is not required by the rules, an outpatient treatment center authorized to provide emergency services that is seeking designation may incur up to substantial costs to comply with requirements in the rules.

The Department anticipates that updated requirements in an application for initial designation or to renew designation may cause a minimal cost to a health care institution applying for designation. This includes the requirement that a health care institution not licensed by the Department would need to provide, as part of an application, documentation demonstrating that the health care institution is operating as an administrative unit of the U.S. government or a sovereign tribal nation. In addition, having to undergo a review of the health care institution's capabilities and staffing, rather than just attesting to meeting the requirements for provisional designation, as in the current rules, may cause up to a substantial burden on a health care institution seeking designation that does not have the requisite capabilities. However, changes phasing out provisional designation, rather than removing it totally as of the effective date of the rules, could provide a health care institution with as much as a substantial benefit, depending on whether the health care institution has provisional designation and whether it can meet standards specified in rule or for verification by a national verification organization by the effective date.

The Department anticipates that changes made in the new R9-25-1306 may provide a significant benefit to a health care institution in knowing how and under what circumstances an inspection may be made and from the Department's flexibility in determining whether an inspection is necessary. The changes may also cause up to a substantial cost to a health care institution that may not be in compliance at the time a random announced inspection is scheduled. Similarly, the clarifications made in R9-25-1307, reduction in the time to process an application, and changes in the term for a modified designation should provide a significant benefit to a health care institution.

Reorganizing requirements that had been in Exhibit I or its footnotes into R9-25-1308, removing the footnotes, and specifying which requirements apply to all trauma centers and which only apply to a trauma center whose designation is not based on verification may improve clarity and provide a significant benefit to a trauma center or a health care institution considering designation. The Department believes that changes requiring a health care institution to develop policies and procedures for operating rooms and operating room teams may cause a health care institution to incur minimal-to-moderate costs, but that a health care institution will receive up to a substantial benefit from not having a requirement that an operating room team in a Level I trauma center is on the premises at all times, as long as the team is present within 15 minutes after notification or patient arrival, whichever is later. Similarly, a surgeon on the trauma team of a Level I trauma center is required by the new rules to be present in the emergency department within 15 minutes after notification or at the time the patient arrives in the emergency department, whichever is later. In both cases, response times and patient outcomes are required to be monitored through the performance improvement program. The new rules also require a patient transfer plan rather than a patient transfer agreement, due to difficulties experienced by some tribal health care institutions in complying with the requirement for a patient transfer agreement, and may provide a significant benefit to a health care institution. As requested by stakeholders, the Department is allowing health care institutions under the same governing authority to establish a single, centralized trauma registry and submit consolidated information from the trauma registry to the Department if specific requirements are met. A health care institution meeting these requirements may receive up to a substantial benefit from having a centralized trauma registry.

The Department believes that replacing the requirement for ATLS, defined in the current R9-25-1301, with a requirement for a "trauma critical care course," as defined in the new R9-25-1301, may provide a health care institution with as much as a moderate benefit. Requirements in Exhibit I related to the availability of blood products were clarified in the new rules, with policies and procedures being required in R9-25-1308 for the availability of blood products, consistent with the Level of trauma center, which may cause a trauma center to incur minimal costs in developing these policies and procedures if they have not already been developed and implemented. Some requirements that had been listed in Exhibit I and were moved into R9-25-1308 unchanged may be clearer in the new rules, providing a significant benefit to a health care institution. Other elements of Exhibit I were retained in Table 13.1, with unnecessary requirements removed. These changes may provide a significant benefit to a health care institution due to the improved clarity of the rules.

Some requirements that are now standards of care were added to Table 13.1 to improve patient health and safety. The Department estimates that these additions could cause a health care institution that does not meet these requirements and plans to seek designation as a trauma center to incur substantial costs. However, the health care institution could also receive a substantial benefit from compliance with these standards and from receiving a designation. The Department also anticipates that the clarification of what information from a health care institution's trauma registry is required to be submitted may provide a significant benefit to a submitting health care institution. Some additional information is being required to be submitted, but health care institutions have already been voluntarily providing much of this information. The Department anticipates that a health care institution that had not been submitting this additional information may incur at most a moderate increased cost. Since health care institutions use information from the trauma registry to assess the performance of staff, determine opportunities for improvement in trauma care, and the need for education or outreach in the community, the Department anticipates that the addition of this information and the removal of requirements for hard-to-collect information may provide a significant benefit to a health care institution.

The Department anticipates that having rules to follow that are clearer and easier to understand may provide a significant benefit to physicians and other health care providers working in a trauma center. Physicians and other health care providers may incur a minimal cost to participate in monitoring trauma care parameters as part of the trauma center's performance improvement program. They may also receive a significant benefit from being able to assess what treatment strategies worked better than others to enable them to provide better clinical care to their patients. Being required to be present in the emergency department within 15 minutes after notification or at the time the patient arrives in the emergency department, whichever is later, rather than being on the premises at all times may also provide a significant benefit to a physician who is a surgeon or other member of a trauma team in a Level I trauma center. Making a more general requirement for training consistent with the ATLS course may also provide a significant benefit to a physician. Since the use of physician assistants and registered nurse practitioners was not as extensive when the



current rules were adopted as it is today, there are few requirements specific to these health care providers in the current rules. Requirements in the new rules for these health care providers to obtain and maintain current certification in a trauma critical care course may cause a physician assistant or registered nurse practitioner to incur none-to-minimal costs for the course. The new rules may also provide up to a substantial benefit to a physician assistant or registered nurse practitioner if the rules encourage a trauma center to employ more physician assistants or registered nurse practitioners.

EMS providers and ambulance services provide a trauma center with information about treatment provided to a patient during transport. Some of this information is included in the trauma center’s trauma registry and is submitted to the Department. The Department believes that an EMS provider or ambulance service may receive a significant benefit from the clarification of what information is required to be provided to a trauma center. Updating requirements related to trauma registry data to improve data quality and usefulness may also provide a significant benefit to an EMS provider or ambulance service, as well as to an EMCT. Providing additional information to a trauma center, such as the incident number, country of injury, activity that the patient was engaged in at the time of the injury, and type of vehicle involved in the injury, if applicable, may impose up to a minimal burden on an EMS provider or ambulance service, as well as on an EMCT.

The Department believes that clarifying and updating requirements related to providing a trauma service are expected to improve the care of trauma patients and may provide a significant benefit to trauma patients and their families. The Department anticipates that the general public will receive a significant benefit from the rules changes, which were developed to improve trauma service and patient outcomes.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

Based on a stakeholder comment, R9-25-1308(B)(7)(f) was changed to clarify the types of issues the policies and procedures should address. The Department also clarified requirements related to the renewal of a one-year designation by separating requirements that had been in R9-25-1307(F) into revised R9-25-1307(F) and (G), renumbering subsequent subsections in R9-25-1307, and making corresponding changes to cross-references. Minor grammatical changes were also made at the request of Council staff. The Department does not believe these are substantive changes.

11. An agency’s summary of the public stakeholder comments made about the rulemaking and the agency response to the comments:

The Department received two written comments during the public comment period. The Department thanks the stakeholders for their comments. The Department held an oral proceeding for the proposed rules on June 15, 2017, which two stakeholders/members of the public attended but at which no oral comments were provided. A summary of the concerns expressed in the written comments are shown below, along with the Department’s responses.

Comment	Department’s Response
<p>A comment was made by the Arizona Hospital and Healthcare Association (AzHHA) asking why a “corrective action pathway” to designation does not exist for Level III or Level IV trauma centers and asking that Level III and Level IV trauma centers be included in R9-25-1302(C).</p>	<p>R9-25-1302(C) provides the “safety-net” pathway for Level I and Level II trauma centers, which cannot otherwise apply for designation based on the Department’s assessment. A “corrective action pathway” to designation already exists in the new rules for Level III or Level IV trauma centers. A hospital is eligible for designation as a Level III trauma center, according to R9-25-1302(A)(2)(c)(iii), and a health care institution is eligible for designation as a Level IV trauma center, according to R9-25-1302(B)(2)(b), based on the Department’s assessment against standards in R9-25-1308 and Table 13.1. As part of the Department’s assessment of an applicant’s compliance with requirements in statute or rule, the Department may conduct an inspection of the facility according to R9-25-1306 and may accept a corrective action plan submitted according to R9-25-1306(E). According to R9-25-1307(E)(2), the Department may designate a health care institution as a trauma center if the trauma center is in substantial compliance with applicable requirements in the Article and the Department has accepted a corrective action plan submitted according to R9-25-1306(E). No change will be made to the rule.</p>
<p>A comment was made by AzHHA stating that a facility might not be “able to anticipate and include in its performance improvement policies and procedures every type of issue that might arise and necessitate a corrective action plan.” AzHHA asked that the Department remove R9-25-1308(B)(7)(f).</p>	<p>The Department agrees that a health care institution cannot anticipate every type of situation that may arise and include them in policies and procedures, and the rules do not require that level of specificity. However, the Department believes that policies and procedures should include the process by which the health care institution would address an issue, which is what is being required in R9-25-1308(B)(7)(f). To clarify the types of issues that the policies and procedures should cover, the Department is changing the subsection to read: “If an issue related to trauma care or to trauma care parameters is identified.” The Department does not believe this is a substantive change.</p>



<p>A question was asked by a hospital “about NPs or PAs having ATLS” when there is always a board-certified physician in the emergency department.</p>	<p>R9-25-1308(F)(10)9a(iii) requires current certification in a trauma critical care course (a more generic description of the Advanced Trauma Life Support (ATLS) course developed by ACS, allowing for other equivalent training to satisfy the requirement) for “[e]ach physician assistant or registered nurse practitioner who is responsible for patients in an emergency department in the absence of an emergency physician;”. The intent is to ensure that a health care provider with adequate skills is immediately available to begin treatment of a patient who enters an emergency department until an emergency physician or trauma surgeon can take over the patient’s care. If there is always a board-certified physician in the emergency department of the hospital, then the hospital’s physician assistants and registered nurse practitioners would not be required to have this certification. No change will be made to the rule.</p>
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12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rules do not require a permit, but allow for designation. A health care institution may provide the same services with or without designation.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No business competitiveness analysis was received by the Department.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

Not applicable

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:

**TITLE 9. HEALTH SERVICES
CHAPTER 25. DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES**

ARTICLE 13. TRAUMA CENTER DESIGNATION CENTERS AND TRAUMA REGISTRIES

Section

- R9-25-1301. Definitions (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- R9-25-1302. Eligibility for Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1304-R9-25-1303.~~ Initial Application and Designation Process (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1303.01.~~ Health Care Institutions with Provisional Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1305.~~ Eligibility for Provisional Designation; Provisional Designation Process (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1306.~~ Designation Renewal Process (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1307.~~ Term of Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1308-R9-25-1304.~~ Changes Affecting Designation Status (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1309-R9-25-1305.~~ Modification of Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1310.~~ On-Site Survey for Designation as a Level IV Trauma Center Based on Meeting the State Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1306.~~ Inspections (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1312-R9-25-1307.~~ Denial or Revocation of Designation and Dedenignation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~R9-25-1313-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))
- Table 1. Application Processing Time Periods (in days) (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4)) ~~Repealed~~
- Exhibit I. Arizona Trauma Center Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4)) ~~Repealed~~
- Table 13.1. Arizona Trauma Center Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))
- ~~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))
- ~~R9-25-1406-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))



- R9-25-1311. Investigations (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4) and (5)) Repealed
- R9-25-1312. Renumbered
- R9-25-1313. Renumbered
- R9-25-1315. Application Processing Time Periods (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4)) Repealed

ARTICLE 14. TRAUMA REGISTRY; TRAUMA SYSTEM QUALITY ASSURANCE REPEALED

Section

- R9-25-1401. Definitions (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)) Repealed
- R9-25-1402. Data Submission Requirements (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)) Repealed
- Table 1. Trauma Registry Data Set (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)) Repealed
- R9-25-1403. Trauma System Data Reports; Requests for Trauma Registry Reports (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)) Repealed
- R9-25-1405. Confidentiality and Retention of Trauma System Quality Assurance Data (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2221, 36-2222(E)(3), 36-2225(A)(5) and (6), 36-2403(A), and 36-2404) Repealed
- R9-25-1406. 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)) Renumbered

ARTICLE 13. TRAUMA CENTER-DESIGNATION 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. “ACS” means the American College of Surgeons Committee on Trauma.
2. “ACS site visit” means an on-site inspection of a trauma facility conducted by ACS for the purpose of determining compliance with ACS trauma facilities criteria, or ACS trauma facilities criteria and state standards, at the Level of designation sought.
3. “Administrative completeness time period” means the number of days from the Department’s receipt of an application until the Department determines that the application contains all of the items of information required by rule to be submitted with an application.
4. “ATLS” means the ACS Advanced Trauma Life Support Course.
5. “Available” means accessible for use.
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.
6. “Chief administrative officer” means an individual assigned to control and manage the day-to-day operations of a health care institution on behalf of the owner or the body designated by the owner to govern and manage the health care institution.
7. “CME” means continuing medical education courses for physicians.
8. “Comply with” means to satisfy the requirements of a stated provision.
9. “CT” means computed tomography.
10. “Current” means up-to-date and extending to the present time.
11. “CVP” means central venous pressure.
12. “Department” means the Arizona Department of Health Services.
- 13.3. “Designation” means a formal determination by the Department that a health care institution ~~has the resources and capabilities necessary to provide trauma services at~~ complies with requirements in A.R.S. § 36-2225 and this Article for providing a particular Level and is a of trauma center service.
4. “Emergency department” means a designated area of a hospital that provides emergency services, as defined in A.A.C. R9-10-201, as an organized service, 24 hours per day, seven days per week, to individuals who present for immediate medical services.
14. “EMS” means emergency medical services.
15. “Health care institution” has the same meaning as in A.R.S. § 36-401.
16. “Hospital” has the same meaning as in A.A.C. R9-10-201.
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.
17. “ICU” means intensive care unit.
18. “In compliance with” means satisfying the requirements of a stated provision.
19. “In-house” means on the premises at the health care institution.
20. “ISS” means injury severity score, the sum of the squares of the abbreviated injury scale scores of the three most severely injured body regions.
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.
21. “Major resuscitation” means a patient:



- a. If an adult, with a confirmed blood pressure < 90 at any time or, if a child, with confirmed age-specific hypotension;
 - b. With respiratory compromise, respiratory obstruction, or intubation, if the patient is not transferred from another health care institution;
 - e. Who is transferred from another hospital and is receiving blood to maintain vital signs;
 - d. Who has a gunshot wound to the abdomen, neck, or chest;
 - e. Who has a Glasgow Coma Scale score < 8 with a mechanism attributed to trauma; or
 - f. Who is determined by an emergency physician to be a major resuscitation.
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.
22. “Meet the ACS standards,” “meeting the ACS standards,” or “meets the ACS standards” means be operated, being operated, or is operated in compliance with each applicable criterion for verification as required by ACS for verification.
23. “Meet the state standards,” “meeting the state standards,” or “meets the state standards” means be operated, being operated, or is operated in compliance with each applicable criterion listed in Exhibit I at least as frequently or consistently as required by the minimum threshold stated for the criterion in Exhibit I or at least 95% of the time, whichever is less.
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.
- 24-11. “On-call” means assigned to respond and, if necessary, come to a health care institution when ~~called~~ notified by a personnel member of the health care institution personnel.
12. “Organized service” has the same meaning as in A.A.C. R9-10-201.
- 25-13. “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.
26. “Person” means:
- a. An individual;
 - b. A business organization such as an association, cooperative, corporation, limited liability company, or partnership; or
 - e. An administrative unit of the U.S. government, state government, or a political subdivision of the state.
- 27-14. “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.
28. “PGY” means postgraduate year, a classification for residents in postgraduate training indicating the year that they are in during their post-medical-school residency program.
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.
29. “Self-designated Level I trauma facility” means a health care institution that as of July 1, 2004, met the definition of a Level I trauma center under A.A.C. R9-22-2101(F)(1).
30. “SICU” means surgical intensive care unit.
- 34-16. “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.
32. “Substantive review time period” means the number of days after completion of the administrative completeness time period during which the Department determines whether an application and owner comply with all substantive criteria required by rule for issuance of an approval.
18. “Transport” means the conveyance of a patient by ground ambulance or air ambulance from one location to another location.
33. “Transfer agreement” means a written contract between the owners of two health care institutions in which one owner agrees to have its health care institution receive a patient from the other owner’s health care institution if the patient falls within specified criteria related to diagnosis, acuity, or treatment needs.
19. “Trauma care” means medical services and nursing services provided to a patient suffering from a sudden physical injury.
- 34-20. “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.
- 35. “Valid” means that a license, certification, or other form of authorization is in full force and effect and not suspended or otherwise restricted.
- ~~36-26.~~ “Verification” means formal confirmation by ACS a national verification organization that a health care institution has the resources and capabilities necessary to provide-meets the national verification organization’s standards for providing trauma services as care at a Level I, Level II, Level III, or Level IV specific Level of trauma facility service.
- 37. “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.

R9-25-1302. Eligibility for Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** To be eligible to obtain designation for a health care institution, an owner shall:
 - 1. If applying for designation as a Level I trauma center:
 - a. Comply with one of the following:
 - i. Hold a current and valid regular license for the health care institution to operate as a hospital, issued by the Department under 9 A.A.C. 10, Article 2; or
 - ii. Be an administrative unit of the U.S. government or a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law; and
 - b. Comply with one of the following:
 - i. Hold current verification for the health care institution as a Level I trauma facility; or
 - ii. Have current documentation issued by ACS stating that the health care institution meets the state standards for a Level I trauma center;
 - 2. If applying for designation as a Level II trauma center:
 - a. Comply with one of the following:
 - i. Hold a current and valid regular license for the health care institution to operate as a hospital, issued by the Department under 9 A.A.C. 10, Article 2; or
 - ii. Be an administrative unit of the U.S. government or a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law; and
 - b. Comply with one of the following:
 - i. Hold current verification for the health care institution as a Level II trauma facility; or
 - ii. Have current documentation issued by ACS stating that the health care institution meets the state standards for a Level II trauma center;
 - 3. If applying for designation as a Level III trauma center:
 - a. Comply with one of the following:
 - i. Hold a current and valid regular license for the health care institution to operate as a hospital, issued by the Department under 9 A.A.C. 10, Article 2; or
 - ii. Be an administrative unit of the U.S. government or a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law; and
 - b. Comply with one of the following:
 - i. Hold current verification for the health care institution as a Level III trauma facility; or
 - ii. Have current documentation issued by ACS stating that the health care institution meets the state standards for a Level III trauma center; and
 - 4. If applying for designation as a Level IV trauma center:
 - a. Comply with one of the following:
 - i. Hold a current and valid regular license for the health care institution to operate, issued by the Department under 9 A.A.C. 10; or
 - ii. Be an administrative unit of the U.S. government or a sovereign tribal nation operating the health care institution under federal or tribal law; and
 - b. Comply with one of the following:
 - i. Hold current verification for the health care institution as a Level IV trauma facility; or
 - ii. Demonstrate, during an on-site survey of the health care institution conducted by the Department as described in R9-25-1310, that the health care institution meets the state standards for a Level IV trauma center.
- B.** To be eligible to retain designation for a health care institution, an owner shall:
 - 1. Maintain a current and valid regular license for the health care institution to operate, if applicable; and
 - 2. Comply with the trauma center responsibilities in R9-25-1313.
- 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



- g. Unless the owner is an administrative unit of the U.S. government or a sovereign tribal nation, the hospital or health care institution license number for the health care institution for which designation is sought;
 - h. If applying for designation as a Level I, Level II, or Level III trauma center, the name and telephone number and, if available, fax number and e-mail address of the health care institution's trauma medical director;
 - i. 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;
 - j. Attestation that the owner knows all applicable requirements in A.R.S. Title 36, Chapter 21.1 and this Article;
 - k. Attestation that the information provided in the application, including the information in the documents attached to the application form, is accurate and complete; and
 - l. The dated signature of:
 - i. If the owner is an individual, the individual;
 - ii. If the owner is a corporation, an officer of the corporation;
 - iii. If the owner is a partnership, one of the partners;
 - iv. If the owner is a limited liability company, a manager or, if the limited liability company does not have a manager, a member of the limited liability company;
 - v. If the owner is an association or cooperative, a member of the governing board of the association or cooperative;
 - vi. If the owner is a joint venture, one of the individuals signing the joint venture agreement;
 - vii. If the owner is a governmental agency, the individual in the senior leadership position with the agency or an individual designated in writing by that individual; and
 - viii. If the owner is a business organization type other than those described in subsections (A)(1)(i) through (vi), an individual who is a member of the business organization;
 - 2. Unless the owner is an administrative unit of the U.S. government or a sovereign tribal nation, a copy of the current regular hospital or health care institution license issued by the Department for the health care institution for which designation is sought;
 - 3. If applying for designation based on verification, documentation issued by ACS establishing that the owner holds current verification for the health care institution at the Level of designation sought and showing the effective and expiration dates of the verification; and
 - 4. If applying for designation as a Level I, Level II, or Level III trauma center based on meeting the state standards, current documentation issued by ACS establishing that the owner's health care institution meets the state standards listed in Exhibit I for the Level of designation sought.
- B.** The Department shall process an application as provided in R9-25-1315.
- C.** The Department shall approve designation if the Department determines that an owner is eligible for designation as described in R9-25-1302.
- 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, e-mail address, telephone number, and, if available, fax number;
 - c. The name, e-mail 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 e-mail 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 e-mail 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;
 - i. The name, e-mail 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, e-mail 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, e-mail 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.
- R9-25-1303.01. Health Care Institutions with Provisional Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))**
- A.** A health care institution that held provisional designation before the effective date of the rules in this Article may retain the provisional designation until the expiration date of the provisional designation.
- B.** At least 60 calendar days and no more than 90 calendar days before the expiration of a provisional designation, an owner of a health care institution with a provisional designation shall submit to the Department an application for initial designation according to R9-25-1303(A).
- C.** If an owner of a health care institution with a provisional designation does not submit an application for initial designation according to subsection (B), the health care institution is no longer designated as a trauma center, as of the expiration date of the provisional designation.
- ~~R9-25-1305. Eligibility for Provisional Designation; Provisional Designation Process (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))~~**
- ~~A.~~** The owner of a health care institution may apply for one 18-month provisional designation as a Level I, Level II, or Level III trauma center if:
1. When the owner applies for provisional designation, the owner's health care institution has not produced at least 12 consecutive months of data related to trauma services provided at the health care institution; and
 2. The owner cannot comply with R9-25-1302(A)(1)(b), (A)(2)(b), or (A)(3)(b).
- ~~B.~~** To be eligible to obtain provisional designation for a health care institution, an owner shall:
1. Comply with one of the following:



- a. Hold a current and valid regular license for the health care institution to operate as a hospital, issued by the Department under 9 A.A.C. 10, Article 2; or
- b. Be an administrative unit of the U.S. government or a sovereign tribal nation operating the health care institution as a hospital under federal or tribal law; and
- 2. Make the attestations described in subsection (C)(2).
- C.** An owner applying for provisional designation shall submit to the Department an application including:
 - 1. An application form that contains the information and items listed in R9-25-1304(A)(1)(a) through (A)(1)(d), (A)(1)(e) through (A)(1)(l), and (A)(2); and
 - 2. Attestation that:
 - a. The owner's health care institution has the resources and capabilities necessary to meet the state standards for the Level of designation sought and will meet the state standards for the Level of designation sought during the term of the provisional designation; and
 - b. During the term of the provisional designation, the owner will:
 - i. Ensure that the trauma center meets the state standards;
 - ii. Apply for verification for the trauma center; and
 - iii. Provide to the Department, within 30 days after applying for verification, documentation issued by ACS establishing that the owner has applied for verification.
- D.** The Department shall process an application submitted under this Section as provided in R9-25-1315.
- E.** The Department shall approve provisional designation if the Department determines that an owner is eligible for provisional designation as described in subsection (B).
- F.** To be eligible to retain provisional designation for a health care institution, an owner shall:
 - 1. Comply with subsection (B)(1)(a) or (b);
 - 2. Comply with the trauma center responsibilities in R9-25-1313;
 - 3. Apply for verification for the trauma center; and
 - 4. Provide to the Department, within 30 days after applying for verification, documentation issued by ACS establishing that the owner has applied for verification.
- G.** An owner who holds provisional designation and who desires to retain designation shall, before the expiration date of the provisional designation:
 - 1. If the owner can comply with R9-25-1302(A)(1)(b), (A)(2)(b), or (A)(3)(b), apply for initial designation under R9-25-1304; or
 - 2. If the owner cannot comply with R9-25-1302(A)(1)(b), (A)(2)(b), or (A)(3)(b), apply for an extension of the provisional designation under subsection (H).
- H.** An owner who holds provisional designation and who will not be able to comply with R9-25-1302(A)(1)(b), (A)(2)(b), or (A)(3)(b) on the expiration date of the provisional designation may apply to the Department, on a form provided by the Department, for one 180-day extension of the provisional designation and shall include with the application documentation issued by ACS showing the owner's progress in obtaining an ACS site visit.
- I.** The Department shall grant an extension if an owner provides documentation issued by ACS:
 - 1. Establishing that the owner has applied for verification; and
 - 2. Showing the owner's progress in obtaining an ACS site visit.
- J.** The Department may:
 - 1. Investigate, as provided under R9-25-1311, a trauma center that is the subject of a provisional designation; and
 - 2. Revoke, as provided under R9-25-1312, a provisional designation.

R9-25-1306. Designation Renewal Process (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** At least 60 days before the expiration date of a current designation, an owner who desires to obtain renewal of designation shall submit to the Department an application including:
 - 1. An application form that contains the information listed in R9-25-1304(A)(1);
 - 2. If applying for renewal of designation as a Level I, Level II, or Level III trauma center based on meeting the state standards, one of the following:
 - a. Documentation issued by ACS no more than 60 days before the date of application establishing that the owner's trauma center meets the state standards listed in Exhibit I for the Level of designation sought; or
 - b. Documentation issued by ACS establishing that the owner has applied for verification for the trauma center, at the Level corresponding to the Level of designation sought, for the three-year period directly following the expiration of the owner's current designation; and
 - 3. If applying for renewal of designation based on verification, documentation issued by ACS establishing that the owner:
 - a. Holds verification for the trauma center, at the Level corresponding to the Level of designation sought, for the three-year period directly following the expiration of the owner's current verification and designation; or
 - b. Has applied for verification for the trauma center, at the Level corresponding to the Level of designation sought, for the three-year period directly following the expiration of the owner's current verification and designation.
- B.** The Department shall process an application as provided in R9-25-1315.
- C.** The Department shall renew designation if the Department determines that the owner is eligible to retain designation as described in R9-25-1302(B).
- D.** The Department shall not renew designation based on verification or ACS's determination that a trauma center meets the state standards until the Department receives documentation that complies with subsection (A)(2)(a) or (A)(3)(a).

R9-25-1307. Term of Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** The Department shall issue initial designation or renewal of designation:



1. When based on verification, with a term beginning on the date of issuance and ending on the expiration date of the verification upon which designation is based; and
 2. When based on meeting the state standards or eligibility under R9-25-1303, with a term beginning on the date of issuance and ending three years later.
- B.** The Department shall issue a provisional designation with a term beginning on the date of issuance and ending 18 months later and an extension of provisional designation with a term beginning on the expiration date of the provisional designation and ending 180 days later.
- C.** The Department shall issue a modified designation with a term beginning on the date of issuance and ending on the expiration date of the designation issued before the application for modification of designation under R9-25-1309.
- D.** If an owner submits an application for renewal of designation as described in R9-25-1306 before the expiration date of the current designation, or submits an application for extension of provisional designation as described in R9-25-1305 before the expiration date of the provisional designation, the current designation does not expire until the Department has made a final determination on the application for renewal of designation or extension of provisional designation.

~~R9-25-1308~~R9-25-1304. Changes Affecting Designation Status (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- A.** At least 30 days before the date of a change in a trauma center's name, the owner of the trauma center shall send the Department written notice of the name change.
- B.** At least 90 days before a trauma center ceases to offer trauma services, the owner of the trauma center shall send the Department written notice of the intention to cease offering trauma services and the desire to relinquish designation.
- 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 designation that incorporates the name change but retains the expiration date of the current designation; or
 2. For a notice described in subsection (B), send the owner written confirmation of the voluntary relinquishment of designation, with an effective date consistent with the written notice.
- D.** An owner of a trauma center shall notify the Department in writing within three working days after:
1. The trauma center's hospital or health care institution license expires or is suspended, revoked, or changed to a provisional license;
 2. A change in the trauma center's verification status; or
 3. A change in the trauma center's ability to meet the state standards or, if designation is based on verification, to meet the ACS standards, that is expected to last for more than one week.
- E.** An owner of a trauma center who obtains verification for the trauma center during a term of designation based on meeting the state standards may obtain a new initial designation based on verification, with a designation term based on the dates of the verification, by submitting an initial application as provided in R9-25-1304.
- 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:
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.

~~R9-25-1309~~R9-25-1305. Modification of Designation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- ~~A. An owner of a trauma center who desires to obtain a designation that requires fewer resources and capabilities than the trauma center's current designation shall, at least 30 days before ceasing to provide trauma services consistent with the current designation, send the Department an application for modification of the trauma center's designation, including:~~
 - 1. ~~The name, address, and main telephone number of the trauma center for which the owner seeks modification of designation;~~
 - 2. ~~The owner's name, address, and telephone number and, if available, fax number and e-mail address;~~
 - 3. ~~A list of the applicable ACS or state criteria for the current designation with which the owner no longer intends to comply;~~
 - 4. ~~An explanation of the changes being made in the trauma center's resources or operations related to each criterion listed under subsection (A)(3);~~
 - 5. ~~The state Level of designation requested;~~
 - 6. ~~Attestation that the owner knows the state standards for the Level of designation requested and will ensure that the trauma center meets the state standards if modified designation is issued;~~
 - 7. ~~Attestation that the information provided in the application is accurate and complete; and~~
 - 8. ~~The dated signature of the owner, as prescribed in R9-25-1304(A)(1)(I).~~
- ~~B. The Department shall process an application as provided in R9-25-1315.~~
- ~~C. The Department shall issue a modified designation if the Department determines that, with the changes being made in the trauma center's resources and operations, the trauma center will meet the state standards for the Level of designation requested.~~
- ~~D. An owner who obtains modified designation shall, during the term of the modified designation, ensure that the owner's trauma center meets the state standards that were the subject of the owner's attestation described in subsection (A)(6).~~
- ~~E. The Department may:~~
 - 1. ~~Investigate, as provided under R9-25-1311, a trauma center that is the subject of a modified designation; and~~
 - 2. ~~Revoke, as provided under R9-25-1312, a modified designation.~~
- ~~F. An owner who holds modified designation shall, before the expiration date of the modified designation:~~
 - 1. ~~If the owner desires to retain designation based on the trauma center's meeting the state standards at the Level of the modified designation, apply for renewal of designation under R9-25-1306; or~~
 - 2. ~~If the owner desires to obtain designation based on verification or based on the trauma center's meeting the state standards at a Level other than the Level of the modified designation, apply for initial designation under R9-25-1304.~~
- 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.

~~R9-25-1310. On Site Survey for Designation as a Level IV Trauma Center Based on Meeting the State Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))~~



- A.** Before issuing initial or renewal designation to an owner applying for designation as a Level IV trauma center based on meeting the state standards, the Department shall complete an announced on-site survey of the owner's health care institution that includes:
1. Reviewing equipment and the physical plant;
 2. Interviewing personnel; and
 3. Reviewing:
 - a. Medical records;
 - b. Patient discharge summaries;
 - c. Patient care logs;
 - d. Personnel rosters and schedules;
 - e. Performance-improvement-related documents other than peer review documents privileged under A.R.S. §§ 36-445.01 and 36-2403, including reports prepared as required under R9-10-204(B)(2) and the supporting documentation for the reports; and
 - f. Other documents relevant to the provision of trauma services as a Level IV trauma center and that are not privileged under federal or state law.
- B.** A Department surveyor shall make a verbal report of findings to an owner upon completion of an on-site survey.
- C.** Within 30 days after completing an on-site survey, the Department shall send to an owner a written report of the Department's findings, including a list of any deficiencies identified during the on-site survey and a request for a written corrective action plan.
- D.** Within 10 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 deficiency:
1. A description of how the deficiency will be corrected, and
 2. A date of correction for the deficiency.
- E.** The Department shall accept a written corrective action plan if it:
1. Describes how each identified deficiency will be corrected, and
 2. Includes a date for correcting each deficiency as soon as practicable based upon the actions necessary to correct the deficiency.

R9-25-1311. Investigations (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4) and (5))

- A.** If the Department determines based upon Trauma Registry data collected by the Department or receives a complaint alleging that a trauma center is not meeting the state standards or, if designation is based on verification, is not meeting the ACS standards, the Department shall conduct an investigation of the trauma center:
1. The Department may conduct an announced or unannounced onsite survey as part of an investigation.
 2. Within 30 days after completing an investigation, the Department shall send to the owner of the trauma center investigated a written report of the Department's findings, including a list of any deficiencies identified during the investigation and a request for a written corrective action plan.
- B.** Within 10 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 deficiency:
1. A description of how the deficiency will be corrected, and
 2. A date of correction for the deficiency.
- C.** The Department shall accept a written corrective action plan if it:
1. Describes how each identified deficiency will be corrected, and
 2. Includes a date for correcting each deficiency as soon as practicable based upon the actions necessary to correct the deficiency.

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.

R9-25-1312, R9-25-1307, Denial or Revocation of Designation and DEDesignation (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4))

- ~~A. The Department may deny or revoke designation 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, if applicable, R9-25-1305(B) or (F);~~
 - ~~3. Fails to submit to the Department all of the information requested in a written request for additional information within the time prescribed in R9-25-1315 and Table 1;~~
 - ~~4. Fails to submit a written corrective action plan as requested and required under R9-25-1310 or R9-25-1311;~~
 - ~~5. Fails to comply with a written corrective action plan accepted by the Department under R9-25-1310 or R9-25-1311;~~
 - ~~6. Fails to allow the Department to enter the premises of the owner's health care institution, to interview personnel, or to review documents that are not documents privileged under federal or state law; or~~
 - ~~7. Fails to comply with any applicable provision in A.R.S. Title 36, Chapter 21.1 or this Article.~~
- ~~B. In determining whether to deny or revoke designation, the Department shall consider:~~
 - ~~1. The severity of each violation relative to public health and safety;~~
 - ~~2. The number of violations;~~
 - ~~3. The nature and circumstances of each violation;~~
 - ~~4. Whether each violation was corrected, the manner of correction, and the duration of the violation; and~~
 - ~~5. Whether the violations indicate a lack of commitment to having the trauma center meet the state standards or, if applicable, the ACS standards.~~
- ~~C. If the Department denies or revokes designation, the Department shall send to the owner a written notice setting forth the information required under A.R.S. § 41-1092.03.~~
 - ~~1. An owner may file a written notice of appeal with the Department within 30 days after receiving a notice of denial or revocation, as provided in A.R.S. § 41-1092.03.~~
 - ~~2. An appeal shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.~~
- A. For 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. 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), for 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, 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 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) for renewal of a one-year designation, for 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, e-mail address, telephone number, and, if available, fax number of the health care institution's emergency department physician director;
 - e. If applicable, the name, e-mail 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, e-mail 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) for renewal of a one-year designation, for 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);
 - 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 as provided in subsection (G) for renewal of a one-year designation, for designation of a health care institution based on an assessment by the Department, 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, 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.** Except as specified in subsection (H), 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 shall review according to R9-25-1303(C) and subsection (A), (B), or (E), as applicable, an application for renewal of designation submitted by the owner of a trauma center that:
 - 1. Had been issued a one-year designation according to subsection (B)(2) or (E)(2); and
 - 2. 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.
- 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:
 - 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.

~~R9-25-1313~~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))

The owner of a trauma center shall ensure that:

1. ~~The trauma center meets the state standards or, if designation is based on verification, meets the ACS standards;~~
 2. ~~Data related to the trauma services provided at the trauma center are submitted to the Department's Trauma Registry as required by the Department;~~
 3. ~~The owner and the trauma center staff comply with the applicable provisions of A.R.S. Title 36, Chapter 21.1 and this Article; and~~
 4. ~~The owner and the trauma center staff comply with all applicable federal and state laws relating to confidentiality of information.~~
- 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. Appoint 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 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)(6)(a);
 - c. The role each personnel member specified according to subsection (B)(6)(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, e-mail 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:
 - 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. Other patient outcomes;
 - l. Trauma care parameters for pediatric patients, including pediatric-specific measures; and
 - m. 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 patients in an emergency department in the absence of an emergency physician; or
 - b. Have held certification in a trauma critical care course:
 - 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 (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 (C)(3)(f) is fellowship-trained, and
 - b. A fellowship-trained pediatric emergency medicine physician provides supervision for pediatric emergency trauma care and 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, 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 include:
 - 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 the trauma center holds a designation as a Level I trauma center, Level I Pediatric trauma center, Level II trauma center, or Level II Pediatric trauma center, 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,
 - (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
 - 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;
 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).
- R9-25-1315. Application Processing Time Periods (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4)) Repealed**
- ~~A. The application processing time periods for each type of approval granted by the Department under this Article are listed in Table 1 and may be extended through a written agreement between an owner and the Department.~~
 - ~~B. The Department shall, within the administrative completeness time period specified in Table 1, review each application submitted for administrative completeness:

 - 1. ~~If an application is incomplete, the Department shall send to the owner a written notice listing each deficiency and the information or items needed to complete the application.~~
 - 2. ~~If an owner fails to submit to the Department all of the information or items listed in a notice of deficiencies within the time period specified in Table 1, the Department shall consider the application withdrawn.~~~~
 - ~~C. After determining that an application is administratively complete, the Department shall review the application for substantive compliance with the requirements for approval:

 - 1. ~~The Department shall complete its substantive review of each application, and send an owner written notice of approval or denial, within the substantive review time period specified in Table 1.~~
 - 2. ~~As part of the substantive review for an application for initial designation or renewal of designation as a Level IV trauma center based on meeting the state standards, the Department shall conduct an announced onsite survey of the health care institution or trauma center as described in R9-25-1310.~~
 - 3. ~~An owner applying for renewal of designation who submits documentation of the owner's having applied for verification as permitted under R9-25-1306(A)(2)(b) or (A)(3)(b) shall submit to the Department during the substantive review time period documentation that complies with R9-25-1306(A)(2)(a) or (A)(3)(a).~~
 - 4. ~~During the substantive review time period, the Department may make one written request for additional information, listing the information or items needed to determine whether to approve the application, including, for an owner applying for renewal described in subsection (C)(3), a request for documentation that complies with R9-25-1306(A)(2)(a) or (A)(3)(a).~~
 - 5. ~~For an application for initial designation or renewal of designation as a Level IV trauma center based on meeting the state standards, a written request for additional information may include a request for a corrective action plan to correct any deficiencies identified during an onsite survey of the health care institution or trauma center.~~
 - 6. ~~If an owner fails to submit to the Department all of the information or items listed in a written request for additional information, including, if applicable, a corrective action plan, within the time period specified in Table 1, the Department shall deny the application.~~~~
 - ~~D. In applying this Section, the Department shall:

 - 1. ~~In calculating an owner's time to respond, begin on the postmark date of a notice of deficiencies or written request for additional information and end on the date that the Department receives all of the information or documents requested in the notice of deficiencies or written request for additional information; and~~
 - 2. ~~In calculating the Department's time periods, not include any time during which the Department is waiting for an owner to submit information or documents to the Department as requested by the Department in a notice of deficiencies or written request for additional information.~~~~
 - ~~E. If the Department denies an application, the Department shall send to the owner a written notice of denial setting forth the information required under A.R.S. § 41-1092.03.

 - 1. ~~An owner may file a written notice of appeal with the Department within 30 days after receiving the notice of denial, as provided in A.R.S. § 41-1092.03.~~
 - 2. ~~An appeal shall be conducted according to A.R.S. Title 41, Chapter 6, Article 10.~~~~



Table 1. Application Processing Time Periods (in days) (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4)) Repealed

Type of Approval	Department's Administrative Completeness Time Period	Owner's Time to Respond to Notice of Deficiencies	Department's Substantive Review Time-Period	Owner's Time to Respond to Written Request for Additional Information
Initial Designation (R9-25-1304)	30	30	90	60
Provisional Designation (R9-25-1305)	30	30	90	60
Extension of Provisional Designation (R9-25-1305)	15	30	15	30
Renewal of Designation (R9-25-1306)	30	30	90	120
Modification of Designation (R9-25-1309)	30	30	90	60

Exhibit I. Arizona Trauma Center Standards (A.R.S. §§ 36-2202(A)(4), 36-2209(A)(2), and 36-2225(A)(4)) Repealed
E= Essential and required

Trauma Facilities Criteria	Levels			
	I	II	III	IV
A. Institutional Organization				
1. Trauma program	E	E	E	-
2. Trauma service	E	E	E	-
3. Trauma team	E	E	E	E
4. Trauma program medical director ¹	E	E	E	-
5. Trauma multidisciplinary committee	E	E	E	-
6. Trauma coordinator/trauma program manager ²	E	E	E	E
B. Hospital Departments/Divisions/Sections				
1. Surgery	E	E	E	-
2. Neurological surgery	E	E	-	-
a. Neurosurgical trauma liaison	E	E	-	-
3. Orthopaedic surgery	E	E	E	-
a. Orthopaedic trauma liaison	E	E	E	-
4. Emergency medicine	E	E	E	-
a. Emergency medicine liaison ³	E	E	E	-
5. Anesthesia	E	E	E	-
C. Clinical Capabilities				
1. Published on-call schedule for each listed specialty required in (C)(2) and (3)	E	E	E	-
2. Specialty immediately available 24 hours/day				
a. General surgery ⁴	E	E	E	-



i. Published back-up schedule	E	E	-	-
ii. Dedicated to single hospital when on-call	E	E	-	-
b. Anesthesia ⁵	E	E	E	-
e. Emergency medicine ⁶	E	E	E	-
3. On-call and promptly available 24 hours/day ⁷				
a. Cardiac surgery ⁸	E	-	-	-
b. Hand surgery	E	E	-	-
e. Microvascular/replant surgery	E	-	-	-
d. Neurologic surgery	E	E	-	-
i. Dedicated to one hospital or back-up call	E	E	-	-
e. Obstetrics/gynecologic surgery	E	-	-	-
f. Ophthalmic surgery	E	E	-	-
g. Oral/maxillofacial surgery ⁹	E	E	-	-
h. Orthopaedic surgery	E	E	E	-
i. Dedicated to one hospital or back-up call	E	E	-	-
i. Plastic surgery	E	E	-	-
j. Critical care medicine	E	E	-	-
k. Radiology	E	E	E	-
l. Thoracic surgery	E	E	-	-
D. Clinical Qualifications				
1. General/Trauma Surgeon				
a. Board certification ¹⁰	E	E	E	-
b. 16 hours CME/year ¹¹	E	E	-	-
e. ATLS certification ¹²	E	E	E	E
d. Multidisciplinary peer review committee attendance > 50% ¹³	E	E	E	-
2. Emergency Medicine ³				
a. Board certification ¹⁰	E	E	-	-
b. Trauma education—16 hours CME/year ¹¹	E	E	-	-
e. ATLS certification ¹²	E	E	E	E
d. Multidisciplinary peer review committee attendance > 50% ¹³	E	E	E	-
3. Neurosurgery				
a. Board certification	E	E	-	-
b. 16 hours CME/year ¹¹	E	E	-	-
e. Multidisciplinary peer review committee attendance > 50% ¹³	E	E	E	-
4. Orthopaedic Surgery				
a. Board certification	E	E	-	-
b. 16 hours CME/year in skeletal trauma ¹¹	E	E	-	-
e. Multidisciplinary peer review committee attendance > 50% ¹³	E	E	E	-
E. Facilities/Resources/Capabilities				
1. Volume Performance ¹⁴	E	-	-	-
2. Presence of surgeon at resuscitation (immediately available) ¹⁵	E	E	-	-
3. Presence of surgeon at resuscitation (promptly available) ¹⁶	-	-	E	-
4. Presence of surgeon at operative procedures	E	E	E	E
5. Emergency Department				



a. Personnel				
i. Designated physician director-	E	E	E	-
b. Resuscitation Equipment for Patients of All Ages				
i. Airway control and ventilation equipment	E	E	E	E
ii. Pulse oximetry	E	E	E	E
iii. Suction devices	E	E	E	E
iv. Electrocardiograph-oscilloscope-defibrillator	E	E	E	E
v. Internal paddles	E	E	E	-
vi. CVP monitoring equipment	E	E	E	-
vii. Standard intravenous fluids and administration sets	E	E	E	E
viii. Large-bore intravenous catheters	E	E	E	E
ix. Sterile Surgical Sets for				
(1) Airway control/crioethyrotomy	E	E	E	E
(2) Thoracostomy	E	E	E	E
(3) Venous cutdown	E	E	E	E
(4) Central line insertion	E	E	E	-
(5) Thoracotomy	E	E	E	-
(6) Peritoneal lavage	E	E	E	-
x. Arterial catheters	E	E	-	-
xi. Drugs necessary for emergency care	E	E	E	E
xii. X-ray availability 24 hours/day	E	E	E	-
xiii. Broselow tape	E	E	E	E
xiv. Thermal Control Equipment				
(1) For patient	E	E	E	E
(2) For fluids and blood	E	E	E	E
xv. Rapid infuser system	E	E	E	E
xvi. Qualitative end-tidal CO ₂ determination	E	E	E	E
e. Communication with EMS vehicles	E	E	E	E
d. Capability to resuscitate, stabilize, and transport pediatric patients ¹⁷	E	E	E	E
6. Operating Room				
a. Immediately available 24 hours/day	E	E	-	-
b. Personnel				
i. In-house 24 hours/day ¹⁸	E	-	-	-
ii. Available 24 hours/day ¹⁹	-	E	E	-
e. Age-Specific Equipment				
i. Cardiopulmonary bypass	E	-	-	-
ii. Operating microscope	E	-	-	-
d. Thermal Control Equipment				
i. For patient	E	E	E	E
ii. For fluids and blood	E	E	E	E
e. X-ray capability including C-arm image intensifier	E	E	E	-
f. Endoscopes, bronchoscope	E	E	E	-
g. Craniotomy instruments	E	E	-	-
h. Equipment for long bone and pelvic fixation	E	E	E	-



i. Rapid infuser system	E	E	E	E
7. Postanesthetic Recovery Room (SICU is acceptable)				
a. Registered nurses available 24 hours/day	E	E	E	-
b. Equipment for monitoring and resuscitation	E	E	E	E
e. Intracranial pressure monitoring equipment	E	E	-	-
i. Pulse oximetry	E	E	E	E
ii. Thermal control	E	E	E	E
8. Intensive or Critical Care Unit for Injured Patients				
a. Registered nurses with trauma training	E	E	E	-
b. Designated surgical director or surgical co-director	E	E	E	-
e. Surgical ICU service physician in-house 24 hours/day ²⁰	E	-	-	-
d. Surgically directed and staffed ICU service ²⁰	E	E	-	-
e. Equipment for monitoring and resuscitation	E	E	E	-
f. Intracranial pressure monitoring equipment	E	E	-	-
g. Pulmonary artery monitoring equipment	E	E	E	-
9. Respiratory Therapy Services				
a. Available in-house 24 hours/day	E	E	-	-
b. On-call 24 hours/day	-	-	E	-
10. Radiological Services (Available 24 hours/day)				
a. In-house radiology technologist	E	E	-	-
b. Angiography	E	E	-	-
e. Sonography	E	E	E	-
d. Computed tomography	E	E	E	-
i. In-house CT technician	E	E	-	-
e. Magnetic resonance imaging	E	-	-	-
11. Clinical Laboratory Service (Available 24 hours/day)				
a. Standard analyses of blood, urine, and other body fluids, including microsampling when appropriate	E	E	E	E
b. Blood typing and cross-matching	E	E	E	-
e. Coagulation studies	E	E	E	E
d. Comprehensive blood bank or access to a community central blood bank and adequate storage facilities	E	E	E	-
e. Blood gases and pH determinations	E	E	E	E
f. Microbiology	E	E	E	-
12. Acute Hemodialysis				
a. In-house	E	-	-	-
b. Transfer agreement	-	E	E	E
13. Burn Care—Organized	E			
a. In-house or transfer agreement with burn center	E	E	E	E
14. Acute Spinal Cord Management	E			
a. In-house or transfer agreement with regional acute spinal cord injury rehabilitation center	E	E	E	E
F. Rehabilitation Services				
1. Transfer agreement to an approved rehabilitation facility	E	E	E	E



2. Physical therapy	E	E	E	-
3. Occupational therapy	E	E	-	-
4. Speech therapy	E	E	-	-
5. Social Services	E	E	E	-
G. Performance Improvement				
1. Performance improvement programs	E	E	E	E
2. Trauma Registry				
a. In-house	E	E	E	E
b. Participation in state, local, or regional registry	E	E	E	E
3. Audit of all trauma deaths	E	E	E	E
4. Morbidity and mortality review	E	E	E	E
5. Trauma conference—multidisciplinary	E	E	E	-
6. Medical nursing audit	E	E	E	E
7. Review of prehospital trauma care	E	E	E	-
8. Review of times and reasons for trauma-related bypass	E	E	-	-
9. Review of times and reasons for transfer of injured patients	E	E	E	E
10. Performance improvement personnel dedicated to care of injured patients	E	E	-	-
H. Continuing Education/Outreach				
1. Outreach activities ²¹	E	E	-	-
2. Residency program ²²	E	-	-	-
3. ATLS provide/participate ²³	E	-	-	-
4. Programs provided by hospital for:				
a. Staff/community physicians (CME)	E	E	E24	-
b. Nurses	E	E	E	-
c. Allied health personnel	E	E	E	-
d. Prehospital personnel provision/participation	E	E	E	-
I. Prevention				
1. Prevention program ²⁵	E	E	-	-
2. Collaboration with existing national, regional, state, and community programs ²⁶	E	E	E	E
J. Research				
1. Research program ²⁷	E	-	-	-
2. Trauma registry performance improvement activities	E	E	E	-
3. Identifiable Institutional Review Board process	E	-	-	-
4. Extramural education presentations	E28	-	-	-
K. Additional Requirements for Trauma Centers Represented as Caring for Pediatric Trauma Patients²⁹				
1. Trauma surgeons credentialed for pediatric trauma care	E	E	-	-
2. Pediatric emergency department area	E	E	-	-
3. Pediatric resuscitation equipment in all patient care areas	E	E	-	-
4. Microsampling	E	E	E	-
5. Pediatric specific performance improvement program	E	E	E	E
6. Pediatric intensive care unit	E30	E31	-	-

¹ An individual may not serve as trauma medical director for more than one trauma center at the same time.

² For a Level I trauma center, this shall be a full-time position.

³ This does not apply if emergency medicine physicians do not participate in the care of a hospital's trauma patients.



⁴ For this criterion, “immediately available” means that:

1. For a Level I trauma center, a PGY 4 or 5 surgery resident or a trauma surgeon is on the hospital premises at all times; and
2. For all major resuscitations in a Level I, II, or III trauma center:
 - a. If advance notice is provided from the field, a trauma surgeon is present in the emergency department upon patient arrival; and
 - b. If advance notice is not provided from the field, a trauma surgeon is present in the emergency department:
 - i. For a Level I or II trauma center, no later than 15 minutes after patient arrival; or
 - ii. For a Level III trauma center, no later than 30 minutes after patient arrival.

The minimum threshold for compliance with #2 is 80%.

A PGY 4 or 5 surgery resident may begin resuscitation while awaiting the arrival of the trauma surgeon, but is not a replacement for the trauma surgeon.

⁵ For this criterion, “immediately available” means that:

1. For a Level I trauma center, an anesthesiologist, anesthesiology chief resident, or certified registered nurse anesthetist is on the hospital premises at all times;
2. For a Level II trauma center, an anesthesiologist, anesthesiology chief resident, or certified registered nurse anesthetist is present in the emergency department no later than 15 minutes after patient arrival;
3. For a Level III trauma center, an anesthesiologist, anesthesiology chief resident, or certified registered nurse anesthetist is present in the emergency department no later than 30 minutes after patient arrival; and
4. For a Level I, II, or III trauma center, an anesthesiologist is present for all surgeries.

⁶ For this criterion, “immediately available” means that an emergency medicine physician is physically present in the emergency department at all times. However, if emergency medicine physicians do not participate in the care of a hospital’s trauma patients, an emergency medicine physician is not required to be immediately available 24 hours per day.

⁷ For the criteria in (C)(3)(a) (I), “promptly available” means that:

1. A physician specialist is present in the emergency department no later than 45 minutes after notification, based on patient need; or
2. For hand surgery and microvascular/replant surgery, the owner has transfer agreements to ensure that a patient in need of hand surgery or microvascular/replant surgery can be expeditiously transferred to a health care institution that has a hand surgeon or microvascular/replant surgeon on the premises.

⁸ This criterion is satisfied by a physician authorized by the hospital to perform cardiothoracic surgery.

⁹ This criterion is satisfied by a dentist or physician authorized by the hospital to perform oral and maxillofacial surgery. If a physician, the individual shall be a plastic surgeon or an otolaryngologist.

¹⁰ In a Level I or II trauma center, a non-board-certified physician may be included in the trauma service if the physician:

1. If a surgeon, is in the examination process by the American Board of Surgery;
2. If the trauma medical director, is a Fellow of ACS;
3. Unless the trauma medical director, complies with the following:
 - a. Has a letter written by the trauma medical director demonstrating that the health care institution’s trauma program has a critical need for the physician because of the physician’s individual experience or the limited physician resources available in the physician’s specialty;
 - b. Has successfully completed an accredited residency training program in the physician’s specialty, as certified by a letter from the director of the residency training program;
 - c. Has current ATLS certification as a provider or instructor, as established by documentation;
 - d. Has completed 48 hours of trauma CME within the past three years, as established by documentation;
 - e. Has attended at least 50% of the trauma quality assurance and educational meetings, as established by documentation;
 - f. Has been a member or attended local, regional, and national trauma organization meetings within the past three years, as established by documentation;
 - g. Has a list of patients treated over the past year with accompanying ISS and outcome for each;
 - h. Has a quality assurance assessment by the trauma medical director showing that the morbidity and mortality results for the physician’s patients compare favorably with the morbidity and mortality results for comparable patients treated by other members of the trauma service; and
 - i. Has full and unrestricted privileges in the physician’s specialty and in the department with which the physician is affiliated;
4. Complies with the following:
 - a. Has provided exceptional care of trauma patients, as established by documentation such as a quality assurance assessment by the trauma medical director;
 - b. Has numerous publications, including publication of excellent research;
 - c. Has made numerous presentations; and
 - d. Has provided excellent teaching, as established by documentation.

In a Level III trauma center, only the trauma medical director is required to be board-certified.

¹¹ This criterion applies only to the trauma medical director, the emergency medicine liaison, the neurosurgical trauma liaison, and the orthopaedic trauma liaison. This criterion is satisfied by an average of 16 hours annually, or 48 hours over three years, of verifiable external trauma related CME. External CME includes programs given by visiting professors or invited speakers and teaching an ATLS course.

¹² Among the trauma surgeons, only the trauma medical director is required to have current ATLS certification. The other trauma surgeons are required to have held ATLS certification at one time. Among the emergency medicine physicians, only non-board-certified physicians are required to have current ATLS certification. The other emergency medicine physicians are required to have held ATLS certification at one time.



¹³ Among the trauma surgeons, 50% attendance is required for each member of the trauma surgical core group. In the other specialty areas, 50% attendance is required only for the emergency medicine liaison, the neurosurgical trauma liaison, and the orthopaedic trauma liaison.

¹⁴ Except for Level I trauma centers that care only for pediatric patients, each Level I trauma center shall satisfy one of the following volume performance standards:

1. 1200 trauma admissions per year,
2. 240 admissions with ISS > 15 per year, or
3. An average of 35 patients with ISS > 15 for the trauma panel surgeons per year.

Burn patients may be included in annual trauma admissions if the trauma service, not a separate burn service, is responsible for burn care in the trauma center.

¹⁵ For this criterion, “immediately available” means that for all major resuscitations in a Level I or II trauma center:

1. If advance notice is provided from the field, a trauma surgeon is present in the emergency department upon patient arrival; and
2. If advance notice is not provided from the field, a trauma surgeon is present in the emergency department no later than 15 minutes after patient arrival.

The minimum threshold for compliance with this criterion is 80%.

A PGY 4 or 5 surgery resident may begin resuscitation while awaiting the arrival of the trauma surgeon, but is not a replacement for the trauma surgeon.

¹⁶ For this criterion, “promptly available” means that for all major resuscitations in a Level III trauma center:

1. If advance notice is provided from the field, a trauma surgeon is present in the emergency department upon patient arrival; and
2. If advance notice is not provided from the field, a trauma surgeon is present in the emergency department no later than 30 minutes after patient arrival.

The minimum threshold for compliance with this criterion is 80%.

A PGY 4 or 5 surgery resident may begin resuscitation while awaiting the arrival of the trauma surgeon, but is not a replacement for the trauma surgeon.

¹⁷ A trauma center that does not admit pediatric patients shall be capable of resuscitating, stabilizing, and transporting pediatric trauma patients.

¹⁸ A Level I trauma center shall have a complete operating room team in the hospital at all times, so that an injured patient who requires operative care can receive it in the most expeditious manner. The members of the operating room team shall be assigned to the operating room as their primary function; they cannot also be dedicated to other functions within the institution.

¹⁹ A Level II trauma center shall have a complete operating room team available when needed. The need to have an in-house operating room team depends on a number of things, including the patient population served, the ability to share responsibility for operating room coverage with other hospital staff, prehospital communication, and the size of the community served by the trauma center. If an out-of-house operating room team is used, then this aspect of care shall be monitored by the performance improvement program.

²⁰ This requirement may be satisfied by a physician authorized by the hospital to admit patients into the intensive care unit as the attending physician or to perform critical care procedures.

²¹ This requirement is met through having an independent outreach program or participating in a collaborative outreach program. “Collaborative outreach program” means an organized effort, including multiple hospitals or sponsored or coordinated by a Regional Council or the Department, through which participating hospitals educate the general public or current or prospective physicians, nurses, prehospital providers, or allied health professionals regarding injury prevention, trauma triage, interfacility transfer of trauma patients, or trauma care.

²² A Level I trauma center shall have a functional and documented teaching commitment. This requirement may be met through:

1. A trauma fellowship program; or
2. Active participation with one of the following types of residency programs in emergency medicine, general surgery, orthopaedic surgery, or neurosurgery:
 - a. An independent residency program;
 - b. A regional residency rotation program; or
 - c. A collaborative residency program that includes multiple hospitals, with each non-sponsor participating hospital hosting at least one rotation.

²³ This requirement is met through participating in the provision of ATLS courses and having ATLS instructors on staff.

²⁴ When a Level III trauma center is in an area that contains a Level I or Level II trauma center, this is not required.

²⁵ This requirement is met through having an independent prevention program or participating in a collaborative prevention program. “Collaborative prevention program” means an organized effort, including multiple hospitals or sponsored or coordinated by a Regional Council or the Department, through which participating health care institutions promote injury prevention through primary, secondary, or tertiary prevention strategies. An independent or collaborative prevention program shall include:

1. Conducting injury control studies;
2. Monitoring the progress and effect of the prevention program;
3. Providing information resources for the public, and
4. Each participating hospital’s designating a prevention coordinator who serves as the hospital’s spokesperson for prevention and injury control activities.

²⁶ This requirement is met through participating in a prevention program organized at the national, regional, state, or local community level.

²⁷ This requirement is met through having an independent research program or participating in a collaborative research program. “Collaborative research program” means an organized effort, including multiple hospitals or sponsored or coordinated by a Regional Council or the Department, through which participating hospitals systematically investigate issues related to trauma and trauma care.

Injury control studies are considered to be research program activities if they have a stated focused hypothesis or research question.

²⁸ The trauma program shall provide at least 12 educational presentations every three years outside the academically affiliated institutions of the trauma center.



29 A trauma center is required to comply with the requirements of (K)(1) through (6), in addition to the requirements in (A) through (J), if the trauma center is represented as caring for pediatric trauma patients. "Represented as caring for pediatric trauma patients" means that a trauma center's availability or capability to care for pediatric trauma patients is advertised to the general public, health care providers, or emergency medical services providers through print media, broadcast media, the Internet, or other means such as the EMS system, administered by the Department.

30 The trauma center shall have a PICU available on-site.

31 This requirement may be satisfied by a transfer agreement.

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

Table with 7 columns: Trauma Facilities Criteria, I, I(P), II, II(P), III, IV. Rows include Institutional Organization, Hospital Departments/Divisions/Sections, and Clinical Capabilities.



Trauma Facilities Criteria	Levels					
	I	I(P)	II	II(P)	III	IV
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	-	-
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	-	-	-	-
D. Facilities/Resources/Capabilities						
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



Trauma Facilities Criteria	Levels					
	I	II(P)	II	II(P)	III	IV
xiii. Rapid infusion system/capability	E	E	E	E	E	E
xiv. Qualitative end-tidal CO2 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	-
g. Craniotomy instruments	E	E	E	E	-	-
h. Equipment for long bone and pelvic fixation	E	E	E	E	E	-
i. 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
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



Trauma Facilities Criteria	Levels					
	I	I(P)	II	II(P)	III	IV
c. <u>Resuscitation equipment for patients of all sizes, as specified in subsection (D)(1)(c)(i) to (v)</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>
d. <u>Angiography</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=	=
e. <u>Sonography</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
f. <u>Computed tomography (CT)</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
i. <u>In-house CT technician</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=	=
ii. <u>CT technician on-call and available within 45 minutes after notification</u>	=	=	=	=	<u>E</u>	=
f. <u>Magnetic resonance imaging</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=	=
7. <u>Clinical laboratory service (Available 24 hours/day)</u>						
a. <u>Standard analyses of blood, urine, and other body fluids</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>
b. <u>Blood typing and cross-matching</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
c. <u>Coagulation studies</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>
d. <u>Comprehensive blood bank or access to a community central blood bank and adequate storage facilities</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
e. <u>Blood gases and pH determinations</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>
f. <u>Microbiology</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
8. <u>Child maltreatment assessment capability</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>
<u>E. Rehabilitation Services Specific to the Patient Population</u>						
1. <u>Physical therapy</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
2. <u>Occupational therapy</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=	=
3. <u>Speech therapy</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=	=
<u>F. Social Services Specific to the Patient Population</u>						
1. <u>Social services</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
2. <u>Child life program</u>	=	<u>E</u>	=	<u>E</u>	=	=
<u>G. Performance Improvement</u>						
1. <u>Multidisciplinary peer review committee</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=
2. <u>Performance improvement personnel dedicated to the trauma service</u>	<u>E</u>	<u>E</u>	<u>E</u>	<u>E</u>	=	=

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 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:
 - 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;
 - 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.

~~R9-25-1406.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 submitting health care institution shall allow the Department to review the following, upon prior notice from the Department of at least five business days:

 - 1. The submitting health care institution's database that includes data regarding cases;
 - 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.~~
- ~~B. Upon prior notice from the Department of at least five business days, a submitting health care institution shall provide the Department with all of its patient medical records for a time period specified by the Department, to allow the Department to review the patient medical records and determine whether the submitting health care institution has submitted data to the trauma registry for the cases who received medical services within the time period.~~
- ~~C. For purposes of subsection (B), the Department considers a submitting health care institution to be in compliance with R9-25-1402(A) if the submitting health care institution submitted data to the trauma registry for 97% of the cases who received medical services within the time period.~~
- ~~D. The Department shall return to a submitting health care institution data not submitted in compliance with R9-25-1402 and shall identify the revisions that are needed to bring the data into compliance with R9-25-1402.~~
- ~~E. A submitting health care institution that has trauma registry data returned as provided in subsection (D) shall revise the data as identified by the Department and shall submit the revised data to the Department within 15 business days after the date the Department returned the data or within a longer period agreed upon between the Department and the submitting health care institution.~~
- ~~F. Within 15 business days after receiving a written request from the Department that includes a simulated patient medical record, a submitting health care institution shall prepare and submit to the Department the data set identified in Table 1 for the patient described in the simulated patient medical record.~~
- ~~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 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.~~

ARTICLE 14. TRAUMA REGISTRY; TRAUMA SYSTEM QUALITY ASSURANCE REPEALED

R9-25-1401. Definitions (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))
Repealed

The following definitions apply in this Article, unless otherwise specified:

- 1. "Aggregate trauma data" means a collection of data from the trauma registry that is compiled so that it is not possible to identify a particular trauma patient, trauma patient's family, health care provider, or health care institution.
- 2. "AIS" means abbreviated injury scale, an anatomic severity scoring system established in Association for the Advancement of Automotive Medicine Committee on Injury Scoring, *Abbreviated Injury Scale (AIS) 2005* (2005), incorporated by reference, including no future editions or amendments, and available from Association for the Advancement of Automotive Medicine, P.O. Box 4176, Barrington, IL 60011-4176, and www.eaerash.org.
- 3. "ALS base hospital" has the same meaning as "advanced life support base hospital" in A.R.S. 36-2201.



4. "Case" means a patient who meets R9-25-1402(A)(1), (2), or (3).
5. "Category" means a group of related codes within the ICD-9-CM, identified by the first three digits of each code number within the group, and including all code numbers that share the same first three digits.
6. "Data element" means a categorized piece of information.
7. "Data set" means a collection of data elements that includes, for each case, data that complies with Table 1.
8. "Department" means the Arizona Department of Health Services.
9. "ED" means emergency department, an organized area of a hospital that provides unscheduled emergency services, as defined in A.A.C. R9-10-201, 24 hours per day, seven days per week, to individuals who present for immediate medical attention.
10. "EMS" has the same meaning as "emergency medical services" in A.R.S. § 36-2201.
11. "EMS provider" has the same meaning as "emergency medical services provider" in A.R.S. § 36-2201.
12. "GCS" means Glasgow Coma Scale, a scoring system that defines eye, motor, and verbal responses in the patient with injury.
13. "Health care institution" has the same meaning as in A.R.S. § 36-401.
14. "Health care provider" means a caregiver involved in the delivery of trauma services to a patient, whether in a prehospital setting, in a hospital setting, or during rehabilitation.
15. "Hospital" has the same meaning as in A.A.C. R9-10-201.
16. "ICD-9-CM" has the same meaning as in A.A.C. R9-4-101.
17. "ICD-9-CM E code" means the external cause of injury as coded according to the ICD-9-CM.
18. "ICD-9-CM N code" means the nature of injury as coded according to the ICD-9-CM.
19. "ICD-9-CM Procedure Code" means the procedure performed on a patient as coded according to the ICD-9-CM.
20. "Injury" means the result of an act that damages, harms, or hurts; unintentional or intentional damage to the body resulting from acute exposure to mechanical, thermal, electrical, or chemical energy or from the absence of such essentials as heat or oxygen.
21. "ISS" has the same meaning as in R9-25-1301.
22. "Owner" has the same meaning as in R9-25-1301.
23. "Patient" means an individual who is sick, injured, or dead and who requires medical monitoring, medical treatment, or transport.
24. "Scene" means a location, other than a health care institution, from which a patient is transported.
25. "Submitting health care institution" means a health care institution that submits data to the trauma registry as provided in R9-25-1402.
26. "Trauma center" means a health care institution that meets the definition of "trauma center" in A.R.S. § 36-2201 or the definition of "trauma center" in A.R.S. § 36-2225.
27. "Trauma registry" has the same meaning as in A.R.S. § 36-2201.
28. "Trauma team" means a group of health care providers organized to provide care to trauma patients.
29. "Trauma team activation" means notification of trauma team members in response to triage information received concerning a patient with injury or suspected injury.
30. "Trauma triage protocol" means a "triage protocol," as defined in R9-25-101, specifically designed for use with patients with injury.

R9-25-1402. Data Submission Requirements (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)) Repealed

- A.** As required under A.R.S. § 36-2221 and R9-25-1313, an owner of a trauma center shall ensure that the data set identified in Table 1 is submitted to the Department, as prescribed in subsection (B), for each patient who meets one or more of the following criteria:
1. A patient with injury or suspected injury who is triaged from a scene to a trauma center or ED based upon the responding EMS provider's trauma triage protocol;
 2. A patient with injury or suspected injury for whom a trauma team activation occurs; or
 3. A patient with injury who is admitted as a result of the injury or who dies as a result of the injury, who has an ICD-9-CM N code within categories 800 through 959, and who does not only have:
 - a. Late effects of injury or another external cause, as demonstrated by an ICD-9-CM N code within categories 905 through 909;
 - b. A superficial injury or contusion, as demonstrated by an ICD-9-CM N code within categories 910 through 924;
 - c. Effects of a foreign body entering through an orifice, as demonstrated by an ICD-9-CM N code within categories 930 through 939;
 - d. An isolated femoral neck fracture from a same-level fall, as demonstrated by:
 - i. An ICD-9-CM N code within category 820; and
 - ii. An ICD-9-CM E code within category E885 or E886;
 - e. An isolated distal extremity fracture from a same-level fall, as demonstrated by:
 - i. An ICD-9-CM N code within categories 813 through 817 or within categories 823 through 826; and
 - ii. An ICD-9-CM E code within category E885 or E886;
 - f. An isolated burn, as demonstrated by an ICD-9-CM N code within categories 940 through 949.
- B.** An owner of a trauma center shall submit the data required under subsection (A) to the Department:
1. On a quarterly basis according to the following schedule:
 - a. For cases identified between January 1 and March 31, so that it is received by the Department by July 1 of the same calendar year;
 - b. For cases identified between April 1 and June 30, so that it is received by the Department by October 1 of the same calendar year;
 - c. For cases identified between July 1 and September 30, so that it is received by the Department by January 2 of the following calendar year; and



- d. For cases identified between October 1 and December 31, so that it is received by the Department by April 1 of the following calendar year;
 - 2. Through an electronic reporting system authorized by the Department;
 - 3. In a format authorized by the Department; and
 - 4. Along with the following information:
 - a. The name and physical address of the trauma center;
 - b. The date the trauma data is being submitted to the Department;
 - c. The total number of cases for whom trauma data is being submitted;
 - d. The quarter and year for which trauma data is being submitted;
 - e. The range of ED or hospital arrival dates for the cases for whom trauma data is being submitted;
 - f. The name, title, phone number, fax number, and e-mail address of the trauma center's point of contact for the trauma data; and
 - g. Any special instructions or comments to the Department from the trauma center's point of contact.
- C. An ALS base hospital certificate holder that chooses to submit trauma data to the Department, as provided in A.R.S. § 36-2221, shall comply with the data submission requirements in this Section for an owner of a trauma center.

Table 1. Trauma Registry Data Set (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)) Repealed

KEY:

Required for TC Levels I, II, and III – An owner of a hospital designated as a Level I, Level II, or Level III trauma center under Article 13 of this Chapter shall include these data elements in the data submission required under R9-25-1402.

Required for TC Level IV, Non-Designated TC, and ALS Base Hospital – An owner of a health care institution designated as a Level IV trauma center under Article 13 of this Chapter; an owner of a trauma center, as defined in A.R.S. § 36-2201, that is not designated as a trauma center under Article 13 of this Chapter; or an ALS base hospital certificate holder that submits trauma data as provided under A.R.S. § 36-2221 shall include these data elements in the data submission required under R9-25-1402.

* – Only required for hospitals designated as Level I trauma centers under Article 13 of this Chapter.

Field Name/Data Element Description	Required for TC Levels I, II, and III	Required for TC Level IV, Non-Designated TC, and ALS Base Hospital
DEMOGRAPHIC DATA ELEMENTS		
Reporting Facility Site ID	X	X
Registration Number	X	X
Medical Record Number	X	X
Hospital Admission Date	X	X
Admission Status	X	X
Patient Last Name	X	X
Patient First Name	X	X
Patient Middle Initial	X	X
Social Security Number	X	X
Date of Birth	X	X
Age	X	X
Units of Age	X	X
Gender	X	X
Race	X	X
Ethnicity	X	X
Zip Code of Residence	X	
City of Residence	X	
County of Residence	X	
State of Residence	X	X
Country of Residence	X	
Alternate Home Residence	X	
Co-Morbid Conditions (Pre-Existing)	X	



INJURY DATA ELEMENTS		
Injury Date	X	X
Injury Time	X	X
Actual versus Estimated Injury Time	X	
Injury Location ICD-9-CM E-code (E849)	X	X
Street Location of Injury	X	
Zip Code of Injury	X	X
City of Injury	X	X
County of Injury	X	
State of Injury	X	
Primary ICD-9-CM E-code Injury Descriptor	X	X
Additional ICD-9-CM E-code Injury Descriptor	X	
Trauma Type	X	
Work-Related	X	
Patient Occupational Industry	X	
Patient Occupation	X	
Patient Position in Vehicle	X	
Protective Devices	X	X
Child Specific Restraint	X	
Airbag Deployment	X	
Safety Equipment Issues	X	
PREHOSPITAL TRANSPORT DATA ELEMENTS		
EMS Provider Type	X	
Transport Mode (Into Reporting Facility)	X	X
Other Transport Modes	X	
Transport Agency	X	
Run Sheet Available?	X	
Run Sheet Date	X	
Transported From	X	
Date EMS Provider Notified	X	
Time EMS Provider Notified	X	
Date EMS Provider Left for Scene	X	
Time EMS Provider Left for Scene	X	
Date EMS Provider Arrived at Scene	X	
Time EMS Provider Arrived at Scene	X	
Date of EMS Patient Contact	X	
Time of EMS Patient Contact	X	
Date EMS Provider Departed Scene	X	
Time EMS Provider Departed Scene	X	
Date of Arrival at Destination	X	
Time of Arrival at Destination	X	
EMS Destination	X	
Total EMS Response Time (Minutes)	X	
Total EMS Scene Time (Minutes)	X	
Transport Time—Scene to Destination (Minutes)	X	
Total EMS Time (Minutes)	X	
System Access	X	
Triage Criteria	X	X
Date of Measurement of Vital Signs	X	
Time of Measurement of Vital Signs	X	



Initial Field Pulse Rate	X	
Initial Field Respiratory Rate	X	
Initial Field Oxygen Saturation	X	
Field Airway Management Details	X	
Field Intubation Status	X	
Field Paralytic Agent in Effect	X	
Initial Field Systolic Blood Pressure	X	
Initial Field GCS—Eye Opening	X	
Initial Field GCS—Verbal Response	X	
Initial Field GCS—Motor Response	X	
Initial Field GCS—Total	X	
Field Revised Trauma Score	X	
REFERRING/TRANSFER HOSPITAL DATA ELEMENTS		
Interfacility Transfer	X	
Date of Arrival at First Referring Hospital	X	
Time of Arrival at First Referring Hospital	X	
Date of Transfer from First Referring Hospital	X	
Time of Transfer from First Referring Hospital	X	
Transferring Facility (First Referring)	X	
Length of Stay in First Referring Hospital (Hours)	X	
Destination Facility	X	
Date of Arrival at Second Referring Hospital	X	
Time of Arrival at Second Referring Hospital	X	
Date of Transfer from Second Referring Hospital	X	
Time of Transfer from Second Referring Hospital	X	
Transferring Facility (Second Referring)	X	
Length of Stay in Second Referring Hospital (Hours)	X	
Destination Facility	X	
Vital Signs Designation (If First or Second Referring)	X	
Initial Respiratory Rate in Referring Facility	X	
Initial Systolic Blood Pressure in Referring Facility	X	
Initial GCS Total in Referring Facility	X	
Initial Revised Trauma Score in Referring Facility	X	
ED/TRAUMA DATA ELEMENTS		
ED/Hospital Arrival Date	X	X
ED/Hospital Arrival Time	X	X
ED Exit Date	X	X
ED Exit Time	X	X
Length of Stay in ED (Hours)	X	X
Complete Trauma Team Arrival Time	X	
ED Discharge Disposition	X	X
ED Discharge Destination Hospital	X	X
Discharge Transport Agency	X	
Transfer Reason	X	
ED/Hospital Initial Pulse Rate	X	
ED/Hospital Initial Respiratory Rate	X	
ED/Hospital Initial Respiratory Assistance	X	
ED/Hospital Initial Oxygen Saturation	X	
ED/Hospital Initial Supplemental Oxygen	X	
ED/Hospital Intubation Status	X	
ED/Hospital Paralytic Agent in Effect	X	



ED/Hospital Initial Systolic Blood Pressure	X	
ED/Hospital Initial GCS— Eye Opening	X	
ED/Hospital Initial GCS— Verbal Response	X	
ED/Hospital Initial GCS— Motor Response	X	
ED/Hospital Initial GCS— Total	X	
ED/Hospital Initial GCS Assessment Qualifiers	X	
ED/Hospital Initial Temperature	X	
ED/Hospital Initial Units of Temperature	X	
ED/Hospital Initial Temperature Route	X	
ED/Hospital Initial Revised Trauma Score	X	
Alcohol Use Indicator	X	
Blood Alcohol Content (mg/dl)	X	
Drug Use Indicator	X	
Toxicology Substances Found	X	
DISCHARGE DATA ELEMENTS		
Hospital Discharge Date	X	X
Hospital Discharge Time	X	X
Hospital Admission Length of Stay (Days)	X	X
Total Length of Hospital Stay— ED plus Admission (Days)	X	
Final Outcome— Dead or Alive	X	X
Total ICU Length of Stay (Days)	X	X
Total Ventilator Days	X	
Hospital Discharge Disposition	X	X
Hospital Discharge Destination Hospital	X	X
Discharge Transport Agency	X	
Transfer Reason	X	
Autopsy Identification Number	X	
Injury Diagnoses— ICD-9-CM-N codes	X	X
AIS Six-Digit Injury Identifier	X*	
AIS Severity Code	X	
AIS Body Region of Injury	X	
Injury Severity Score	X	
Probability of Survival	X	
ED/Hospital Procedure Location	X	
ED/Hospital Procedure Start Date	X	
ED/Hospital Procedure Start Time	X	
ED/Hospital ICD-9-CM Procedure Codes	X	
Hospital Complications-	X	
Primary Method of Payment	X	
Secondary Method of Payment	X	
Total Hospital Charges	X	
Total Reimbursements	X	

R9-25-1403. Trauma System Data Reports; Requests for Trauma Registry Reports (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)) Repealed

- A.** The Department shall produce and disseminate to each submitting health care institution a quarterly trauma system data report that includes statewide aggregate trauma data.
- B.** A person may request to receive a report containing statewide aggregate trauma data for data elements not included in the quarterly trauma system data report by submitting a written public records request to the Department as provided in A.A.C. R9-1-303.
- C.** The Department shall process a request for a report submitted under subsection (B) as provided in A.A.C. R9-1-303.
- D.** As provided in A.R.S. § 36-2220(A)(1), Trauma Registry data from which a patient, the patient’s family, or the patient’s health care provider or facility might be identified is confidential and is not available to the public.



R9-25-1405. Confidentiality and Retention of Trauma System Quality Assurance Data (Authorized by A.R.S. §§ 36-2202(A)(4), 36-2208(A), 36-2209(A)(2), 36-2220(A), 36-2221, 36-2222(E)(3), 36-2225(A)(5) and (6), 36-2403(A), and 36-2404) Repealed

A. As provided in A.R.S. §§ 36-2220(A)(2) and 36-2403(A), all data and documents obtained by the Department or considered by the Department, the State Trauma Advisory Board, or a State Trauma Advisory Board subcommittee for purposes of trauma system quality assurance are confidential and are not available to the public.

B. The Department shall ensure that:

1. Each member of the State Trauma Advisory Board or member of a State Trauma Advisory Board subcommittee who will have access to the data and documents described in subsection (A) executes a written confidentiality statement before being allowed access to the data and documents;
2. All trauma system quality assurance activities are completed in executive session during State Trauma Advisory Board or State Trauma Advisory Board subcommittee meetings;
3. Except for one historical copy, all copies of data and documents described in subsection (A) and used during an executive session are collected at the end of the executive session and destroyed after the State Trauma Advisory Board or State Trauma Advisory Board subcommittee meeting; and
4. Executive session minutes and all copies of data and documents described in subsection (A) are maintained in a secure area and are accessible only to authorized Department employees.

R9-25-1406. Renumbered



GOVERNOR EXECUTIVE ORDERS

The Administrative Procedure Act (APA) requires the full-text publication of Governor Executive Orders.

With the exception of egregious errors, content (including spelling, grammar, and punctuation) of these orders has been reproduced as submitted.

In addition, the Register shall include each statement filed by the Governor in granting a commutation, pardon or reprieve, or stay or suspension of execution where a sentence of death is imposed.

EXECUTIVE ORDER 2017-02

Internal Review of Administrative Rules; Moratorium to Promote Job Creation and Customer-Service-Oriented Agencies

[M17-23]

Editor's Note: This Executive Order is being reproduced in each issue of the Administrative Register until its expiration on December 31, 2017, as a notice to the public regarding state agencies' rulemaking activities.

WHEREAS, burdensome regulations inhibit job growth and economic development;

WHEREAS, job creators and entrepreneurs are especially hurt by red tape and regulations;

WHEREAS, all government agencies of the State of Arizona should promote customer-service-oriented principles for the people that it serves;

WHEREAS, each State agency should undertake a critical and comprehensive review of its administrative rules and take action to reduce the regulatory burden, administrative delay, and legal uncertainty associated with government regulation;

WHEREAS, overly burdensome, antiquated, contradictory, redundant, and nonessential regulations should be repealed;

WHEREAS, Article 5, Section 4 of the Arizona Constitution and Title 41, Chapter 1, Article 1 of the Arizona Revised Statutes vests the executive power of the State of Arizona in the Governor;

NOW, THEREFORE, I, Douglas A. Ducey, by virtue of the authority vested in me by the Constitution and laws of the State of Arizona hereby declare the following:

- 1. A State agency subject to this Order, shall not conduct any rulemaking except as permitted by this Order.
2. A State agency subject to this Order, shall not conduct any rulemaking, whether informal or formal, without the prior written approval of the Office of the Governor. In seeking approval, a State agency shall address one or more of the following as justification for the rulemaking:
a. To fulfill an objective related to job creation, economic development, or economic expansion in this State.
b. To reduce or ameliorate a regulatory burden while achieving the same regulatory objective.
c. To prevent a significant threat to the public health, peace, or safety.
d. To avoid violating a court order or federal law that would result in sanctions by a court of the federal government against an agency for failure to conduct the rulemaking action.
e. To comply with a federal statutory or regulatory requirement if such compliance is related to a condition for the receipt of federal funds or participation in any federal program.
f. To comply with a state statutory requirement.
g. To fulfill an obligation related to fees or any other action necessary to implement the State budget that is certified by the Governor's Office of Strategic Planning and Budgeting.
h. To promulgate a rule or other item that is exempt from Title 41, Chapter 6, Arizona Revised Statutes, pursuant to section 41-1005, Arizona Revised Statutes.
i. To address matters pertaining to the control, mitigation, or eradication of waste, fraud, or abuse within an agency or wasteful, fraudulent, or abusive activities perpetrated against an agency.
j. To eliminate rules that are antiquated, redundant or otherwise no longer necessary for the operation of state government.
3. All directors of state agencies subject to this Order shall engage their respective regulated or stakeholder communities to solicit comment on which rules the regulated community believes to be overly burdensome and not necessary to protect consumers, public health, or public safety. Each agency shall submit a report regarding the aforementioned information to the Governor's Office no later than September 1, 2017.
4. For the purposes of this Order, the term "State agencies," includes without limitation, all executive departments, agencies, offices, and all state boards and commissions, except for: (a) any State agency that is headed by a single elected State official, (b) the Corporation Commission and (c) any board or commission established by ballot measure during or after the November 1998 general election. Those State agencies, boards and commissions excluded from this Order are strongly encouraged to voluntarily comply with this Order in the context of their own rulemaking processes.
5. This Order does not confer any legal rights upon any persons and shall not be used as a basis for legal challenges to rules, approvals, permits, licenses or other actions or to any inaction of a State agency. For the purposes of this Order, "person," "rule," and "rulemaking" have the same meanings prescribed in Arizona Revised Statutes Section 41-1001.



6. This Executive Order expires on December 31, 2017.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona.

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this Eleventh day of January in the Year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-First.

ATTEST:

Michele Reagan
SECRETARY OF STATE



GOVERNOR PROCLAMATIONS

The Administrative Procedure Act (APA) requires the publication of Governor proclamations of general applicability, and ceremonial dedications issued by the Governor.

ARIZONA PURPLE HEART DAY

[M17-281]

WHEREAS, the Purple Heart is the oldest military decoration in the United States in present use; and

WHEREAS, General George Washington established the Purple Heart during the Revolutionary War in Newburgh, New York on August 7, 1782 as an incentive for members of the Continental Army; and

WHEREAS, the Purple Heart was the first award made available to the common soldier to recognize outstanding valor or merit; and

WHEREAS, the Purple Heart is a combat decoration that is awarded to living military members of the United States armed forces who are wounded by an instrument of war in the hands of the enemy or that is awarded posthumously to the next of kin in the name of those who were killed in action or who died from wounds received in action; and

WHEREAS, recipients of the Purple Heart know the meaning of sacrifice in the preservation of the United States of America and national interests at home and abroad; and

WHEREAS, there are approximately 1.7 million Purple Heart recipients in our nation’s history, many of whom are from the State of Arizona.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 7, 2017, as

ARIZONA PURPLE HEART DAY

in special tribute to current and former members of the United States Armed Forces who have received the Purple Heart and to honor the families of fallen Purple Heart recipients.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this twenty-second day of June in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-First.

ATTEST:
Michele Reagan
SECRETARY OF STATE

CHILD SUPPORT AWARENESS MONTH

[M17-282]

WHEREAS, the State of Arizona joins the Nation in recognizing August as Child Support Awareness Month, and reaffirms its commitment to strengthening Arizona’s families by providing child support services to improve the economic stability and well-being of Arizona’s children; and

WHEREAS, the State of Arizona will always be tireless advocates for our children, whose safety and security remains top of mind; and

WHEREAS, the Arizona Department of Economic Security, Division of Child Support Services collaborates with the Office of the Attorney General, federal and state agencies, tribal governments, County Attorney Offices, County Clerks of Court, faith-based and community organizations, fatherhood groups, enforcement agencies, the business community and employers, and other interested parties in sustaining a stalwart community that assists parents in establishing a financial partnership to support their children; and

WHEREAS, a child who receives emotional and financial support is more likely to feel safe and secure and is better equipped to be their very best in life; and

WHEREAS, child support awareness month salutes the diligent parents who spend time with their child and who make regular child support payments, to safeguard their children’s future; and

WHEREAS, the Department of Economic Security Division of Child Support Services, is robustly committed to putting Arizona’s children first and to humbly serving Arizonans with excellence, respect, integrity and kindness, as well as being an overall champion for economic growth and opportunity.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 2017 as

**CHILD SUPPORT AWARENESS MONTH**

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this twenty-fifth day of April in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-First.

ATTEST:
Michele Reagan
SECRETARY OF STATE

CONCRETE PIPE WEEK

[M17-283]

WHEREAS, reinforced concrete pipe and precast concrete products are of vital importance to sustainable communities and to the health, safety, and well-being of the people of Arizona; and

WHEREAS, such reinforced concrete pipe and precast concrete products and services could not be provided without the dedicated efforts of the concrete pipe and precast concrete industry, the trucking industry, the sand and rock producers, the cement producers, and Arizona employees, owners, and contractors, who design, construct, and maintain our infrastructure, which is essential to our state; and

WHEREAS, it is in the public interest for the citizens, civic leaders, and children in Arizona to gain knowledge of and understand the importance of reinforced concrete pipe and precast concrete in their respective communities; and

WHEREAS, the year 2017 marks the 113th year of the American Concrete Pipe Association, which began as a means of exchanging ideas and establishing a high quality, standardized product, which the American Concrete Pipe Association fully supports in both actions and deeds.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona do hereby proclaim August 20 – 26, 2017, as

CONCRETE PIPE WEEK

and I encourage the citizens of Arizona to join with representatives of the Arizona Precast Concrete Pipe Association and the American Concrete Pipe Association in activities and ceremonies designed to pay tribute to our reinforced concrete pipe and precast concrete industry producers, associate members, and Arizona employees associated with this industry.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this twenty-sixth day of July in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-Second.

ATTEST:
Michele Reagan
SECRETARY OF STATE

DROWNING IMPACT AWARENESS MONTH

[M17-284]

WHEREAS, Arizona's future prosperity depends upon the long-term health, safety, and well-being of the nearly two million children and teens in our state; and

WHEREAS, drowning is a top cause of injury and death for children and teens in Arizona, affecting not only the victims, but also families, emergency personnel, and our society as a whole; and

WHEREAS, child drownings are nearly 100 percent preventable, including drownings which are classified as maltreatment; and

WHEREAS, research-proven strategies can save lives, including constant and capable supervision, restricting access to water, use of life jackets, swimming lessons for adults and children at the appropriate age, rapid emergency response, including CPR, and safe, stable and nurturing relationships and communities to break the cycle of maltreatment; and

WHEREAS, awareness of the problem is just the first step; evidence-based programs to bring these strategies to families is the best way to save lives; and

WHEREAS, during the month of August, Phoenix Children's Hospital, in collaboration with state and local governments, community organizations, and private citizens, will be engaging communities throughout Arizona in a coordinated and comprehensive response.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 2017 as



DROWNING IMPACT AWARENESS MONTH

and urge all communities and citizens of Arizona to participate in efforts to reduce drowning risk, strengthen families, and protect children and teens.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey

GOVERNOR

DONE at the Capitol in Phoenix on this first day of June in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-First.

ATTEST:

Michele Reagan

SECRETARY OF STATE

EMPLOYER SUPPORT OF THE GUARD AND RESERVE WEEK

[M17-285]

WHEREAS, National Guard and Reserve forces comprise nearly half of our Nation’s military strength, and are essential to America’s national security; and

WHEREAS, Reserve Component forces stand ready to answer the call to serve, whether alongside active duty counterparts all across the globe or responding to humanitarian crisis at home and abroad; and

WHEREAS, employers provide critical support to members of the National Guard and Reserve; allowing Citizen Warriors to serve whenever the Nation calls, often foregoing financial gain and making sacrifices in the process; and

WHEREAS, employer support is stronger than ever, more than 43 years after President Richard Nixon authorized the Secretary of Defense to establish the National Committee for Employer Support of the Guard and Reserve (ESGR); and

WHEREAS, our Nation is indebted to the Citizen Warriors who leave the comforts of home to ensure our freedoms remain intact. Likewise, America pays special tribute to the commitment of dedicated and supportive employers who continue to make service in the Reserve Components possible.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 20 – 26, 2017, as

EMPLOYER SUPPORT OF THE GUARD AND RESERVE WEEK

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey

GOVERNOR

DONE at the Capitol in Phoenix on this eighteenth day of August in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-Second.

ATTEST:

Michele Reagan

SECRETARY OF STATE

GASTROPARESIS AWARENESS MONTH

[M17-286]

WHEREAS, gastroparesis is a chronic illness that affects more than 1.5 million people in the United States; yet is little known to those in our state; and

WHEREAS, gastroparesis is “paralysis of the stomach” which causes sometimes debilitating pain, nausea, vomiting, early satiety, and can lead to serious complications such as malnourishment, dehydration, extreme weight loss, and overwhelming fatigue; and

WHEREAS, there is little awareness, no known cure, and few effective treatment options or medications; and

WHEREAS, more research is needed to improve medications and develop additional treatment options, better support, and hope for our future; and

WHEREAS, we seek to educate the medical community and the general public regarding the devastating effects of this disorder and promote awareness of our condition for the good of the public health.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 2017 as



GASTROPARESIS AWARENESS MONTH

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey

GOVERNOR

DONE at the Capitol in Phoenix on this thirty-first day of May in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-First.

ATTEST:

Michele Reagan

SECRETARY OF STATE

INTERNATIONAL ASSISTANCE DOG WEEK

[M17-287]

WHEREAS, assistance dogs transform the lives of their human partners who have physical, mental, and emotional disabilities; and

WHEREAS, assistance dogs serve as devoted partners, aides, best friends, and close family members; and

WHEREAS, assistance dogs include guide dogs, hearing alert dogs, service dogs, and seizure alert/response dogs; and

WHEREAS, guide dogs assist people with vision loss, leading these individuals around physical obstacles; and

WHEREAS, alert dogs notify people with a hearing loss to the presence of specific sounds such as doorbells, telephones, and sirens, as well as smoke and fire alarms; and

WHEREAS, service dogs assist people with disabilities such as difficulty walking and balancing by retrieving and carrying items, pulling wheelchairs, and aiding with household chores; and

WHEREAS, seizure alert/response dogs alert or respond to medical conditions such as seizures, epilepsy, dizziness, and chronic pain; and

WHEREAS, International Assistance Dog Week provides an opportunity for us to raise awareness of the selfless way all types of assistance dogs assist individuals with mitigating their disability-related limitations.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 6 – 12, 2017, as

INTERNATIONAL ASSISTANCE DOG WEEK

and I encourage all citizens of the State of Arizona to join assistance dog partners and organizations in raising awareness of assistance dogs and observing International Assistance Dog Week.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey

GOVERNOR

DONE at the Capitol in Phoenix on this twelfth day of June in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-First.

ATTEST:

Michele Reagan

SECRETARY OF STATE

KURT WARNER DAY

[M17-288]

WHEREAS, Kurt Warner has been an integral part of the Arizona community since his first season with the Arizona Cardinals in 2005; and

WHEREAS, his time as an Arizona Cardinal reinvigorated the fan base, as he led the team to multiple playoff victories and the first Super Bowl appearance in team history; and

WHEREAS, his talent and leadership on the field surpassed many all-time greats, solidifying his place among the best to ever play the game and earning him a bust in the Pro Football Hall of Fame; and

WHEREAS, through his philanthropic efforts, Kurt Warner's impact on Arizona extends beyond the sport of football. In partnership with his wife, Brenda, he established the 501(c)(3) non-profit First Things First, which seeks to support the community through various programs such as *Warner's Corner*, *Warners' Warm-Up Coat Drive*, and *Treasure House*; and

WHEREAS, Arizonans are proud to have Kurt Warner as a member of the community and are thankful for his service to those in need.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, in honor of the number 13 dawned on his jersey for more than a decade, do hereby proclaim August 13, 2017, as



KURT WARNER DAY

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this eleventh day of August in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-Second.

ATTEST:
Michele Reagan
SECRETARY OF STATE

MUSCULAR DYSTROPHY AWARENESS MONTH

[M17-289]

WHEREAS, muscular dystrophy is not a single disease or disorder that effects everyone the same way but an umbrella term covering more than 52 different types of muscular and neuromuscular diseases ranging in severity; and

WHEREAS, all muscular dystrophies result in progressive muscle weakness, from mild muscle weakness to complete paralysis of all voluntary muscles, including those used for breathing and/or swallowing; and

WHEREAS, muscular dystrophy strikes people regardless of race, sex, age or ethnicity; and

WHEREAS, raising public awareness of these diseases will continue to facilitate the discovery of treatments and cures, as well as bring much needed funding for support and services for families in the State of Arizona affected by muscular dystrophy and neuromuscular diseases; and

WHEREAS, Muscular Dystrophy Awareness Month and “Light it Up Green for MD” Month is a special opportunity to educate the public about muscular dystrophy and issues in the muscular dystrophy community.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 2017 as

MUSCULAR DYSTROPHY AWARENESS MONTH

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this tenth day of July in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-Second.

ATTEST:
Michele Reagan
SECRETARY OF STATE

SHORT BOWEL SYNDROME AWARENESS MONTH

[M17-290]

WHEREAS, Short Bowel Syndrome, a rare disease in which individuals suffer from various complications such as malabsorption and chronic deficiencies because of the inability to absorb enough water, vitamins, minerals, protein, fat, calories, and other nutrients from food. Classification of Short Bowel Syndrome is by surgical removal of 50% or more of the small intestine, or due to the complete dysfunction of a large segment of the small bowel; is a condition affecting an estimated 10,000 to 20,000 people in the United States; this condition strikes without regard to gender, race, age, or economic status; and

WHEREAS, the primary onset of Short Bowel Syndrome can happen at any age (though primarily in infants and children) whether it be while the fetus is in utero, any aged child, teenager, or adult who has experienced a trauma to the small intestine; and

WHEREAS, programs allow for various treatments, education, therapies and assistance such as intravenous and enteral nutrition, to all who may need it, which may allow for the management of the serious implications of this incurable condition; and

WHEREAS, support and advocacy for Short Bowel Syndrome is scarce. There are very few resources and organizations that exist to provide patient support and advocacy efforts. Resources such as the Short Bowel Syndrome Foundation (SBSF) aide in research, drug development, patient support groups-with the primary population being family or patient’s and fundraising events, allowing the Foundation to provide patient and physician support for Short Bowel Syndrome; and

WHEREAS, SBSF increases the public’s awareness of Short Bowel Syndrome in individuals of all ages, help children, parents, adults, and health care providers to understand, recognize, and treat the complexities of an that which come with Short Bowel Syndrome.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 2017 as



SHORT BOWEL SYNDROME AWARENESS MONTH

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this tenth day of July in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-Second.

ATTEST:
Michele Reagan
SECRETARY OF STATE

SPINAL MUSCULAR ATROPHY AWARENESS MONTH

[M17-291]

WHEREAS, Spinal Muscular Atrophy (SMA) is the leading genetic cause of death in children under the age of two, and 1 in 40 Americans carry the gene that causes SMA; and

WHEREAS, SMA is a motor neuron disease which affects the voluntary muscles that are used for activities such as crawling, walking, head and neck control, and swallowing, and there is currently no treatment or cure for SMA, which is known to cause degeneration in voluntary muscle movement for those that survive with this disease; and

WHEREAS, SMA crosses all racial, ethnic, and religious boundaries, and can occur in anyone of any age or gender; and

WHEREAS, increased awareness of SMA will lead to increased knowledge and increased support for families affected by the condition and research, hopefully leading to effective treatment and a cure; and

WHEREAS, August is designated as National Spinal Muscular Atrophy Awareness Month in order to raise awareness and help promote research into this devastating disease; and

WHEREAS, the local Arizona Chapter can offer family support, resources, assistance in finding knowledgeable medical professionals and helping to gain necessary equipment to our families impacted by SMA.

NOW, THEREFORE, I, Douglas A. Ducey, Governor of the State of Arizona, do hereby proclaim August 2017 as

SPINAL MUSCULAR ATROPHY AWARENESS MONTH

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this twelfth day of June in the year Two Thousand and Seventeen and of the Independence of the United States of America the Two Hundred and Forty-First.

ATTEST:
Michele Reagan
SECRETARY OF STATE

REGISTER INDEXES

The *Register* is published by volume in a calendar year (See “General Information” in the front of each issue for more information).

Abbreviations for rulemaking activity in this Index include:

PROPOSED RULEMAKING

PN = Proposed new Section
PM = Proposed amended Section
PR = Proposed repealed Section
P# = Proposed renumbered Section

SUPPLEMENTAL PROPOSED RULEMAKING

SPN = Supplemental proposed new Section
SPM = Supplemental proposed amended Section
SPR = Supplemental proposed repealed Section
SP# = Supplemental proposed renumbered Section

FINAL RULEMAKING

FN = Final new Section
FM = Final amended Section
FR = Final repealed Section
F# = Final renumbered Section

SUMMARY RULEMAKING**PROPOSED SUMMARY**

PSMN = Proposed Summary new Section
PSMM = Proposed Summary amended Section
PSMR = Proposed Summary repealed Section
PSM# = Proposed Summary renumbered Section

FINAL SUMMARY

FSMN = Final Summary new Section
FSMM = Final Summary amended Section
FSMR = Final Summary repealed Section
FSM# = Final Summary renumbered Section

EXPEDITED RULEMAKING**PROPOSED EXPEDITED**

PEN = Proposed Expedited new Section
PEM = Proposed Expedited amended Section
PER = Proposed Expedited repealed Section
PE# = Proposed Expedited renumbered Section

SUPPLEMENTAL EXPEDITED

SPEN = Supplemental Proposed Expedited new Section
SPEM = Supplemental Proposed Expedited amended Section
SPER = Supplemental Proposed Expedited repealed Section
SPE# = Supplemental Proposed Expedited renumbered Section

FINAL EXPEDITED

FEN = Final Expedited new Section
FEM = Final Expedited amended Section
FER = Final Expedited repealed Section
FE# = Final Expedited renumbered Section

EXEMPT RULEMAKING**EXEMPT PROPOSED**

PXN = Proposed Exempt new Section
PXM = Proposed Exempt amended Section
PXR = Proposed Exempt repealed Section
PX# = Proposed Exempt renumbered Section

EXEMPT SUPPLEMENTAL PROPOSED

SPXN = Supplemental Proposed Exempt new Section
SPXR = Supplemental Proposed Exempt repealed Section
SPXM = Supplemental Proposed Exempt amended Section
SPX# = Supplemental Proposed Exempt renumbered Section

FINAL EXEMPT RULEMAKING

FXN = Final Exempt new Section
FXM = Final Exempt amended Section
FXR = Final Exempt repealed Section
FX# = Final Exempt renumbered Section

EMERGENCY RULEMAKING

EN = Emergency new Section
EM = Emergency amended Section
ER = Emergency repealed Section
E# = Emergency renumbered Section
EEXP = Emergency expired

RECODIFICATION OF RULES

RC = Recodified

REJECTION OF RULES

RJ = Rejected by the Attorney General

TERMINATION OF RULES

TN = Terminated proposed new Sections
TM = Terminated proposed amended Section
TR = Terminated proposed repealed Section
T# = Terminated proposed renumbered Section

RULE EXPIRATIONS

EXP = Rules have expired
See also “emergency expired” under emergency rulemaking

CORRECTIONS

C = Corrections to Published Rules

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R9-6-328.	P#-1524; PM-1524	R9-6-361.	P#-1524; PN-1524	R9-6-393.	P#-1524; PM-1524
R9-6-329.	P#-1524; PM-1524	R9-6-362.	P#-1524; PM-1524	R9-6-394.	P#-1524; PM-1524
R9-6-330.	P#-1524; PM-1524	R9-6-363.	P#-1524; PM-1524	R9-6-395.	P#-1524; PM-1524
R9-6-331.	P#-1524; PM-1524	R9-6-364.	PR-1524; P#-1524; PM-1524	R9-6-396.	P#-1524; PM-1524
R9-6-332.	P#-1524; PM-1524	R9-6-365.	P#-1524; PM-1524	R9-6-397.	P#-1524; PM-1524
R9-6-333.	P#-1524; PM-1524	R9-6-366.	P#-1524; PM-1524	R9-6-398.	PN-1524
R9-6-334.	P#-1524; PM-1524	R9-6-367.	P#-1524; PM-1524	R9-6-1002.	PM-1524
R9-6-335.	P#-1524; PM-1524	R9-6-368.	P#-1524; PM-1524	R9-6-1102.	PM-1524
R9-6-336.	P#-1524; PM-1524	R9-6-369.	PM-1524 PR-1524; P#-1524; PM-1524	R9-6-1103.	PM-1524
R9-6-337.	P#-1524; PN-1524			R9-6-1202.	PM-1524
R9-6-338.	P#-1524; PM-1524	R9-6-370.	P#-1524; PN-1524	Health Services, Department of - Emergency Medical Services	
R9-6-339.	P#-1524; PM-1524	R9-6-371.	P#-1524; PM-1524	Table 5.1.	FXM-1161
R9-6-340.	P#-1524; PM-1524	R9-6-372.	P#-1524; PM-1524	Table 5.2.	FXM-1161
R9-6-341.	P#-1524; PM-1524	R9-6-373.	P#-1524; PM-1524	R9-25-601.	PM-577; FM-1728
R9-6-342.	P#-1524; PM-1524	R9-6-374.	P#-1524; PM-1524	R9-25-602.	PM-577; FM-1728
R9-6-343.	P#-1524; PM-1524	R9-6-375.	P#-1524; PM-1524	R9-25-1301.	PM-1067
R9-6-344.	P#-1524; PM-1524	R9-6-376.	P#-1524; PM-1524	R9-25-1302.	PM-1067
R9-6-345.	P#-1524; PM-1524	R9-6-377.	P#-1524; PN-1524	R9-25-1303.	P#-1067; PM-1067
R9-6-346.	P#-1524; PM-1524	R9-6-378.	P#-1524; PM-1524	R9-25-1303.01.	PN-1067
				R9-25-1304.	P#-1067; PM-1067
				R9-25-1305.	PR-1067; P#-1067; PM-1067
				R9-25-1306.	PR-1067; PN-1067

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R13-5-102.	PM-1478; FM-2564	R4-29-212.	RC-1976	Pharmacy, Board of	
R13-5-402.	PM-1478; FM-2564	R4-29-213.	RC-1976	R4-23-205.	FXM-2058; FXM-2383
R13-5-701.	PM-1478; FM-2564	R4-29-214.	RC-1976	R4-23-402.	PM-1009
R13-5-702.	PM-1478; FM-2564	R4-29-215.	RC-1976	R4-23-407.1.	PN-5; EN-31; FN-967
R13-5-703.	PM-1478; FM-2564	R4-29-216.	RC-1976	R4-23-411.	FM-211
R13-5-704.	PM-1478; FM-2564	R4-29-301.	RC-1976	R4-23-703.	SPM-607; FM-2424
R13-5-706.	PN-1478; FN-2564	R4-29-302.	RC-1976	R4-23-1104.	PM-1009
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R4-16-201.1.	PM-2461	R4-29-306.	RC-1976	R4-26-403.	FM-215
R4-16-205.	FXM-2056; PM-2461	R4-29-307.	RC-1976	R4-26-404.	FM-215
		R4-29-308.	RC-1976	R4-26-404.1.	FN-215
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R4-19-205.	FM-1420	R4-29-313.	RC-1976	R4-26-409.	FM-215
R4-19-207.	FM-1420	R4-29-314.	RC-1976	R4-26-410.	FM-215
R4-19-209.	FM-1420	R4-29-315.	RC-1976	R4-26-414.	FM-215
R4-19-216.	FM-1420	R4-29-316.	RC-1976	R4-26-417.	FM-215
R4-19-301.	FM-1420	R4-29-317.	RC-1976	Public Safety, Department of - Criminal Identification Section	
R4-19-305.	FM-1420	R4-29-318.	RC-1976	R13-1- 502.	PM-2166
R4-19-312.	FM-1420	R4-29-319.	RC-1976	R13-1-504.	PM-2166
R4-19-511.	FM-1420	R4-29-320.	RC-1976	Racing Commission, Arizona	
R4-19-801.	FM-1420	R4-29-401.	RC-1976	R19-2-205.	FXM-837
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		R4-29-403.	RC-1976	R4-45-102.	FXM-834
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R4-29-102.	RC-1976	R4-29-410.	RC-1976	R2-8-125.	PN-647
R4-29-103.	RC-1976	R4-29-411.	RC-1976	R2-8-201.	EXP-34; FN-1414
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R4-29-107.	RC-1976	R4-29-415.	RC-1976	R2-8-205.	FN-1414
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R4-29-203.	RC-1976	R4-29-501.	RC-1976	R2-8-303.	PN-441
R4-29-204.	RC-1976	R4-29-502.	RC-1976	R2-8-304.	PN-441
R4-29-205.	RC-1976	R4-29-503.	RC-1976	R2-8-305.	PN-441
R4-29-206.	RC-1976	R4-29-504.	RC-1976	R2-8-306.	PN-441
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		R4-29-602.	RC-1976		
		R4-29-603.	RC-1976		
		R4-29-604.	RC-1976		
		R4-29-605.	RC-1976		
		R4-29-606.	RC-1976		
		R4-29-607.	RC-1976		
		R4-29-608.	RC-1976		
		R4-29-609.	RC-1976		
		R4-29-701.	RC-1976		
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		R4-29-703.	RC-1976		
		R4-29-704.	RC-1976		
		R4-29-705.	RC-1976		



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RULES EFFECTIVE DATES CALENDAR

A.R.S. § 41-1032(A), as amended by Laws 2002, Ch. 334, § 8 (effective August 22, 2002), states that a rule generally becomes effective 60 days after the day it is filed with the Secretary of State's Office. The following table lists filing dates and effective dates for rules that follow this provision. Please also check the rulemaking Preamble for effective dates.

January		February		March		April		May		June	
Date Filed	Effective Date										
1/1	3/2	2/1	4/2	3/1	4/30	4/1	5/31	5/1	6/30	6/1	7/31
1/2	3/3	2/2	4/3	3/2	5/1	4/2	6/1	5/2	7/1	6/2	8/1
1/3	3/4	2/3	4/4	3/3	5/2	4/3	6/2	5/3	7/2	6/3	8/2
1/4	3/5	2/4	4/5	3/4	5/3	4/4	6/3	5/4	7/3	6/4	8/3
1/5	3/6	2/5	4/6	3/5	5/4	4/5	6/4	5/5	7/4	6/5	8/4
1/6	3/7	2/6	4/7	3/6	5/5	4/6	6/5	5/6	7/5	6/6	8/5
1/7	3/8	2/7	4/8	3/7	5/6	4/7	6/6	5/7	7/6	6/7	8/6
1/8	3/9	2/8	4/9	3/8	5/7	4/8	6/7	5/8	7/7	6/8	8/7
1/9	3/10	2/9	4/10	3/9	5/8	4/9	6/8	5/9	7/8	6/9	8/8
1/10	3/11	2/10	4/11	3/10	5/9	4/10	6/9	5/10	7/9	6/10	8/9
1/11	3/12	2/11	4/12	3/11	5/10	4/11	6/10	5/11	7/10	6/11	8/10
1/12	3/13	2/12	4/13	3/12	5/11	4/12	6/11	5/12	7/11	6/12	8/11
1/13	3/14	2/13	4/14	3/13	5/12	4/13	6/12	5/13	7/12	6/13	8/12
1/14	3/15	2/14	4/15	3/14	5/13	4/14	6/13	5/14	7/13	6/14	8/13
1/15	3/16	2/15	4/16	3/15	5/14	4/15	6/14	5/15	7/14	6/15	8/14
1/16	3/17	2/16	4/17	3/16	5/15	4/16	6/15	5/16	7/15	6/16	8/15
1/17	3/18	2/17	4/18	3/17	5/16	4/17	6/16	5/17	7/16	6/17	8/16
1/18	3/19	2/18	4/19	3/18	5/17	4/18	6/17	5/18	7/17	6/18	8/17
1/19	3/20	2/19	4/20	3/19	5/18	4/19	6/18	5/19	7/18	6/19	8/18
1/20	3/21	2/20	4/21	3/20	5/19	4/20	6/19	5/20	7/19	6/20	8/19
1/21	3/22	2/21	4/22	3/21	5/20	4/21	6/20	5/21	7/20	6/21	8/20
1/22	3/23	2/22	4/23	3/22	5/21	4/22	6/21	5/22	7/21	6/22	8/21
1/23	3/24	2/23	4/24	3/23	5/22	4/23	6/22	5/23	7/22	6/23	8/22
1/24	3/25	2/24	4/25	3/24	5/23	4/24	6/23	5/24	7/23	6/24	8/23
1/25	3/26	2/25	4/26	3/25	5/24	4/25	6/24	5/25	7/24	6/25	8/24
1/26	3/27	2/26	4/27	3/26	5/25	4/26	6/25	5/26	7/25	6/26	8/25
1/27	3/28	2/27	4/28	3/27	5/26	4/27	6/26	5/27	7/26	6/27	8/26
1/28	3/29	2/28	4/29	3/28	5/27	4/28	6/27	5/28	7/27	6/28	8/27
1/29	3/30			3/29	5/28	4/29	6/28	5/29	7/28	6/29	8/28
1/30	3/31			3/30	5/29	4/30	6/29	5/30	7/29	6/30	8/29
1/31	4/1			3/31	5/30			5/31	7/30		



July		August		September		October		November		December	
Date Filed	Effective Date										
7/1	8/30	8/1	9/30	9/1	10/31	10/1	11/30	11/1	12/31	12/1	1/30
7/2	8/31	8/2	10/1	9/2	11/1	10/2	12/1	11/2	1/1	12/2	1/31
7/3	9/1	8/3	10/2	9/3	11/2	10/3	12/2	11/3	1/2	12/3	2/1
7/4	9/2	8/4	10/3	9/4	11/3	10/4	12/3	11/4	1/3	12/4	2/2
7/5	9/3	8/5	10/4	9/5	11/4	10/5	12/4	11/5	1/4	12/5	2/3
7/6	9/4	8/6	10/5	9/6	11/5	10/6	12/5	11/6	1/5	12/6	2/4
7/7	9/5	8/7	10/6	9/7	11/6	10/7	12/6	11/7	1/6	12/7	2/5
7/8	9/6	8/8	10/7	9/8	11/7	10/8	12/7	11/8	1/7	12/8	2/6
7/9	9/7	8/9	10/8	9/9	11/8	10/9	12/8	11/9	1/8	12/9	2/7
7/10	9/8	8/10	10/9	9/10	11/9	10/10	12/9	11/10	1/9	12/10	2/8
7/11	9/9	8/11	10/10	9/11	11/10	10/11	12/10	11/11	1/10	12/11	2/9
7/12	9/10	8/12	10/11	9/12	11/11	10/12	12/11	11/12	1/11	12/12	2/10
7/13	9/11	8/13	10/12	9/13	11/12	10/13	12/12	11/13	1/12	12/13	2/11
7/14	9/12	8/14	10/13	9/14	11/13	10/14	12/13	11/14	1/13	12/14	2/12
7/15	9/13	8/15	10/14	9/15	11/14	10/15	12/14	11/15	1/14	12/15	2/13
7/16	9/14	8/16	10/15	9/16	11/15	10/16	12/15	11/16	1/15	12/16	2/14
7/17	9/15	8/17	10/16	9/17	11/16	10/17	12/16	11/17	1/16	12/17	2/15
7/18	9/16	8/18	10/17	9/18	11/17	10/18	12/17	11/18	1/17	12/18	2/16
7/19	9/17	8/19	10/18	9/19	11/18	10/19	12/18	11/19	1/18	12/19	2/17
7/20	9/18	8/20	10/19	9/20	11/19	10/20	12/19	11/20	1/19	12/20	2/18
7/21	9/19	8/21	10/20	9/21	11/20	10/21	12/20	11/21	1/20	12/21	2/19
7/22	9/20	8/22	10/21	9/22	11/21	10/22	12/21	11/22	1/21	12/22	2/20
7/23	9/21	8/23	10/22	9/23	11/22	10/23	12/22	11/23	1/22	12/23	2/21
7/24	9/22	8/24	10/23	9/24	11/23	10/24	12/23	11/24	1/23	12/24	2/22
7/25	9/23	8/25	10/24	9/25	11/24	10/25	12/24	11/25	1/24	12/25	2/23
7/26	9/24	8/26	10/25	9/26	11/25	10/26	12/25	11/26	1/25	12/26	2/24
7/27	9/25	8/27	10/26	9/27	11/26	10/27	12/26	11/27	1/26	12/27	2/25
7/28	9/26	8/28	10/27	9/28	11/27	10/28	12/27	11/28	1/27	12/28	2/26
7/29	9/27	8/29	10/28	9/29	11/28	10/29	12/28	11/29	1/28	12/29	2/27
7/30	9/28	8/30	10/29	9/30	11/29	10/30	12/29	11/30	1/29	12/30	2/28
7/31	9/29	8/31	10/30			10/31	12/30			12/31	3/1



REGISTER PUBLISHING DEADLINES

The Secretary of State's Office publishes the Register weekly. There is a three-week turnaround period between a deadline date and the publication date of the Register. The weekly deadline dates and issue dates are shown below. Council meetings and Register deadlines do not correlate. Also listed are the earliest dates on which an oral proceeding can be held on proposed rulemakings or proposed delegation agreements following publication of the notice in the Register.

Deadline Date (paper only) Friday, 5:00 p.m.	Register Publication Date	Oral Proceeding may be scheduled on or after
August 4, 2017	August 25, 2017	September 25, 2017
August 11, 2017	September 1, 2017	October 2, 2017
August 18, 2017	September 8, 2017	October 10, 2017
August 25, 2017	September 15, 2017	October 16, 2017
September 1, 2017	September 22, 2017	October 23, 2017
September 8, 2017	September 29, 2017	October 30, 2017
September 15, 2017	October 6, 2017	November 6, 2017
September 22, 2017	October 13, 2017	November 13, 2017
September 29, 2017	October 20, 2017	November 20, 2017
October 6, 2017	October 27, 2017	November 27, 2017
October 13, 2017	November 3, 2017	December 4, 2017
October 20, 2017	November 10, 2017	December 11, 2017
October 27, 2017	November 17, 2017	December 18, 2017
November 3, 2017	November 24, 2017	December 26, 2017
November 10, 2017	December 1, 2017	January 2, 2018
November 17, 2017	December 8, 2017	January 8, 2018
November 24, 2017	December 15, 2017	January 16, 2018
December 1, 2017	December 22, 2017	January 22, 2018
December 8, 2017	December 29, 2017	January 29, 2018
December 15, 2017	January 5, 2018	February 5, 2018
December 22, 2017	January 12, 2018	February 12, 2018
December 29, 2017	January 19, 2018	February 20, 2018
January 5, 2018	January 26, 2018	February 26, 2018
January 12, 2018	February 2, 2018	March 5, 2018
January 19, 2018	February 9, 2018	March 12, 2018
January 26, 2018	February 16, 2018	March 19, 2018
February 2, 2018	February 23, 2018	March 26, 2018
February 9, 2018	March 2, 2018	April 2, 2018
February 16, 2018	March 9, 2018	April 9, 2018
February 23, 2018	March 16, 2018	April 16, 2018



GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES

The following deadlines apply to all Five-Year-Review Reports and any adopted rule submitted to the Governor’s Regulatory Review Council. Council meetings and *Register* deadlines do not correlate. We publish these deadlines as a courtesy.

All rules and Five-Year Review Reports are due in the Council office by 5 p.m. of the deadline date. The Council’s office is located at 100 N. 15th Ave., Suite 402, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit www.grrc.state.az.us.

GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES FOR 2017

[M16-300]

DEADLINE FOR PLACEMENT ON AGENDA	FINAL MATERIALS SUBMITTED TO COUNCIL	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
Tuesday November 22, 2016	Tuesday December 20, 2016	Wednesday December 28, 2016	Wednesday January 4, 2017
Tuesday December 27, 2016	Tuesday January 24, 2017	Tuesday January 31, 2017	Tuesday February 7, 2017
Tuesday January 24, 2017	Tuesday February 21, 2017	Tuesday February 28, 2017	Tuesday March 7, 2017
Tuesday February 21, 2017	Tuesday March 21, 2017	Tuesday March 28, 2017	Tuesday April 4, 2017
Tuesday March 21, 2017	Tuesday April 18, 2017	Tuesday April 25, 2017	Tuesday May 2, 2017
Tuesday April 25, 2017	Tuesday May 23, 2017	Wednesday May 31, 2017	Tuesday June 6, 2017
Tuesday May 23, 2017	Tuesday June 20, 2017	Tuesday June 27, 2017	Thursday July 6, 2017
Tuesday June 20, 2017	Tuesday July 18, 2017	Tuesday July 25, 2017	Tuesday August 1, 2017
Tuesday July 25, 2017	Tuesday August 22, 2017	Tuesday August 29, 2017	Wednesday September 6, 2017
Tuesday August 22, 2017	Tuesday September 19, 2017	Tuesday September 26, 2017	Tuesday October 3, 2017
Tuesday September 26, 2017	Tuesday October 24, 2017	Tuesday October 31, 2017	Tuesday November 7, 2017
Tuesday October 24, 2017	Tuesday November 21, 2017	Tuesday November 28, 2017	Tuesday December 5, 2017
Tuesday November 21, 2017	Tuesday December 19, 2017	Wednesday December 27, 2017	Wednesday January 3, 2018

*Materials must be submitted by **5 P.M.** on dates listed as a deadline for placement on a particular agenda. Placement on a particular agenda is not guaranteed.