



Arizona Administrative REGISTER

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From the Publisher

ABOUT THIS PUBLICATION

The authenticated pdf of the *Administrative Register* (A.A.R.) posted on the Arizona Secretary of State's website is the official published version for 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 *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 notices of rules terminated by the agency and rules that have expired.

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Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number).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

New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.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 authenticated pdf of *Code* chapters posted on the Arizona Secretary of State's website are the official published version of rules in the A.A.C. 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.

Arizona Administrative REGISTER

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ADMINISTRATIVE REGISTER
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.

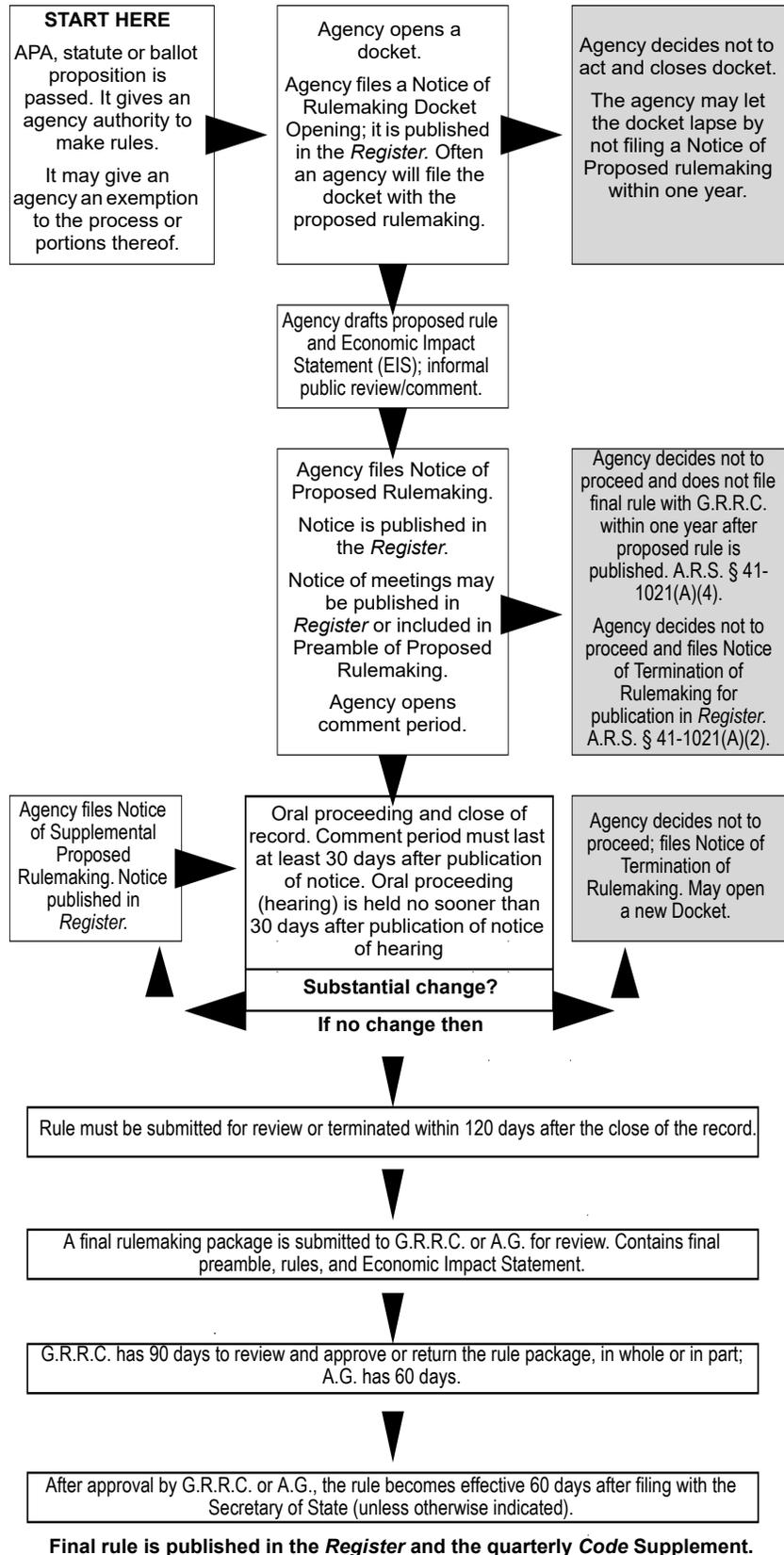
An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

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 4. DEPARTMENT OF HEALTH SERVICES
NONCOMMUNICABLE DISEASES**

[R19-248]

PREAMBLE

- 1. Article, Part, or Section Affected (as applicable)**

<u>Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action</u>
R9-4-101	Amend
R9-4-201	Amend
R9-4-202	Amend
R9-4-301	Amend
R9-4-302	Amend
R9-4-401	Amend
R9-4-402	Amend
R9-4-403	Amend
R9-4-404	Amend
R9-4-405	Amend
R9-4-501	Amend
R9-4-502	Amend
R9-4-503	Amend
R9-4-504	Amend

- 2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**
 Authorizing statute: A.R.S. § 36-136(G)
 Implementing statute: A.R.S. §§ 36-133, 36-606, 36-1673, 36-1675

- 3. The effective date of the rules:**
 January 1, 2020

 The Arizona Department of Health Services (Department) requested an effective date of January 1, 2020, under A.R.S. § 41-1032(A)(1) and (4) to provide sufficient time for the Department and stakeholders to implement the new rules and enable the Department to begin collecting public health information about noncommunicable diseases under the new rules at the beginning of the calendar year to better ensure consistency in data that is aggregated by calendar year.

- 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 rule:**
 Notice of Rulemaking Docket Opening: 25 A.A.R. 1341, May 31, 2019
 Notice of Proposed Rulemaking: 25 A.A.R. 2011, August 9, 2019

- 5. The agency’s contact person who can answer questions about the rulemaking:**
 Name: Georgia Yee, Office Chief
 Address: Department of Health Services
 Bureau of Public Health Statistics
 150 N. 18th Ave., Suite 550
 Phoenix, AZ 85007-3248

 Telephone: (602) 542-7321
 Fax: (602) 364-0296
 E-mail: Georgia.Yee@azdhs.gov
 or
 Name: Eric Thomas, Office Chief



Address: Department of Health Services
Office of Environmental Health
150 N. 18th Ave., Suite 140
Phoenix, AZ 85007-3248

Telephone: (602) 364-3142
Fax: (602) 364-3146
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Name: Robert Lane, Office Chief
Address: 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.) § 36-133 requires the Arizona Department of Health Services (Department) to develop a chronic disease surveillance system for the collection, management, and analysis of information on the incidence of chronic diseases in Arizona. A.R.S. § 36-606 states that the Department "shall develop and implement ... a system for reporting and preventing pesticide provoked illnesses." A.R.S. §§ 36-1673 and 36-1675 require the Department to adopt rules for reporting blood test results showing significant levels of lead and other rules "necessary and feasible to implement the purposes" of A.R.S. Title 36, Chapter 13, Article 6. The Department has implemented these statutes in Arizona Administrative Code (A.A.C.) Title 9, Chapter 4, Articles 1 through 5. The Department has identified several issues with the current rules that cause the rules to impose an undue burden on some regulated entities and reduce their effectiveness. After receiving an exception from the Governor's rulemaking moratorium established by Executive Order 2019-01, the Department has revised the rules in 9 A.A.C. 4, to address these issues, including moving definitions used throughout Chapter 4 to Article 1; updating and clarifying definitions, cross-references, and formatting; making revisions to comply with statutory changes; and updating and clarifying reporting requirements and time-frames. The changes 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 either relied on or did not 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:

The Department anticipates that the rulemaking may affect the Department; the Arizona Department of Agriculture; hospitals; clinical laboratories; pathology laboratories; genetic testing facilities; prenatal diagnostic facilities; high-risk perinatal practices; clinics; physicians; registered nurse practitioners; physician assistants; doctors of naturopathic medicine; dentists; poison control centers; individuals who have a pesticide illness, elevated blood lead levels, cancer, or a birth defect and their parents or guardians; employers of individuals who have a pesticide illness, elevated blood lead levels, or cancer; and the general public. Annual costs/revenues changes are designated as minimal when more than \$0 and \$1,000 or less, moderate when between \$1,000 and \$10,000, and substantial when \$10,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification.

Consolidating definitions, updating cross-references, and correcting grammar and formatting may provide a significant benefit to all affected persons. Clarifying requirements for reporting pesticide illness to match the current reporting forms and practice may provide a significant benefit to the Department, the Arizona Department of Agriculture, poison control centers, physicians, registered nurse practitioners, physician assistants, and other health professionals. If a poison control center or health professional were not reporting according to current practice, the additions of requirements to report race and ethnicity, occupations not necessarily related to a pesticide exposure, symptoms reported by the individual, laboratory test information if applicable, and information about the person reporting the pesticide illness may cause these persons to incur minimal increased costs. If a poison control center were not reporting monthly, as required in the current rules, the change to quarterly reporting could impose a minimal increased burden, rather than a minimal decrease in costs that a poison control center reporting according to the current rules would experience. Similarly, clarifying requirements for reporting blood lead levels to match the current reporting forms and practice may provide a significant benefit to the Department, physicians, and clinical laboratories. However, the Department anticipates that a physician or clinical laboratory that was not reporting according to current practice may incur a minimal increased cost due to the changes. This is especially true for a physician performing a point-of-care test for blood lead, who may not have reported the results of a test resulting in a blood lead level under 10 µg of lead per dL of whole blood under the current rules, even though the physician would have been asked to report as a clinical laboratory under current practice.

Since the current rules in Article 4 were adopted, many large physician group practices have formed due to savings on over-



head over single-physician practices. The Department anticipates that revising the definition of “clinic” to include physician group cancer practices will provide a significant benefit to the Department and the general public through more complete and accurate reporting, but may cause up to a substantial increase in cost for a large physician group cancer practice that would be required to report as a clinic, rather than as a physician. The new rules update requirements for cancer case reports and for cancer follow-up reports to match current reporting practices, and may also provide a significant benefit to the Department and the general public through more complete and accurate reporting. The updated methods for assessing cancer data quality and completeness to match current practice may also provide a significant benefit to the Department and the general public. Reporting entities are already complying with the reporting, follow-up, and many of the quality assurance requirements in the new rules, so there are few, if any, new real costs being imposed by the changes. However, compared with requirements in the current rules, the new rules are adding reporting requirements for hospitals, physicians, doctors of naturopathic medicine, dentists, registered nurse practitioners, and clinics, which could result in minimal-to-moderate additional costs to an entity that was not reporting as is now standard practice. Under the current rules in Article 4, a pathology laboratory is required to allow the Department to review their records at least once every 90 days. Under the new rules, pathology laboratories will be required to electronically submit reports to the Department through active reporting. While a pathology laboratory may incur minimal-to-moderate costs to set up and implement such a reporting system, these costs may be offset by not incurring the minimal-to-moderate costs for the pathology laboratory to provide hard-copy or electronic records, space for the Department to review the records, and staff to assist the Department in reviewing and abstracting data from the records.

In Article 5, the definition of “clinic” is also being revised to include other types of health care institution in which a birth defect may be detected; requirements for clinics are also being updated. Facilities now included in the definition of “clinic” that had not already been reporting may incur a minimal-to-moderate increase in costs associated with the rule change. However, the new rules are also potentially reducing the frequency of reporting for birth defects, from monthly to upon the request of the Department and no more often than once per month, with a concomitant reduction in costs. The Department anticipates that this change may result in a no-to-moderate reduction in costs to a reporting facility. Combining birth defect reporting requirements for a prenatal diagnostic facility, high-risk perinatal practice, or clinic may help reduce confusion as to which reporting requirements a facility should be following, and provide a significant benefit to the facility as well as the Department. The new rules also allow for more flexibility in when a genetic testing facility reports, providing a significant benefit to these facilities. Clarifying requirements for review of records and services related to birth defects may provide a significant benefit to the Department and all persons from which the Department may review records, as well as to a patient with a birth defect or the patient’s parent or guardian. A patient with a birth defect or the patient’s parent or guardian may also receive a significant benefit from the changes clarifying with whom the Department may discuss information.

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

Changes made to the rules between the proposed rulemaking and the final rulemaking include removing abortion clinics from the definition of “clinic” to avoid a statutory conflict and the correction of typographical errors.

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

No written comments were received about the rulemaking during the public comment period. The Department held an oral proceeding for the proposed rules on September 16, 2019, which no stakeholder/member of the public attended.

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 4. DEPARTMENT OF HEALTH SERVICES
NONCOMMUNICABLE DISEASES

ARTICLE 1. DEFINITIONS

Section
R9-4-101. Definitions, General

ARTICLE 2. PESTICIDE ILLNESS

Section
R9-4-201. Definitions
R9-4-202. Pesticide Illness Reporting Requirements

ARTICLE 3. BLOOD LEAD LEVELS

Section
R9-4-301. Definitions
R9-4-302. Reporting Significant Blood Lead Levels Level Reporting Requirements

ARTICLE 4. CANCER REGISTRY

Section
R9-4-401. Definitions
R9-4-402. Exceptions
R9-4-403. Case Reports
R9-4-404. Requirements for Submitting Case Reports and Follow-up Reports and Allowing Review of Hospital Records
R9-4-405. Data Quality Assurance

ARTICLE 5. BIRTH DEFECTS MONITORING PROGRAM

Section
R9-4-501. Definitions
R9-4-502. Reporting Sources; Information Submitted to the Department
R9-4-503. Review of Records; Information Collected
R9-4-504. Data Quality Assurance and Follow-up

ARTICLE 1. DEFINITIONS

R9-4-101. Definitions, General

In this Chapter, unless otherwise specified:

- 1. "Admitted" means the same as in A.A.C. R9-10-101.
2. "Business day" means any day of the week other than a Saturday, a Sunday, a state legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
3. "Calendar day" means any day of the week, including a Saturday or a Sunday.
4. "Clinical laboratory" means a facility that:
a. Meets the definition in A.R.S. § 36-451;
b. Holds a certificate of accreditation or certificate of compliance issued by the United States Department of Health and Human Services under the 1988 amendments to the Clinical Laboratories Improvement Act of 1967; and
c. Is located within Arizona.
5. "Code" means a single number or letter, a set of numbers or letters, or a set of both numbers and letters that represents specific information.
6. "Dentist" means an individual licensed under A.R.S. Title 32, Chapter 11, Article 2.
7. "Department" means the Arizona Department of Health Services.
8. "Diagnosis" means the identification of a disease or injury, by an individual authorized by law to make the identification, that is the cause of an individual's current medical condition.
9. "Discharge" means the same as in A.A.C. R9-10-101.
10. "Discharge date" means the month, day, and year of an individual's discharge from a hospital.
11. "Electronic" means the same as in A.R.S. § 44-7002.
12. "Guardian" means a person appointed as a legal guardian by a court of competent jurisdiction.
13. "Health care institution" means the same as in A.R.S. § 36-401.
14. "Health-related services" means the same as in A.R.S. § 36-401.
15. "Hospital" means the same as in A.A.C. R9-10-201 R9-10-101.
5. "ICD 9 CM" means the version of the ICD 9 CM: International Classification of Diseases codes used by a hospital for billing purposes.
16. "International Classification of Diseases Code" or "ICD Code" means a code, such as the ICD-9-CM or ICD-10-CM codes, which is used by a hospital for billing or reporting purposes.
17. "Medical records" means the same as in A.R.S. § 12-2291.
18. "Medical services" means the same as in A.R.S. § 36-401.



- 19. “Nursing services” means the same as in A.R.S. § 36-401.
- 20. “Ordered” means instructed by a physician, registered nurse practitioner, or physician assistant to perform a test on an individual.
- 21. “Parent” means the:
 - a. Biological or adoptive father of an individual; or
 - b. Woman who:
 - i. Gave birth to an individual; or
 - ii. Adopts an individual.
- 22. “Pathology laboratory” means a clinical laboratory in which human cells or tissues are examined for the purpose of diagnosing diseases.
- 23. “Physician” means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.
- 24. “Physician assistant” has the same meaning as in A.R.S. § 32-2501.
- 25. “Registered nurse practitioner” means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.
- 26. “Treatment” means the same as in A.A.C. R9-10-101.

ARTICLE 2. PESTICIDE ILLNESS

R9-4-201. Definitions

In this Article, unless otherwise specified:

- 1. “Cluster illness” means sickness in two or more individuals that is caused by or may be related to one pesticide exposure incident, as determined by the history, signs, or symptoms of the sickness; laboratory findings regarding the individuals; the individuals’ responses to treatment for the sickness; or the geographic proximity of the individuals.
- 1. “Cluster illness” means pesticide illness in two or more individuals that is caused by or may be related to one pesticide exposure incident.
- 2. “Documented” means evidenced by written information such as pesticide applicator reports, statements of individuals with pesticide illness, or medical records.
- 3. “Health care professional” means a physician, a registered nurse practitioner, a physician assistant, or any other individual who is authorized by law to diagnose human illness.
- 4. “Medical director” means the individual designated by a poison control center as responsible for providing medical direction for the poison control center or for approving and coordinating the activities of the individuals who provide medical direction for the poison control center.
- 5. “Pest” has the same meaning as in A.R.S. Title 3, Chapter 2, Article 5 or as used in A.R.S. Title 3, Chapter 2, Article 6 and A.R.S. Title 32, Chapter 22.
- 6. “Pesticide” means any substance or mixture of substances, including inert ingredients, intended for preventing, destroying, repelling, or mitigating any pest or intended for use as a plant regulator, defoliant, or desiccant, but does not include an antimicrobial agent, such as a disinfectant, sanitizer, or deodorizer, used for cleaning.
- 5. “Pesticide” means the same as in A.R.S. § 3-361, but does not include an antimicrobial agent, such as a disinfectant, sanitizer, or deodorizer, used for cleaning.
- 7-6. “Pesticide illness” means any sickness reasonably believed by a health care professional or medical director to be caused by or related to documented exposure to any pesticide, based upon professional judgment and:
 - a. The history, signs, or symptoms of the sickness;
 - b. Laboratory findings regarding the individual; or
 - c. The individual’s response to treatment for the sickness.
- 8. “Physician assistant” has the same meaning as in A.R.S. § 32-2501.
- 9-7. “Poison control center” means an organization that is a member of and may be certified by the American Association of Poison Control Centers.
- 10. “Registered nurse practitioner” has the same meaning as in A.R.S. § 32-1601.

R9-4-202. Pesticide Illness Reporting Requirements

~~A health care professional or medical director who participates in the diagnosis of or identifies an individual with pesticide illness shall file a report of pesticide illness with the Department as follows:~~

- 1. ~~The health care professional or medical director shall report a pesticide illness within five working days from the date of diagnosis or identification, except:~~
 - a. ~~The health care professional or medical director shall report a pesticide illness where the individual with pesticide illness is hospitalized or dies no later than one working day from the time of hospital admission or death; and~~
 - b. ~~The health care professional or medical director shall report cluster illnesses no later than one working day from the time the second individual with pesticide illness is diagnosed or identified.~~
- 2. ~~The health care professional or medical director shall submit the report to the Department by telephone; in person; in a writing sent by fax, delivery service, or mail; or by an electronic reporting system if an electronic reporting system is developed by the Department. The report shall contain the following information:~~
 - a. ~~The name, address, and telephone number of the individual with pesticide illness;~~
 - b. ~~The date of birth of the individual with pesticide illness;~~
 - c. ~~The gender of the individual with pesticide illness;~~
 - d. ~~The occupation of the individual with pesticide illness, if the documented pesticide exposure is related to the occupation;~~
 - e. ~~The dates of onset of illness and of diagnosis or identification as pesticide illness;~~
 - f. ~~The name of the pesticide, if known;~~



- g. ~~The name, business address, and telephone number of the health care professional or medical director making the report;~~
- h. ~~A statement specifying whether the illness is caused by a documented pesticide exposure or is related to a documented pesticide exposure; and~~
- i. ~~The health care professional's or medical director's reason for believing that the illness is caused by or related to documented exposure to a pesticide.~~
- 3. ~~The health care professional or medical director may designate a representative to make the report to the Department on behalf of the health care professional or medical director.~~
- A.** A health care professional who believes that an individual has pesticide illness shall submit a report to the Department, either personally or through a representative:
 - 1. Except as specified in subsections (A)(2) and (C), within five business days after the health care professional determines that the individual may have pesticide illness; and
 - 2. Within one business days after the individual is admitted to a hospital or dies due to pesticide illness.
- B.** Except as specified in subsection (C), a medical director who believes that an individual has pesticide illness shall submit a report to the Department, either personally or through a representative at least once each month.
- C.** A health care professional or medical director who believes that an individual is part of a cluster illness shall submit a report to the Department, either personally or through a representative, within one business day after determining that the individual has pesticide illness.
- D.** A health care professional or medical director shall ensure that the report required in subsection (A), (B), or (C) includes the following information:
 - 1. The name, address, and telephone number of the individual with pesticide illness;
 - 2. The date of birth of the individual with pesticide illness;
 - 3. The gender, race, and ethnicity of the individual with pesticide illness;
 - 4. The date symptoms of pesticide illness began;
 - 5. The date the health care professional or medical director determined that the individual may have pesticide illness;
 - 6. The occupation of the individual with pesticide illness;
 - 7. The name of the pesticide, if known;
 - 8. The symptoms reported by the individual with pesticide illness;
 - 9. Whether any laboratory tests were performed for the individual with pesticide illness and, if so, for each test:
 - a. The type of specimen collected;
 - b. The date the specimen was collected;
 - c. The type of test performed;
 - d. The results of the test, and
 - e. What results of the test would be considered normal;
 - 10. A description of any treatment provided to the individual with pesticide illness;
 - 11. On what basis the health care professional or medical director believes the individual has pesticide illness;
 - 12. The name and telephone number of the health care professional or medical director who believes that the individual has pesticide illness;
 - 13. The name and address of the health care institution or poison control center at which the health care professional or medical director determined that the individual may have pesticide illness; and
 - 14. A description of the type of health care institution or poison control center specified in subsection (D)(13).
- E.** A health care professional or medical director, either personally or through a representative, shall submit the report required in subsection (A), (B), or (C):
 - 1. By telephone;
 - 2. In person;
 - 3. In a document sent by fax, delivery service, or mail; or
 - 4. Through an electronic reporting system authorized by the Department.

ARTICLE 3. BLOOD LEAD LEVELS

R9-4-301. Definitions

In this Article, unless otherwise specified:

- 1. "Adult" means an individual 16 years of age or older.
- 2. "Child" means an individual younger than 16 years of age.
- 3. ~~"Clinical laboratory" has the same meaning as in A.R.S. § 36-451.~~
- 4. "Patient" means the individual whose blood has been tested for lead content.
- 4. "Point-of-care test for blood lead" means an analysis to screen an individual for exposure to lead:
 - a. That is performed outside a clinical laboratory, and
 - b. For which the results of the analysis are available before the individual leaves the location at which the analysis was performed.
- 5. ~~"Public" means funded by and operated under the direction of the federal or state government or a political subdivision of the state.~~
- 6. ~~"Public insurance" means a public program, such as the Arizona Health Care Cost Containment System, Kids Care, Indian Health Services, or TRICARE, that pays for medical services.~~
- 7. "Whole blood" means human blood from which plasma, erythrocytes, leukocytes, and thrombocytes have not been separated.

R9-4-302. Reporting Significant Blood Lead Levels Level Reporting Requirements



- A.** A physician who receives a laboratory result showing a level of lead equal to or greater than 10 micrograms of lead per deciliter of whole blood for a child or 25 micrograms of lead per deciliter of whole blood for an adult shall report the blood lead level to the Department as follows:
 - 1. The physician shall report the blood lead level within five working days from the date of receipt of the laboratory result if the blood lead level is less than 45 micrograms of lead per deciliter of whole blood for a child or less than 60 micrograms of lead per deciliter of whole blood for an adult.
 - 2. The physician shall report the blood lead level within one working day from the date of receipt of the laboratory result if the blood lead level is equal to or greater than 45 micrograms of lead per deciliter of whole blood for a child or equal to or greater than 60 micrograms of lead per deciliter of whole blood for an adult.
 - 3. A physician may designate a representative to make the report to the Department on behalf of the physician.
- B.** A clinical laboratory director shall report to the Department the results of all tests for lead in whole blood as follows:
 - 1. The clinical laboratory director shall report the blood lead test result within five working days from the date of completing the test if the blood lead level is equal to or greater than 10 but less than 45 micrograms of lead per deciliter of whole blood for a child or equal to or greater than 25 but less than 60 micrograms of lead per deciliter of whole blood for an adult.
 - 2. The clinical laboratory director shall report the blood lead test result within one working day from the date of completing the test if the blood lead level is equal to or greater than 45 micrograms of lead per deciliter of whole blood for a child or equal to or greater than 60 micrograms of lead per deciliter of whole blood for an adult.
 - 3. The clinical laboratory director shall report blood test results that are less than 10 micrograms of lead per deciliter of whole blood for a child or less than 25 micrograms of lead per deciliter of whole blood for an adult at least once each month.
 - 4. A clinical laboratory director may designate a representative to make the report to the Department on behalf of the clinical laboratory director.
- C.** A physician or clinical laboratory director shall submit each report to the Department by telephone; in a writing sent by fax, delivery service, or mail; or by an electronic reporting system authorized by the Department.
- D.** A report shall include the following information:
 - 1. The patient's name, address, and telephone number;
 - 2. The patient's date of birth;
 - 3. The patient's gender;
 - 4. If the patient is an adult, the patient's occupation and the name, address, and telephone number of the patient's employer;
 - 5. An indication of the patient's funding source and the specific health plan name, if applicable:
 - a. Public insurance;
 - b. Private insurance;
 - c. Self-pay;
 - d. Workplace monitoring program;
 - e. Other; or
 - f. Unknown;
 - 6. The type of blood draw used (venous or capillary);
 - 7. The date the blood was drawn;
 - 8. The blood lead level;
 - 9. The date the blood lead level was received by the physician or determined by the laboratory;
 - 10. The name, address, and telephone number of the laboratory that tested the blood; and
 - 11. The name, practice name, address, and telephone number of the physician who ordered the test.
- A.** For each patient, a physician shall submit a report to the Department, either personally or through a representative, for the levels of lead and within the time periods specified in Table 3.1.

Table 3.1: Criteria for Physician Reporting of Blood Lead Levels

	<u>Child</u>	<u>Adult</u>
<u>Within One Business Day After Performing a Point-of-Care Test for Blood Lead or Receiving the Result of a Test for Blood Lead from a Clinical Laboratory</u>	<u>≥ 45 µg of lead per dL of whole blood</u>	<u>≥ 60 µg of lead per dL of whole blood</u>
<u>Within Five Business Days After Performing a Point-of-Care Test for Blood Lead or Receiving the Result of a Test for Blood Lead from a Clinical Laboratory</u>	<u>≥ 10 µg to < 45 µg of lead per dL of whole blood</u>	<u>≥ 25 µg to < 60 µg of lead per dL of whole blood</u>
<u>At Least Once Each Month After Performing a Point-of-Care Test for Blood Lead</u>	<u>< 10 µg of lead per dL of whole blood</u>	<u>< 25 µg of lead per dL of whole blood</u>

- B.** A physician shall ensure that the report required in subsection (A) includes the following information:
 - 1. The patient's name, address, and telephone number;
 - 2. The patient's date of birth;
 - 3. The patient's gender, race, and ethnicity;
 - 4. If the patient is an adult, the patient's occupation and the name, address, and telephone number of the patient's employer;
 - 5. Whether the blood collected from the patient was venous blood or capillary blood;
 - 6. The date the blood was collected;
 - 7. The results of the blood lead level test;
 - 8. The date of the test result;



- 9. If the test result indicates a blood lead level greater than or equal to 25 µg of lead per dL of whole blood for an adult or greater than or equal to 10 µg of lead per dL of whole blood for a child:
 - a. The funding source for the medical services provided to the patient and, if applicable, the name of the patient’s health plan and the identification number for the patient assigned by the health plan;
 - b. The language predominantly spoken in the patient’s home, if known; and
 - c. If the patient is a child, the name of the patient’s parent or guardian;
 - 10. The date the physician performed the point-of-care test for blood lead or received the test result from a clinical laboratory;
 - 11. If applicable, the name, address, and telephone number of the clinical laboratory that tested the blood; and
 - 12. The name, practice name, address, and telephone number of the physician who performed the point-of-care test for blood lead or received the test result from the clinical laboratory.
- C. For each blood lead level test, a clinical laboratory director shall submit a report to the Department, either personally or through a representative, for the levels of lead and within the time periods specified in Table 3.2.

Table 3.2: Criteria for Clinical Laboratory Director Reporting of Blood Lead Levels

	<u>Child</u>	<u>Adult</u>
<u>Within One Business Day After Completing the Test</u>	<u>> 45 µg of lead per dL of whole blood</u>	<u>> 60 µg of lead per dL of whole blood</u>
<u>Within Five Business Days After Completing the Test</u>	<u>≥ 10 µg to < 45 µg of lead per dL of whole blood</u>	<u>≥ 25 µg to < 60 µg of lead per dL of whole blood</u>
<u>At Least Once Each Month</u>	<u>< 10 µg of lead per dL of whole blood</u>	<u>< 25 µg of lead per dL of whole blood</u>

- D. A clinical laboratory director shall ensure that the report required in subsection (C) includes the following information:
- 1. The patient’s name, address, and telephone number;
 - 2. The patient’s date of birth;
 - 3. The patient’s gender, race, and ethnicity;
 - 4. If the patient is an adult, the patient’s occupation and the name, address, and telephone number of the patient’s employer if known;
 - 5. The name, practice name, address, and telephone number of the physician who ordered the test;
 - 6. If known, the funding source for the test for blood lead, the name of the patient’s health plan, and the identification number for the patient assigned by the health plan;
 - 7. Whether the blood collected from the patient was venous blood or capillary blood;
 - 8. The date the blood was collected;
 - 9. The results of the blood lead level test;
 - 10. The date of the test result;
 - 11. The name and address of the clinical laboratory that tested the blood; and
 - 12. The name and telephone number of the clinical laboratory director.
- E. A physician or clinical laboratory director, either personally or through a representative, shall submit the report required in subsection (A) or (C):
- 1. By telephone;
 - 2. In person;
 - 3. In a document sent by fax, delivery service, or mail; or
 - 4. Through an electronic reporting system authorized by the Department.

ARTICLE 4. CANCER REGISTRY

R9-4-401. Definitions

In this Article, unless otherwise specified:

- 1. ~~“Accession number” means a unique number, separate from a medical record number, assigned by a hospital’s cancer registry to a patient for identification purposes.~~
- 2. ~~“Admitted” means the same as in A.A.C. R9-10-201.~~
- 3. ~~1. “Analytic patient” means a patient, who is:

 - a. Diagnosed at a facility, or
 - b. Administered any part of a first course of treatment at the facility.~~
- 4. ~~“Basal cell” means a cell of the inner most layer of the skin.~~
- 5. ~~“Behavioral health service agency” means the same as “agency” in A.A.C. R9-20-101.~~
- 6. ~~“Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.~~
- 7. ~~“Calendar day” means any day of the week, including a Saturday or a Sunday.~~
- 8. ~~2. “Calendar year” means January 1 through December 31.~~
- 9. ~~3. “Cancer” means a group of diseases characterized by uncontrolled cell growth and the spread of abnormal cells.~~
- 10. ~~4. “Cancer registry” means a unit within a hospital or clinic that collects, stores, summarizes, distributes, and maintains information specified in R9-4-403 about patients who:

 - a. Are admitted to the hospital;
 - b. Receive diagnostic evaluation at, or cancer-directed treatment from, the hospital or clinic; or
 - c. Show evidence of cancer, carcinoma in situ, or a benign tumor of the central nervous system while receiving treatment from the hospital or clinic.~~
- 11. ~~5. “Carcinoma” means a type of cancer that is characterized as a malignant tumor derived from epithelial tissue.~~



- ~~12-6.~~“Carcinoma in situ” means a cancer that is confined to epithelial tissue within the site of origin.
- ~~13-7.~~“Case report” means an electronic or paper document that includes the information in R9-4-403 for a patient.
- ~~14-8.~~“Chemotherapy” means the treatment of cancer using specific chemical agents or drugs that are selectively destructive to malignant cells and tissues.
- ~~15-9.~~“Clinic” means a facility that is not physically connected to or affiliated with a hospital, where a physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner provides cancer diagnosis, cancer treatment, or both, and that is:
- An outpatient treatment center, as defined in A.A.C. R9-10-101~~5~~;
 - An outpatient surgical center, as defined in A.A.C. R9-10-101~~5~~; ~~or~~
 - An outpatient radiation treatment center; ~~or~~
 - A private office of one or more physicians, doctors of naturopathic medicine, dentists, or registered nurse practitioners that:
 - Is exempt from licensing under A.R.S. § 36-402(A)(3), and
 - Treats 50 or more cancer patients per year.
- ~~16-10.~~“Clinical evaluation” means an examination of the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual by a physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner.
- ~~17-11.~~“Clinical or pathological” means an analysis of evidence either acquired solely before a first course of treatment was initiated, or acquired both before a first course of treatment, and supplemented or modified by evidence acquired during and subsequent to surgery or other treatment.
- ~~18.~~ “Code” means a single number or letter, a set of numbers or letters, or a set of both numbers and letters, that represents specific information.
- ~~19-12.~~“Cytology” means the microscopic examination of cells.
- ~~20-13.~~“Date of first contact” means the day, month, and year a reporting facility first began to provide cancer-related medical services, nursing services, or health-related services, as defined in A.R.S. § 36-401, to a patient.
- ~~21-14.~~“Date of last contact” means the day, month, and year that a reporting facility last knew a patient to be alive.
- ~~22-15.~~“Designee” means a person assigned by the governing authority, as defined in A.R.S. § 36-401, of a hospital or clinic or by an individual acting on behalf of the governing authority to gather information for or report to the Department, as specified in R9-4-403 or R9-4-404.
- ~~23.~~ “Discharge” means the same as in A.A.C. R9-10-201.
- ~~24.~~ “Discharge date” means the month, day, and year when a patient is discharged from a hospital.
- ~~25.~~ “Disease progression” means the process of a disease becoming more severe or spreading from one area of a human body to another area of the human body.
- ~~26-16.~~“Distant lymph node” means a lymph node that is not in the same general area of a human body as the primary site of a tumor.
- ~~27-17.~~“Distant site” means an area of a human body that is not adjacent to or in the same general area of the human body as the primary site of a tumor.
- ~~28-18.~~“Doctor of naturopathic medicine” means an individual licensed under A.R.S. Title 32, Chapter 14.
- ~~29.~~ “Electronic” means the same as in A.R.S. § 44-7002.
- ~~30-19.~~“First course of treatment” means the initial set of cancer- or non-cancer-directed treatment that is planned ~~when a cancer is diagnosed and administered to the patient before disease progression or recurrence~~ when a cancer is diagnosed.
- ~~31-20.~~“Follow-up report” means an electronic document that includes the information stated in R9-4-404(A)(2) for a patient.
- ~~32.~~ “Governing authority” means the same as in A.R.S. § 36-401.
- ~~33.~~ “Grade” means the degree of resemblance of a tumor to normal tissue, and gives an indication of the severity of the cancer.
- ~~34.~~ “Health care institution” means the same as in A.A.C. R9-10-101.
- ~~35.~~ “Histology” means the microscopic structure of cells, tissues, and organs in relation to their function.
- ~~36-21.~~“Inpatient beds” means the same as in A.R.S. § 36-401.
- ~~37.~~ “Laterality” means the side of a paired organ or the side of the body in which the primary site of a tumor is located.
- ~~38-22.~~“Licensed capacity” means the same as in A.R.S. § 36-401.
- ~~39-23.~~“Lymph” means the clear, watery, sometimes faintly yellowish fluid that circulates throughout the lymphatic system.
- ~~40-24.~~“Lymph node” means any of the small bodies located along lymphatic vessels, particularly at the neck, armpit, and groin, that filter bacteria and foreign particles from lymph.
- ~~41-25.~~“Lymphatic system” means the organ system that consists of lymph, lymph nodes, and vessels or channels that contain and convey lymph throughout a human body.
- ~~42-26.~~“Malignant” means an inherent tendency of a tumor to sequentially spread to areas of a human body beyond the site of origin.
- ~~43-27.~~“Medical record number” means a unique number assigned by a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner to an individual for identification purposes.
- ~~44-28.~~“Melanocyte” means a skin cell that makes melanin, which is a dark pigment.
- ~~45-29.~~“Melanoma” means a dark-pigmented, malignant tumor arising from a melanocyte and occurring most commonly in the skin.
- ~~46-30.~~“Metastasis” means the spread of a cancer from a primary site into a regional site or a distant site.
- ~~47-31.~~“Narrative description” means a written text describing an act, occurrence, or course of events.
- ~~48-32.~~“Organ” means a somewhat independent part of a human body, such as a heart or a kidney, that performs a specific function.
- ~~49-33.~~“Organ system” means one or more organs and associated tissues that perform a specific function, such as the circulatory system.
- ~~50-34.~~“Outpatient radiation treatment center” means a facility ~~in which a person, licensed as specified in 12 A.A.C. 1, Article 7, regulated under 9 A.A.C. 7 that provides radiation treatment.~~
- ~~51.~~ “Papillary tumor” means a benign tumor of the skin producing finger-like projections from the skin surface.
- ~~52.~~ “Pathology laboratory” means a facility in which human cells or tissues are examined for the purpose of diagnosing cancer and that is licensed under 9 A.A.C. 10, Article 1.



- ~~53-35.~~ "Patient" means an individual who has been diagnosed with a cancer, carcinoma in situ, or benign tumor of the central nervous system:
 - a. ~~including~~ Including melanoma; ~~but and~~
 - b. ~~excluding~~ Excluding skin cancer that is:
 - a.i. ~~Confined~~ Is confined to the primary site; or
 - ii. Was diagnosed after January 1, 2003.
 - b. ~~Present at regional sites or distant sites, but was diagnosed on or after January 1, 2003.~~
- ~~54-36.~~ "Primary site" means a specific organ or organ system within a human body where the first cancer tumor originated.
- ~~55-37.~~ "Principal diagnosis" means the primary condition for which an individual is admitted to a hospital or treated by the hospital.
- ~~56-38.~~ "Radiation treatment" means the exposure of a human body to a stream of particles or electromagnetic waves for the purpose of selectively destroying certain cells or tissues.
- ~~57-39.~~ "Reconstructive surgery" means a medical procedure that involves cutting into a body tissue or organ with instruments to repair damage or restore function to, or improve the shape and appearance of, a body structure that is missing, defective, damaged, or misshapen by cancer or cancer-directed therapies.
- ~~58.~~ "Recurrence" means the reappearance of a tumor after previous removal or treatment of the tumor, after a period in which the patient was believed to be free of cancer.
- ~~59-40.~~ "Reference date" means the date on which the hospital's cancer registry began reporting patient information to the Department.
- ~~60-41.~~ "Regional lymph node" means a lymph node that is in the same general area of a human body as the primary site of a tumor.
- ~~61-42.~~ "Regional site" means an area of a human body that is adjacent to or in the same general area of the human body as the primary site of a tumor.
- ~~62.~~ "Registered nurse practitioner" means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.
- ~~63.~~ "Rehabilitation services" means the same as in A.A.C. R9-10-201.
- ~~64-43.~~ "Release" means to transfer care of a patient from a hospital to a physician, a doctor of naturopathic medicine, a registered nurse practitioner, an outpatient treatment center, another hospital, the patient, the patient's parent if the patient is under 18 years of age and unmarried, or the patient's legal guardian.
- ~~65-44.~~ "Reporting facility" means a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner that submits a case report to the Department.
- ~~66-45.~~ "Secondary diagnosis" means all other diagnoses of an individual that may be related to cancer made after the principal diagnosis.
- ~~67.~~ "Sequence number" means a unique number assigned by a cancer registry to a specific cancer within the body of a patient.
- ~~68-46.~~ "Skin cancer" means cancer of any of the following types:
 - a. Papillary tumor, a tumor of the skin producing finger-like projections from the skin surface;
 - b. Squamous cell, a flat, scale-like skin cell that forms part of the surface of the skin;
 - c. Basal cell, a cell of the inner-most layer of the skin; or
 - d. Other carcinoma of the skin, where a specific diagnosis has not been determined.
- ~~69.~~ "Special hospital" means the same as in A.A.C. R9-10-201.
- ~~70.~~ "Squamous cell" means a flat, scale-like skin cell.
- ~~71-47.~~ "Stage group" means a scheme for categorizing a patient, based on the staging classification of the patient's cancer, to enable a physician, doctor of naturopathic medicine, or registered nurse practitioner to provide better treatment and outcome information to the patient.
- ~~72-48.~~ "Staging classification" means the categorizing of a cancer according to the size and spread of a tumor from its primary site, based on an analysis of three basic components:
 - a. The tumor at the primary site,
 - b. Regional lymph nodes, and
 - c. Metastasis.
- ~~73.~~ "Subsite" means a specific area within a primary site where a cancer tumor originated.
- ~~74.~~ "Substantiate stage" means a narrative describing the stage group of a cancer at the time of diagnosis.
- ~~75.~~ "Treatment" means the administration to a patient of medical services, nursing services, or health related services, as defined in A.R.S. § 36-401, that are intended to relieve illness or injury.
- ~~76-49.~~ "Tumor" means an abnormal growth of tissue resulting from uncontrolled multiplication of cells and serving no physiological function.
- ~~77.~~ "Usual industry" means the primary type of activity carried out by the business where a patient was employed for the most number of years of the patient's working life before the diagnosis of cancer.
- ~~78.~~ "Usual occupation" means the kind of work performed during the most number of years of a patient's working life before the diagnosis of cancer.
- ~~79.~~ "Working life" means that portion of a patient's life during which the patient was employed for a salary or wages.

R9-4-402. Exceptions

This Article does not apply to a hospital that is a special hospital, as defined in A.A.C. R9-10-101, that:

- 1. Licensed as a special hospital and a behavioral health service agency Is only licensed to provide psychiatric services, or
- 2. A special hospital that limits Limits admission to individuals requiring rehabilitation services, as defined in A.A.C. R9-10-101.

R9-4-403. Case Reports

- A. A physician, doctor of naturopathic medicine, dentist, registered nurse practitioner, or the designee of a clinic shall:
 - 1. Prepare a case report in a format provided by the Department;
 - 2. Include the following information in the case report:



- a. The name, address, and telephone number of, or the identification number assigned by the Department to, the reporting facility;
 - b. The patient's name, and, if applicable, the patient's maiden name and any other name by which the patient is known;
 - c. The patient's address at the date of last contact, and address at diagnosis of cancer;
 - d. The patient's date of birth, Social Security number, sex, race, and ethnicity;
 - e. The date of first contact with the patient for the cancer being reported, as applicable;
 - f. ~~The patient's usual industry and usual occupation, if~~ If the patient is an adult, the:
 - i. Primary type of activity carried out by the business where the patient was employed for the most number of years of the patient's life before the diagnosis of cancer, and
 - ii. Kind of work performed by the patient for the most number of years of the patient's life during which the patient was employed for a salary or wages before the diagnosis of cancer;
 - g. The patient's medical record number, if ~~assigned~~ applicable;
 - h. The date of diagnosis of the cancer being reported;
 - i. If the diagnosis was not made at the reporting facility, the name and address of the facility at which the diagnosis was made;
 - j. The primary site and the specific subsite area within the primary site ~~of for~~ the cancer being reported;
 - k. The following characteristics of the tumor size, histology, grade, and laterality at diagnosis:
 - i. Size;
 - ii. Histology, the microscopic structure of the tumor cells and surrounding tissues in relation to their function;
 - iii. Grade, the degree of resemblance of the tumor to normal tissue, as an indication of the severity of the cancer; and
 - iv. Laterality, the side of a paired organ or the side of the body in which the primary site of the tumor is located;
 - l. A code that describes the presence or absence of malignancy in a tumor;
 - m. Whether the cancer had spread from the primary site at the time of diagnosis and, if so, to where;
 - n. The extent to which the cancer has spread from the primary site;
 - o. A narrative description of the extent to which the cancer had spread at diagnosis, as applicable;
 - p. ~~Whether the diagnosis was made by histology, cytology, clinical evaluation, diagnostic x ray, or any other~~ The method or methods by which the diagnosis was made, or whether the method by which the diagnosis was made is unknown;
 - q. Whether the patient's laboratory results show the presence of specific substances, derived from tumor tissue, whose detection in the blood, urine, or tissues of a human body indicates the presence of a specific type of tumor, if applicable;
 - r. Any other physiological symptoms or diagnostic criteria that may indicate the presence of a specific type of tumor, if applicable;
 - ~~r.s.~~ For each treatment the patient received, the type of treatment, date of treatment, and the name of the facility where the treatment was performed;
 - ~~r.t.~~ Whether any residual tumor cells were left at the edges of a surgical site, after surgery to remove a tumor at the primary site;
 - ~~s.u.~~ Whether the patient is alive or dead, including:
 - i. ~~the~~ The date of last contact if the patient is alive, and
 - ii. ~~the~~ The date, ~~place, and cause~~ of death if the patient is dead;
 - ~~t.v.~~ Whether or not the patient has evidence of a current cancer, carcinoma in situ, or benign tumor of the central nervous system as of the date of last contact or death, or whether this information is unknown;
 - ~~t.w.~~ The name of the physician, nurse practitioner, or doctor of naturopathic medicine providing medical services, ~~as defined in A.R.S. § 36-401,~~ to the patient;
 - ~~v.~~ ~~The name of the individual or the code that identifies the individual completing the case report;~~
 - ~~w.~~ ~~The date the case report was completed;~~ and
 - x. Whether the patient has a history of other cancers, and if so, identification of the primary site and the date the other cancer was diagnosed; and
3. Use codes and a coding format supplied by the Department for data items specified in subsection (A)(2) that require codes on the case report.
- B.** The cancer registry of a hospital ~~with a licensed capacity of fewer than 50 inpatient beds~~ that reports as specified in R9-4-404(A) ~~and the cancer registry of a hospital with a licensed capacity of 50 or more inpatient beds~~ shall:
1. Prepare a case report in a format provided by the Department;
 2. Include the information specified in subsection (A) and the following information ~~on~~ in the case report:
 - a. The patient's unique accession number, separate from a medical record number, that was assigned by the hospital's cancer registry to the patient for identification purposes;
 - b. The unique sequence number assigned by the cancer registry to the specific cancer within the body of the patient being reported;
 - c. The date the patient was admitted to the hospital for diagnostic evaluation, cancer-directed treatment, or evidence of cancer, carcinoma in situ, or a benign tumor of the central nervous system, if applicable;
 - d. The date the patient was discharged from the hospital after the patient received diagnostic evaluation or treatment at the hospital, if applicable;
 - e. The source of payment for diagnosis or treatment of cancer, or both;
 - f. The level of the facility's involvement in the diagnosis or treatment, or both, of the patient for cancer;
 - g. The year in which the hospital first provided diagnosis or treatment to the patient for the cancer being reported;
 - h. The patient's county of residence at diagnosis of cancer;
 - i. The patient's marital status and age at diagnosis of cancer, place of birth, and, if applicable, name of the patient's spouse;
 - j. If the patient is under 18 years of age and unmarried, the name of the patient's parent or legal guardian;
 - k. ~~The patient's religious preference, if applicable;~~



- l. Whether the patient's laboratory results show the presence of specific substances known as Tumor Marker 1 and Tumor Marker 2, which are derived from tumor tissue, and whose detection in the blood of a human body indicates the presence of a specific type of tumor;
- m-k. A narrative description of how the cancer was diagnosed, including a description of the primary site and the microscopic structure of the tumor cells and surrounding tissues;
- n-l. The number of regional lymph nodes examined and the number in which evidence of cancer was detected;
- o-m. The clinical, ~~or~~ pathological, or other staging classification, based on the analysis of tumor, lymph node, and metastasis;
- p-n. The patient's clinical, ~~or~~ pathological, or other stage group;
- q-o. ~~The occupation of~~ If the cancer was diagnosed before 2018, the individual code for the person who determined the clinical or pathological stage group of the patient;
- r-p. A narrative description of the clinical evaluation of x-ray diagnostic films and scans of the patient, and the dates of the films or scans;
- s-q. A narrative description of laboratory tests performed for the patient, including the date, type, and results of any of the patient's laboratory tests;
- t-r. A narrative description of the results of the patient's clinical evaluation;
- u-s. The procedures used by the reporting facility to obtain a diagnosis and staging classification, including:
 - i. ~~the~~ The dates on which the procedures were performed; and
 - ii. ~~the~~ The name of the facilities where the procedures were performed, if different from the reporting facility;
- v-t. A narrative description of any cancer-related surgery on the patient, including the:
 - i. ~~date~~ Date of surgery; and
 - ii. ~~name~~ Name of the facility where the surgery was performed, if different from the reporting facility; and
 - iii. ~~type~~ Type of surgery;
- w-ll. The code associated with the type of surgery performed on the patient and the date of surgery;
- x-v. The codes associated with the:
 - i. ~~Surgical approach;~~
 - ii-i. Extent of lymph node surgery;
 - iii-ii. Number of lymph nodes removed;
 - iv-iii. Surgery of regional sites, distant sites, or distant lymph nodes; and
 - v-iv. Reason for no surgery or that surgery was performed;
- y-w. Whether reconstructive surgery on the patient was performed as a first course of treatment, delayed, or not performed;
- z-x. A narrative description of cancer-related radiation treatment administered to the patient, including the:
 - i. ~~date~~ Date of radiation treatment; and
 - ii. ~~name~~ Name of the facility where the radiation treatment was performed, if different from the reporting facility; and
 - iii. ~~type~~ Type of radiation;
- y. As applicable, the code specifying that radiation treatment was administered or associated with the reason for no radiation treatment;
- aa-z. The code associated with the type of radiation treatment administered to the patient and the date of radiation treatment;
- bb-aa. A narrative description of cancer-related chemotherapy administered to the patient, including the:
 - i. ~~date~~ Date of cancer-related chemotherapy; and
 - ii. ~~name~~ Name of the facility that administered the chemotherapy, if different from the reporting facility; and
 - iii. ~~type~~ Type of chemotherapy;
- ee-bb. The code associated with the type of chemotherapy administered to the patient and the date of chemotherapy;
- dd. ~~If the patient's treatment included both surgery and radiation treatment, the sequence of the two treatments;~~
- cc. The code associated with any other types of cancer- or non-cancer-directed first course of treatment, not otherwise coded on the case report for the patient, including:
 - i. Hormone therapy, immunotherapy, hematologic transplant, or endocrine procedures administered to the patient;
 - ii. Additional surgery, radiation, or chemotherapy administered to the patient; or
 - iii. Other treatment administered to the patient;
- ee-dd. ~~If applicable, a narrative description of any other types of cancer or non-cancer-directed first course of treatment, not otherwise coded on the case report for the patient, including:~~
 - i. ~~Additional surgery, chemotherapy, radiation, or other treatment, administered to the patient;~~
 - ii-i. ~~The dates of the treatment;~~
 - iii-ii. ~~The names of the facilities where the treatment was performed, if different from the reporting facility; and~~
 - iv-iii. ~~The type of treatment;~~
- ff. ~~If additional cancer of the type diagnosed at the primary site is found after cancer directed treatment, the date and location of the additional cancer, and whether the additional cancer was found at the primary site, a regional site, or a distant site;~~
- ee. ~~If the patient's treatment included both surgery and another type of treatment, the sequence of the two treatments;~~
- ff. The code for the status of the patient's treatment, including whether the patient received any treatment or the tumor was being actively observed and monitored;
- gg. The code for whether the patient has had a reappearance of a cancer, carcinoma in situ, or benign tumor of the central nervous system, and, if additional cancer of the type diagnosed at the primary site is found after cancer-directed treatment:
 - i. The date of the reappearance; and
 - ii. A narrative description of the nature of the reappearance, including whether the additional cancer was found at the primary site, a regional site, or a distant site;
- gg-hh. ~~If the patient has died, the place and cause of death and whether an autopsy was performed; and~~
 - ii. The name of the individual or the code that identifies the individual completing the case report;



- ~~hh-ii.~~ The type of records used by the reporting facility to complete the case report;
- ~~kk.~~ If applicable, a code that indicates the reason for a required date not to be included in the case report required in subsection (B)(1); and
- ~~ll.~~ If applicable, a code that indicates that an apparently inconsistent code has been reviewed and is correct; and
3. Use codes and coding format supplied by the Department for data items specified in subsection (B)(2) that require codes in the case report.

R9-4-404. Requirements for Submitting Case Reports and Follow-up Reports and Allowing Review of Hospital Records

- A. The cancer registry of a hospital with a licensed capacity of 50 or more inpatient beds shall ensure that:
1. An electronic case report, ~~prepared according to R9-4-403(B),~~ is submitted to the Department within 180 calendar days ~~from~~ after the date a patient is first released from the hospital; ~~and~~
 2. ~~An electronic follow-up report, including a change of patient address, if applicable, a summary of additional first course of treatment, if applicable, and the information in R9-4-403(A)(2)(q), (s), (t), and (u) and R9-4-403(B)(2)(gg), is submitted to the Department at least annually for:~~
 - a. ~~All living analytic patients in the hospital's cancer registry database, and~~
 - b. ~~All analytic patients in the hospital's cancer registry database who have died since the last follow-up report.~~
 2. An electronic follow-up report, for correcting information previously submitted according to R9-4-403(A)(2)(j) through (l), or (B)(2)(a), (b), (m), (n), or (w), is submitted to the Department:
 - a. Within 30 calendar days after identifying the correct information and at least annually.
 - b. For all patients for whom applicable corrected information is obtained.
 - c. That includes patient identifying information and the information to be corrected, and
 - d. In a format provided by the Department; and
 3. An electronic follow-up report for analytic patients, in a format provided by the Department:
 - a. Is submitted to the Department at least annually for:
 - i. All living analytic patients in the hospital's cancer registry database, and
 - ii. All analytic patients in the hospital's cancer registry database who have died since the last follow-up report; and
 - b. Includes, as applicable:
 - i. A change of patient address;
 - ii. A summary of additional first course of treatment; and
 - iii. The information in R9-4-403(A)(2)(s), (u), (v), and (w) and R9-4-403(B)(2)(gg).
- B. The cancer registry or other designee of a hospital with a licensed capacity of fewer than 50 inpatient beds shall either report as specified in subsection (A), or shall at least once every six months:
1. Prepare and submit ~~a written report~~ to the Department, in a format provided by the Department:
 - a. For all individuals:
 - i. Released by the hospital since the last report was prepared, and
 - ii. Whose medical records include ~~ICD-9-CM diagnosis codes~~ ICD Codes specified in a list provided to the hospital by the Department;
 - b. ~~Containing ICD-9-CM diagnosis codes that are arranged in numeric order, and~~
 - e-b. Including the ~~The~~ following information associated with ~~for~~ each ICD-9-CM diagnosis code individual:
 - i. The individual's medical record number assigned by the hospital,
 - ii. The individual's age ~~date of birth~~,
 - iii. The individual's admission and discharge dates,
 - iv. All applicable ICD Codes for the individual that are in the list in subsection (B)(1)(a)(ii), and
 - ~~iv-v.~~ Whether the diagnosis code ICD Code reflects the individual's principal or secondary diagnosis; ~~and~~
 2. Allow the Department to review the records listed in R9-4-405(A) to obtain the information specified in R9-4-403 about a patient.
- C. If the designee of a clinic submitted 100 or more case reports to the Department in the previous calendar year or expects to submit 100 or more case reports in the current calendar year, the designee of the clinic shall:
1. Submit to the Department a case report, ~~prepared according to R9-4-403(A), to the Department~~ for each patient who is not referred by the clinic to a hospital for the first course of treatment; and
 2. Ensure that the case report in subsection (C)(1) is submitted in electronic format within 90 calendar days ~~of~~ after:
 - a. Initiation of treatment of the patient at the clinic; or
 - b. Diagnosis of cancer in the patient, if the clinic did not provide treatment and did not refer to a hospital for the first course of treatment.
- D. If the designee of a clinic submitted fewer than 100 case reports to the Department in the previous calendar year and expects to submit fewer than 100 case reports in the current calendar year, the designee of the clinic shall submit to the Department an electronic or paper case report, ~~prepared according to R9-4-403(A), to the Department~~ for each patient, within 30 calendar days ~~from~~ after the date of diagnosis of cancer in the patient, if the clinic:
1. Diagnoses cancer in the patient ~~without a pathology report from a pathology laboratory, and~~
 2. Does not refer the patient to a hospital for the first course of treatment.
- E. A physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner who diagnoses cancer in or provides treatment for cancer for fewer than 50 patients per year shall submit an electronic or paper case report to the Department for each patient, within 30 calendar days ~~from~~ after the date of diagnosis of cancer in the patient, if the physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner:
1. ~~Diagnoses cancer in the patient without a pathology report from a pathology laboratory, and~~
 2. ~~Does~~ does not refer the patient to a hospital or clinic for the first course of treatment.



- F. A clinic, physician, dentist, registered nurse practitioner, or doctor of naturopathic medicine that receives a letter from the Department, requesting any of the information specified in R9-4-403 about a patient, shall provide to the Department the requested information on the patient within 15 business days ~~from~~ after the date of the request.
- G. A clinic, physician, dentist, registered nurse practitioner, or doctor of naturopathic medicine that receives a letter from a hospital, requesting any of the information specified in R9-4-403 about a patient, shall provide to the hospital the requested information on the patient within 15 business days ~~from~~ after the date of the request.
- H. A pathology laboratory shall:
 - ~~1. Allow the Department to review pathology reports at least once every 90 calendar days, to obtain the information specified in R9-4-403; and~~
 - ~~2.1. Provide At least once every 90 calendar days, provide to the Department electronic copies, in electronic or written format, of pathology reports of patients; and~~
 - 2. Include in a pathology report the following information:
 - a. The patient's name, address, and telephone number;
 - b. The patient's date of birth;
 - c. The patient's gender, race, and ethnicity;
 - d. Clinical information about the patient, if available;
 - e. The type of tissue collected;
 - f. The procedure by which the tissue was collected;
 - g. The date the tissue was collected;
 - h. The code number assigned by the clinical laboratory to the tissue collected for pathological analysis;
 - i. The results of the pathological analysis of the tissue, including the pathologist's interpretation of the results;
 - j. The date of the results;
 - k. The name, practice name, address, and telephone number of the physician who ordered the pathological analysis of the tissue;
 - l. The name and address of the clinical laboratory that performed the pathological analysis of the tissue; and
 - m. The name and telephone number of the clinical laboratory director.

R9-4-405. Data Quality Assurance

- A. To ensure completeness and accuracy of cancer reporting:
 - 1. ~~upon~~ Upon notice from the Department of at least five business days, a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner required to report under R9-4-404 shall allow the Department to review any of the following records, as are applicable to the facility:
 - ~~1-a.~~ A report meeting the requirements of R9-4-404(B)(1);
 - ~~2-b.~~ Patient medical records;
 - ~~3-c.~~ Medical records of individuals not diagnosed with cancer;
 - ~~4-d.~~ Pathology reports;
 - ~~5-e.~~ Cytology reports;
 - ~~6-f.~~ Logs containing information about surgical procedures, as specified in A.A.C. ~~R9-10-214(A)(6)~~ R9-10-215(6) or A.A.C. ~~R9-10-1709(A)~~ R9-10-911(A); and
 - ~~7-g.~~ Records other than those specified in subsections ~~(A)(1) through (A)(6)~~ (A)(1)(a) through (f) that contain information about diagnostic evaluation, cancer-directed treatment, or other treatment provided to an individual by the hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner;
 - 2. Within 14 calendar days after the Department's request, a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner required to report under R9-4-404 shall submit the following information about patients who were diagnosed with cancer or received treatment for cancer within the time period specified in the Department's request whose medical records include ICD Codes specified in a list provided by the Department:
 - a. The individual's name and date of birth;
 - b. The individual's medical record number;
 - c. The individual's admission and discharge dates;
 - d. All applicable codes for the individual that are in the list provided by the Department, and
 - e. Whether the code reflects the individual's principal or secondary diagnosis; and
 - 3. Within 14 calendar days after the Department's request, a hospital shall resubmit all of the information required in R9-4-403(B)(2) for patients first released from the hospital within the time period specified in the Department's request.
- B. The Department shall consider a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner required to report under R9-4-404 as meeting the criteria in R9-4-404 if the hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner submits a case report to the Department for at least 97% of the patients for whom a case report is required under R9-4-404 during a calendar year.
- C. The Department shall consider a hospital required to report under ~~R9-4-404(A)(2)~~ R9-4-404(A)(3) as meeting the criteria in ~~R9-4-404(A)(2)~~ R9-4-404(A)(3) if the hospital submits a follow-up report specified in ~~R9-4-404(A)(2)~~ R9-4-404(A)(3) to the Department once each calendar year for at least:
 - 1. Eighty percent of all analytic patients from the hospital's reference date; and
 - 2. Ninety percent of all analytic patients diagnosed within the last five years or from the hospital's reference date, whichever is shorter.
- D. The Department shall return a case report not prepared according to R9-4-403 to the hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner that submitted the case report, identifying the revisions that are needed in the case report.



~~E.~~ Upon receiving a case report returned under subsection (D), a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner shall submit the revised case report to the Department within 15 business days ~~from~~ after the date the Department requests the revision.

~~E.F.~~ Upon written request by the Department, a hospital shall:

1. ~~prepare~~ Prepare a case report based on a simulated medical record provided by the Department for the purpose of demonstrating the variability with which data is reported. ~~The hospital shall return, and~~
2. Submit the case report to the Department within 15 business days ~~from~~ after the date of the request.

ARTICLE 5. BIRTH DEFECTS MONITORING PROGRAM

R9-4-501. Definitions

In this Article, unless otherwise specified:

1. ~~“Admitted” means the same as in A.A.C. R9-10-201.~~
- 2-1. ~~“Birth defect” means an abnormality:~~
 - a. Of body structure, function, or chemistry, or of chromosomal structure or composition;
 - b. That is present at or before birth; and
 - c. That may be diagnosed before or at birth, or later in life.
3. ~~“Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.~~
4. ~~“Calendar day” means any day of the week, including a Saturday or a Sunday.~~
- 5-2. ~~“Clinic” means:~~
 - a. A person under contract or subcontract with ~~CRS~~ the Arizona Health Care Cost Containment System to provide the ~~medi-~~ cal services specified in ~~9 A.A.C. 7, Article 4 9 A.A.C. 22, Article 13;~~
 - b. An outpatient treatment center, as defined in A.A.C. R9-10-101; ~~or~~
 - c. An outpatient surgical center, as defined in A.A.C. R9-10-101; ~~or~~
 - d. A birth center, as defined in A.A.C. R9-13-201.
- 6-3. ~~“Clinical evaluation” means an examination of the body of an individual and review of the individual’s laboratory test results to determine the presence or absence of a medical condition that may be related to a birth defect.~~
7. ~~“Clinical laboratory” means a facility that:~~
 - a. ~~Meets the definition in A.R.S. § 36-451;~~
 - b. ~~Is operated, licensed, or certified by the U.S. government; and~~
 - c. ~~Is located within Arizona.~~
8. ~~“Code” means a single number or letter, a set of numbers or letters, or a set of both numbers and letters, that represents specific information.~~
- 9-4. ~~“Conception” means the formation of an entity by the union of a human sperm and ovum, resulting in a pregnancy.~~
- 10-5. ~~“Co-twin” means a sibling of a patient, who was born to the same mother as the patient and as a result of the same pregnancy as the patient.~~
11. ~~“CRS” means the Children’s Rehabilitative Services program, established within the Department as specified in A.R.S. Title 36, Chapter 2, Article 3.~~
- 12-6. ~~“Date of first contact” means the day, month, and year a physician, clinic, or other person specified in R9-4-503(A) first began to provide medical services, nursing services, or health-related services to a patient or the patient’s mother.~~
- 13-7. ~~“Date of last contact” means the day, month, and year:~~
 - a. Of a patient’s death; or
 - b. That a physician, clinic, or other person specified in R9-4-503(A) last clinically evaluated, diagnosed, or provided treatment to a patient or the patient’s mother.
- 14-8. ~~“Designee” means an individual assigned by the governing power of a hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility or by another individual acting on behalf of the governing power to gather information for or report to the Department, as specified in R9-4-502, R9-4-503, or R9-4-504.~~
15. ~~“Discharge” means the same as in A.A.C. R9-10-201.~~
16. ~~“Discharge date” means the month, day, and year of an individual’s discharge from a hospital.~~
17. ~~“Electronic” means the same as in A.R.S. § 44-7002.~~
18. ~~“Enrolled” means approved to receive services specified in 9 A.A.C. Chapter 7 from CRS.~~
- 19-9. ~~“Estimated date of confinement” means an approximation of the date on which a woman will give birth, based on the clinical evaluation of the woman.~~
- 20-10. ~~“Estimated gestational age” means an approximation of the duration of a pregnancy, based on the date of the last menstrual period of the pregnant woman.~~
- 21-11. ~~“Facility” means a building and associated personnel and equipment that perform or are used in connection with performing a particular service or activity.~~
- 22-12. ~~“Family medical history” means an account of past and present illnesses or diseases experienced by individuals who are biologically related to a patient.~~
23. ~~“Follow up services” means activities intended to assist the parent or guardian of a patient who has a birth defect to:~~
 - a. ~~Learn about the birth defect and, if applicable, how the birth defect may be prevented; or~~
 - b. ~~Obtain applicable medical services, nursing services, health related services, or support services.~~
24. ~~“Genetic condition” means a disease or other abnormal state present at birth or before birth, as a result of an alteration of DNA, that impairs normal physiological functioning of a human body.~~
- 25-13. ~~“Genetic testing facility” means an organization, institution, corporation, partnership, business, or entity that conducts tests to detect, analyze, or diagnose a genetic condition disease or other abnormal state present at birth or before birth, as a result of an~~



- alteration of DNA, that may impair normal physiological functioning in an individual, including an evaluation to determine the structure of an individual’s chromosomes.
- ~~26-14.~~ “Governing power” means the individual, agency, group, or corporation appointed, elected, or otherwise designated, in which the ultimate responsibility and authority for the conduct of a hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility are vested.
- 27. “Guardian” means an individual appointed as a legal guardian by a court of competent jurisdiction.
- ~~28.~~ “Health related services” means the same as in A.R.S. § 36-401.
- ~~29-15.~~ “High-risk perinatal practice” means a clinic or physician that routinely provides medical services prenatally to a patient or a patient’s mother with perinatal risk factors to prevent, clinically evaluate, diagnose, or treat the patient for a possible birth defect.
- ~~30-16.~~ “Log” means a chronological list of individuals for or on whom medical services, nursing services, or health-related services were provided by a designated unit of a hospital or by another person specified in R9-4-503(A).
- ~~31-17.~~ “Medical condition” means a disease, injury, other abnormal physiological state, or pregnancy.
- ~~32.~~ “Medical records” means the same as in A.R.S. § 12-2291.
- ~~33-18.~~ “Medical record number” means a unique number assigned by a hospital, clinic, physician, or registered nurse practitioner to an individual for identification purposes.
- ~~34.~~ “Medical services” means the same as in A.R.S. § 36-401.
- ~~35-19.~~ “Midwife” means an individual licensed under A.R.S. Title 36, Chapter 6, Article 7, or certified under A.R.S. Title 32, Chapter 15.
- ~~36-20.~~ “Mother” means the woman:
 - a. Who is pregnant with or gives birth to a patient, or
 - b. From whose fertilized egg a patient develops.
- ~~37-21.~~ “Multiple gestation” means a pregnancy in which a patient is not the only fetus carried in a mother’s womb.
- ~~38.~~ “Nursing services” means the same as in A.R.S. § 36-401.
- ~~39.~~ “Ordered” means instructed by a physician, registered nurse practitioner, or physician assistant to perform a test on an individual.
- ~~40.~~ “Parent” means the:
 - a. Biological or adoptive father of an individual; or
 - b. Woman who:
 - i. Is the mother of an individual; or
 - ii. Adopts an individual.
- ~~41.~~ “Pathology laboratory” means a facility in which human cells, body fluids, or tissues are examined for the purpose of diagnosing diseases and that is licensed under 9 A.A.C. 10, Article 1.
- ~~42-22.~~ “Patient” means an individual, regardless of current age:
 - a. Who, from conception to one year of age, was clinically evaluated for a possible birth defect or a medical condition that may be related to a birth defect:
 - i. By a physician, midwife, registered nurse practitioner, or physician assistant; or
 - (1) A physician;
 - (2) A midwife;
 - (3) A registered nurse practitioner; or
 - (4) A physician assistant; or
 - ii. At a hospital or clinic;
 - b. Whose mother was clinically evaluated during her pregnancy with the individual:
 - i. For a medical condition that may be related to a possible birth defect, and
 - ii. By an individual or facility specified in subsection ~~(42)(a)~~ (22)(a);
 - c. Who, from conception to one year of age, was tested by a genetic testing facility or other clinical laboratory;
 - d. Whose mother was tested during her pregnancy with the individual by a:
 - i. Genetic testing facility or other clinical laboratory, or
 - ii. Prenatal diagnostic facility; or
 - e. Who, from conception to one year of age, was provided treatment or whose mother during her pregnancy with the individual was provided treatment by a hospital, clinic, physician, registered nurse practitioner, or other person specified in R9-4-503(A) for a medical condition that may be related to a possible birth defect; or
 - f. Who has received a diagnosis of having a medical condition that may be related to a birth defect.
- ~~43-23.~~ “Perinatal risk factor” means a situation or circumstance that may increase the chance of an individual being born with a birth defect, such as:
 - a. A family medical history of birth defects or other medical conditions;
 - b. The exposure of the individual or the individual’s mother or biological father to radiation, medicines, chemicals, or diseases before the individual’s birth; or
 - c. An abnormal result of a test performed for the individual or the individual’s mother by a prenatal diagnostic facility or clinical laboratory, including a genetic testing facility.
- ~~44.~~ “Physician assistant” means an individual licensed under A.R.S. Title 32, Chapter 25.
- ~~45-24.~~ “Prenatal diagnostic facility” means an organization, institution, corporation, partnership, business, or entity that conducts diagnostic ultrasound or other medical procedures that may diagnose a birth defect in a human being.
- ~~46-25.~~ “Principal diagnosis” means the primary reason for which an individual is:
 - a. Admitted to a hospital;
 - b. Treated by a hospital, clinic, midwife, physician, registered nurse practitioner, or physician assistant; or
 - c. Tested by a genetic testing facility or prenatal diagnostic facility.



- 47-26. "Procedure" means a set of activities performed on a patient or the mother of a patient that:
- Are invasive;
 - Are intended to diagnose or treat a disease, illness, or injury;
 - Involve a risk to the patient or patient's mother from the activities themselves or from anesthesia; and
 - Require the individual performing the set of activities to be trained in the set of activities.
- 48-27. "Refer" means to provide direction to an individual or the individual's parent or guardian to obtain medical services or a test for assessment, diagnosis, or treatment of a birth defect or other medical condition.
49. ~~"Registered nurse practitioner" means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.~~
- 50-28. "Routinely" means occurring in the regular or customary course of business.
- 51-29. "Secondary diagnosis" means all other diagnoses that may be related to a birth defect for an individual besides the principal diagnosis.
- 52-30. "Singleton gestation" means a pregnancy in which a patient is the only fetus carried in a mother's womb.
- 53-31. "Support services" means activities, not related to the diagnosis or treatment of a birth defect, intended to maintain or improve the physical, mental, or psychosocial capabilities of a patient or those individuals biologically or legally related to the patient.
- 54-32. "Surgical procedure" means making an incision into an individual's body for the:
- Correction of a deformity or defect,
 - Repair of an injury,
 - Excision of a part of the individual's body, or
 - Diagnosis, amelioration, or cure of a disease.
- 55-33. "Test" means:
- An analysis performed on body fluid, tissue, or excretion by a genetic testing facility or other clinical laboratory to evaluate for the presence or absence of a disease; or
 - A procedure performed on the body of a patient or the patient's mother that may be used to evaluate for the presence or absence of a birth defect.
- 56-34. "Transfer" means for a hospital to discharge a patient or the patient's mother and send the patient or the patient's mother to another hospital for inpatient medical services without the intent that the patient or the patient's mother will return to the sending hospital.
- 57-35. "Treatment" means the same as in A.A.C. R9-10-101.
- 58-36. "Unit" means an area of a hospital designated to provide an organized service, as defined in A.A.C. R9-10-201.

R9-4-502. Reporting Sources; Information Submitted to the Department

- A. The designee of a hospital shall:
- Upon the request of the Department and no more often than once per month, prepare ~~Prepare~~ a written report, ~~each month~~ in a format specified by the Department, identifying all individuals:
 - Who are patients or the mothers of patients; and
 - Whose:
 - Discharge date is within the ~~month~~ time period for which the report is being prepared, as specified in subsection (A)(2)(d); and
 - Medical ~~record includes~~ records include for the principal diagnosis, a secondary diagnosis, or a procedure performed on the individual, an ~~ICD-9-CM~~ ICD Code for a diagnosis or a procedure code specified in a list provided to the hospital by the Department;
 - Include the following information in the report specified in subsection (A)(1):
 - The name, address, and telephone number of the hospital, or the identification number assigned by the Department to the hospital;
 - The name, ~~and~~ telephone number, ~~and~~ e-mail address of the designee of the hospital;
 - The date the report was completed;
 - The ~~month~~ time period for which the report is being prepared; and
 - For each patient or the mother of the patient:
 - The patient's or mother's medical record number;
 - The name of the patient or patient's mother, if available, and, if applicable, any other name by which the patient or patient's mother is known;
 - ~~The race and ethnicity of the patient or patient's mother;~~
 - ~~iii.~~ iii. The patient's gender and date of birth, if applicable;
 - ~~iv.~~ iv. The admission and discharge dates;
 - ~~v.~~ v. The principal and secondary diagnoses or the ~~ICD-9-CM diagnosis codes~~ ICD Codes for the principal and secondary diagnoses for the patient or patient's mother; and
 - ~~vii.~~ vi. The ~~procedure~~ codes for procedures provided to the patient or patient's mother; and
 - Submit the report specified in subsection (A)(1) to the Department, in a format specified by the Department, within 30 calendar days after the ~~end of the month for which the report is being prepared~~ Department's request.
- B. The designee of a high-risk perinatal practice shall:
- Prepare a written report each month in a format specified by the Department for all individuals:
 - Who are patients or the mothers of patients; and
 - Whose:
 - Date of last contact is within the month for which the report is being prepared, as specified in subsection (B)(2)(d); and
 - Medical record includes a principal or secondary diagnosis specified in a list provided to the high-risk perinatal practice by the Department;



- 2. Include the following information in the report specified in subsection (B)(1):
 - a. The name, address, and telephone number of the high-risk perinatal practice, or the identification number assigned by the Department to the high-risk perinatal practice;
 - b. The name and telephone number of the designee of the high-risk perinatal practice;
 - c. The date the report was completed;
 - d. The month for which the report is being prepared; and
 - e. For each patient or the mother of the patient:
 - i. The patient's or mother's medical record number, if assigned;
 - ii. The mother's name;
 - iii. The mother's date of birth;
 - iv. The mother's estimated date of confinement;
 - v. The patient's gender, if known;
 - vi. Whether the patient is from a singleton or multiple gestation;
 - vii. The location and date of the patient's birth, if known;
 - viii. Whether the patient was born alive or dead, if known;
 - ix. The date of last contact with the mother;
 - x. The principal and secondary diagnoses for the patient or the patient's mother; and
 - xi. If the principal and secondary diagnoses for the patient were made before the patient's birth, whether the principal and secondary diagnoses were confirmed at birth; and
- 3. Submit the report specified in subsection (B)(1) to the Department, in a format specified by the Department, within 30 calendar days after the end of the month for which the report is being prepared.

B. The designee of a prenatal diagnostic facility, high-risk perinatal practice, or clinic shall:

- 1. Upon the request of the Department and no more often than once per month, prepare a report, in a format specified by the Department, identifying all individuals:
 - a. For whom a specified test was conducted, with test results indicating a diagnosis in a list provided by the Department; or
 - b. Whose medical records include a principal diagnosis or secondary diagnosis specified in a list provided by the Department;
- 2. Include the following information in the report specified in subsection (B)(1):
 - a. Either:
 - i. The name, address, and telephone number of the prenatal diagnostic facility, high-risk perinatal practice, or clinic; or
 - ii. The identification number assigned by the Department to the prenatal diagnostic facility, high-risk perinatal practice, or clinic;
 - b. The name, telephone number, and e-mail address of the designee of the prenatal diagnostic facility, high-risk perinatal practice, or clinic;
 - c. The date the report was completed;
 - d. The time period for which the report is being prepared;
 - e. The mother's name, date of birth, and medical record number;
 - f. The estimated gestational age of the patient at the time of the test or diagnosis, as applicable;
 - g. The mother's estimated date of confinement;
 - h. The outcome of the pregnancy, if known;
 - i. The location and date of the patient's birth, if known;
 - j. The patient's gender, if known;
 - k. The principal diagnosis and secondary diagnoses for the patient or the patient's mother, as applicable; and
 - l. Information about the test leading to the diagnosis, including:
 - i. The type of test performed;
 - ii. The date the test was completed, and
 - iii. The results of the test; and
- 3. Submit the report specified in subsection (B)(1) to the Department, in a Department-provided format, within 30 calendar days after the Department's request.

C. The designee of a genetic testing facility shall:

- 1. Prepare a ~~written~~ report ~~each month~~, in a format specified by the Department, for all individuals:
 - a. Who are patients or the mothers of patients, and
 - b. For whom the genetic testing facility performed a test specified in a list provided by the Department;
 - i. ~~Completed within the month for which the report is being prepared, as specified in subsection (C)(2)(d); and~~
 - ii. ~~Specified in a list provided by the Department to the genetic testing facility;~~
- 2. Include the following information in the report specified in subsection (C)(1):
 - a. The name, address, and telephone number of the genetic testing facility, or the identification number assigned by the Department to the genetic testing facility;
 - b. The name, ~~and~~ telephone number, and e-mail address of the designee of the genetic testing facility;
 - c. The date the report was completed;
 - d. The month for which the report is being prepared, if reporting according to subsection (C)(3)(a); and
 - e. For each patient or mother of a patient:
 - i. If the test was performed on the patient:
 - (1) The patient's name, date of birth, and gender; and
 - (2) The name of the patient's parent or guardian;
 - ii. If the test was performed on the mother of the patient:
 - (1) The mother's name and date of birth;



- (2) The estimated gestational age of the patient when the test was performed, if available; and
 - (3) The mother's estimated date of confinement when the test was performed, if available;
 - iii. The name of the physician, registered nurse practitioner, or physician assistant who ordered the test for the patient or the patient's mother; and
 - iv. Information about the test, including:
 - (1) The type of test performed on the patient or the patient's mother,
 - (2) The date the test was completed, and
 - (3) The results of the test; and
- 3. ~~Submit to the Department~~ the report specified in subsection (C)(1) ~~and a copy of the test results to the Department, in a format specified by the Department, within 30 calendar days after either:~~
 - a. ~~the The~~ end of the month ~~for which the report is being prepared during which the test was completed, or~~
 - b. The date of the test.
- D.** ~~The designee of a prenatal diagnostic facility shall:~~
 - 1. ~~Submit an electronic or paper report to the Department:~~
 - a. ~~For each mother:~~
 - i. ~~On whom the prenatal diagnostic facility conducts a test specified in a list provided by the Department to the prenatal diagnostic facility, and~~
 - ii. ~~Whose test result indicates a diagnosis specified in a list provided by the Department to the prenatal diagnostic facility; and~~
 - b. ~~Within 30 calendar days from the date of the test;~~
 - 2. ~~Include the following information in the report specified in subsection (D)(1):~~
 - a. ~~The name, address, and telephone number of the prenatal diagnostic facility, or the identification number assigned by the Department to the prenatal diagnostic facility;~~
 - b. ~~The name and telephone number of the designee of the prenatal diagnostic facility;~~
 - c. ~~The date the report was completed;~~
 - d. ~~The mother's name and date of birth;~~
 - e. ~~The estimated gestational age of the patient at the time of the test;~~
 - f. ~~The mother's estimated date of confinement;~~
 - g. ~~The outcome of the pregnancy, if known;~~
 - h. ~~The name of the physician, registered nurse practitioner, or physician assistant who ordered the test for the mother; and~~
 - i. ~~Information about the test, including:~~
 - i. ~~The type of test performed on the mother,~~
 - ii. ~~The date the test was completed, and~~
 - iii. ~~The results of the test.~~

R9-4-503. Review of Records; Information Collected

- A. Upon notice from the Department of at least five business days, the following persons or facilities shall allow the Department access to the facility and the electronic or written records specified in subsection (B)(1) to collect the information specified in subsection (B)(2):
 - 1. A hospital,
 - 2. A clinic,
 - 3. A physician,
 - 4. A midwife,
 - 5. A registered nurse practitioner,
 - 6. A genetic testing facility,
 - 7. A prenatal diagnostic facility,
 - 8. A physician assistant,
 - 9. A clinical laboratory, or
 - 10. A medical examiner.
- B. The Department may:
 - 1. Review any of the following records in electronic or written format, as are applicable to the person or facility specified in subsection (A):
 - a. Patient medical records;
 - b. Medical records for the mother of a patient;
 - c. Reports from:
 - i. Physicians or other individuals who clinically evaluated, diagnosed, or treated a patient or the patient's mother, including physical therapists, as defined in A.R.S. § 32-2001; occupational therapists, as defined in A.R.S. § 32-3401; podiatrists, as defined in A.R.S. § 32-801; and speech-language pathologists, licensed according A.R.S. Title 35, Chapter 17;
 - ii. High-risk perinatal practices;₁
 - iii. Prenatal diagnostic facilities;₂
 - iv. Genetic testing facilities;₃
 - v. Pathology laboratories;₄ or
 - vi. Other facilities or clinical laboratories that performed a test for a patient or the patient's mother;
 - d. Logs and registers containing information about surgical procedures, as specified in A.A.C. ~~R9-10-214(A)(6)~~ R9-10-215(6) or A.A.C. ~~R9-10-1709(A)~~ R9-10-911(A);
 - e. Other logs that may contain information about a patient or the mother of a patient with a birth defect, such as:



- i. Labor and delivery unit logs,
 - ii. Nursery unit logs,
 - iii. Pediatric unit logs,
 - iv. Intensive care unit logs,
 - v. Autopsy logs, and
 - vi. Ultrasound logs;
 - f. Autopsy reports; and
 - g. Records other than those specified in subsections (B)(1)(a) through (f) that contain information about or may lead to information about:
 - i. A patient,
 - ii. The patient’s mother, or
 - iii. The patient’s biological sibling; and
2. Collect the following information from a person or facility specified in subsection (A), as applicable to a patient or the mother of a patient:
- a. The name, address, and telephone number of the person or facility, or the identification number assigned by the Department to the person or facility;
 - b. The date of first contact and the date of last contact;
 - c. The date the patient was admitted to a hospital;
 - d. The date the patient was discharged from a hospital;
 - e. The dates the mother of the patient was admitted to and discharged from a hospital for:
 - i. The birth of the patient, or
 - ii. Treatment related to a possible birth defect in the patient;
 - f. The name and address of the hospital or other location in which the patient was born;
 - g. The name and address of a hospital in which the patient or the mother of the patient was admitted for treatment related to a possible birth defect in the patient;
 - h. The specific unit of a hospital that provided medical services to the patient or the patient’s mother;
 - i. The medical record number of the patient or the patient’s mother;
 - j. The patient’s name and any other name by which the patient is known;
 - k. The names, addresses, and dates of birth of the patient’s parents;
 - l. The name, address and telephone number of the patient’s guardian, if a parent of the patient does not have physical custody of the patient;
 - m. The patient’s date of birth and hour of birth;
 - n. The estimated date of confinement for the pregnancy resulting in the patient’s birth;
 - o. The estimated gestational age, length, weight, and head circumference of the patient at birth;
 - p. The patient’s gender, race, and ethnicity;
 - q. The race and ethnicity of the patient’s biological mother and father;
 - r. The address of the patient’s mother at the time of the patient’s birth;
 - s. The address and telephone number of the patient at the date of last contact;
 - t. The county in which the patient was born;
 - u. The name of each physician, registered nurse practitioner, physician assistant, or other person that clinically evaluated, diagnosed, ordered a test for, or treated the patient or the patient’s mother;
 - v. The names of any facility from which or to which the patient or the patient’s mother was transferred or referred;
 - w. Whether the patient was referred to or is enrolled in CRS for or approved to receive services under 9 A.A.C. 22, Article 13, and, if so, the date of referral or enrollment approval;
 - x. Whether the patient is receiving any ~~other follow-up services~~, medical services, nursing services, or health-related services, or other services to support the patient or the patient’s parent related to a birth defect, other than services under 9 A.A.C. 22, Article 13, and, if so, the name of the person providing the services and the date the provision of the services began;
 - y. The name of the insurance company, if applicable, that:
 - i. Paid for the birth of the patient, and
 - ii. Is currently covering medical expenses for the patient or the patient’s mother;
 - z. Any perinatal risk factors documented in:
 - i. The patient’s medical record,
 - ii. The patient’s mother’s medical record, or
 - iii. The patient’s family medical history;
 - aa. Whether any tests were performed on the patient or the patient’s mother by a genetic testing facility and, if so:
 - i. The types of tests performed,
 - ii. The test dates,
 - iii. The test results,
 - iv. The age or estimated gestational age of the patient at the time of each test,
 - v. The estimated date of confinement of the patient’s mother at the time of each test,
 - vi. The name of the genetic testing facility that performed each test; and
 - vii. The names of the individuals who interpreted the test results;
 - bb. Whether any tests were performed on the patient or the patient’s mother by a prenatal diagnostic facility and, if so:
 - i. The types of tests performed,
 - ii. The test dates,
 - iii. The test results,



- iv. The estimated gestational age of the patient at the time of each test,
- v. The estimated date of confinement of the patient's mother at the time of each test,
- vi. The name of the prenatal diagnostic facility that performed each test, and
- vii. The names of the individuals who interpreted the test results;
- cc. Whether any other types of tests were performed on the patient or the patient's mother that may enable the diagnosis of a birth defect and, if so:
 - i. The types of tests performed,
 - ii. The test dates,
 - iii. The test results,
 - iv. The age or estimated gestational age of the patient at the time of each test,
 - v. The estimated date of confinement of the patient's mother at the time of each test,
 - vi. The names of the facilities that performed the tests, and
 - vii. The names of the individuals who interpreted the test results;
- dd. Whether any surgical procedures associated with a birth defect were performed on the patient or the patient's mother and, if so:
 - i. The types of surgical procedures performed,
 - ii. The dates of the surgical procedures,
 - iii. The results of the surgical procedures,
 - iv. The ages or estimated gestational ages of the patient at the time of the surgical procedures,
 - v. The estimated date of confinement of the patient's mother at the times of the surgical procedures, and
 - vi. The names of the facilities at which the surgical procedures were performed, and
 - vii. The names of the individuals who performed the surgical procedures;
- ee. For each diagnosis made for the patient or the patient's mother:
 - i. The diagnosis,
 - ii. Whether the diagnosis is a principal or secondary diagnosis,
 - iii. The facility at which the diagnosis was made,
 - iv. The date on which the diagnosis was made, and
 - v. The name of the individual who made the diagnosis;
- ff. The number of times the patient's mother has been pregnant;
- gg. The number of times a pregnancy of the patient's mother has lasted:
 - i. More than 37 weeks,
 - ii. Between 20 and 37 weeks, and
 - iii. Less than 20 weeks;
- hh. The number of children who were born as a result of the patient's mother's pregnancies, and whether the children were born alive or dead;
- ii. Whether the patient is from a singleton or multiple gestation, and, if from a multiple gestation, whether a co-twin of the patient:
 - i. Is identical or fraternal;
 - ii. Is alive, and, if not alive, the co-twin's date of death; and
 - iii. Has:
 - (1) The same birth defect as the patient,
 - (2) A different birth defect from that of the patient, or
 - (3) No birth defect;
- jj. If the patient is being adopted or living with a guardian rather than a parent;
- kk. If the patient is being adopted, the name, address, and telephone number of the individual who will adopt the patient;
- ll. The date of last contact; and
- mm. If the patient has died:
 - i. The patient's date and county of death,
 - ii. The facility in which the patient's death occurred, and
 - iii. Whether an autopsy was performed on the patient.

R9-4-504. Data Quality Assurance and Follow-up

- A. The Department may request a hospital, clinic, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility to revise a report:
 - 1. That was submitted to the Department by the designee of the hospital, clinic, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility under R9-4-502;
 - 2. That was not prepared according to R9-4-502; and
 - 3. By identifying the revisions that are needed in the report.
- B. If a person receives a request from the Department for revision of a report under subsection (A), the person shall return a revised report, containing the revisions requested by the Department, to the Department within 15 business days after the date of the Department's request, or by a date agreed to by the person and the Department.
- C. The Department may discuss the information submitted to the Department as specified in R9-4-502 or collected as specified in R9-4-503(B)(2) with:
 - 1. ~~any~~ Any of the entities specified in R9-4-503(A) to obtain additional information about a patient's diagnosis or treatment;
 - 2. The Arizona Early Intervention Program, according to A.R.S. § 36-133(E); and
 - 3. The parent or guardian of a patient, as allowed by A.R.S. § 36-133(E).



NOTICES OF EXPIRATION OF RULES UNDER A.R.S. § 41-1056(J)

This section of the Arizona Administrative Register contains Notices of Expiration of Rules. Under A.R.S. § 41-1056(J), if an agency does not file a five-year rule review report with the Governor's Regulatory Review Council (including a revised report); or if an agency does not file an extension before the due date of the report; or if an agency files an extension but does not submit a report

within the extension period; the rules scheduled for review expire.

The Council is required to notify the Secretary of State that the rules have expired and are no longer enforceable. The notice is published in the Register, and the rules are removed from the Code.

GOVERNOR'S REGULATORY REVIEW COUNCIL

NOTICE OF EXPIRATION OF RULES UNDER A.R.S. § 41-1056(J)

DEPARTMENT OF VETERANS' SERVICES ARIZONA STATE VETERAN HOME

[R19-251]

- 1. Agency name: Department of Veterans' Services
2. Title and its heading: 4, Professions and Occupations
3. Chapter and its heading: 40, Department of Veterans' Services - Arizona State Veteran Home
4. Article and its heading: 1, Definitions; 2, General Provisions; 3, Application and Admission Process; 5, Resident Support; 6, Resident Responsibilities and Conduct; 7, Involuntary Resident Discharge; 8, Resident Trust Fund; 9, Appeal Process

As required by A.R.S. § 41-1056(J), the Council provides notice that the rules listed below and all Articles in Title 4, Chapter 40 expired as of October 1, 2019:

- R4-40-101. Definitions
R4-40-201. General Provisions
R4-40-301. Application
R4-40-302. Application Process
R4-40-304. Admissions Process
R4-40-501. Billing
R4-40-601. General Provisions
R4-40-701. Resident Discharge
R4-40-801. General Provisions
R4-40-901. General Provisions
R4-40-902. Rehearing or Review of Decision

Signature is of Nicole Sornsin

/s/

Nicole Sornsin
Council Chair

Date of Signing

November 4, 2019



GOVERNOR EXECUTIVE ORDER

Executive Order 2019-01 is being reproduced in each issue of the *Administrative Register* as a notice to the public regarding state agencies' rulemaking activities.

This order has been reproduced in its entirety as submitted.

EXECUTIVE ORDER 2019-01**Moratorium on Rulemaking to Promote Job Creation and Customer-Service-Oriented Agencies; Protecting Consumers Against Fraudulent Activities**

[M19-04]

WHEREAS, government regulations should be as limited as possible; and

WHEREAS, burdensome regulations inhibit job growth and economic development; and

WHEREAS, protecting the public health, peace and safety of the residents of Arizona is a top priority of state government; and

WHEREAS, in 2015 the State of Arizona implemented a moratorium on all new regulatory rulemaking by State agencies through executive order and renewed the moratorium in 2016, 2017 and 2018; and

WHEREAS, the State of Arizona eliminated or repealed 422 needless regulations in 2018 and 676 in 2017 for a total of 1,098 needless regulations eliminated or repealed over two years; and

WHEREAS, estimates show these eliminations saved job creators more than \$31 million in operating costs in 2018 and \$48 million in 2017 for a total of over \$79 million in savings over two years; and

WHEREAS, approximately 283,300 private sector jobs have been added to Arizona since January 2015; and

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

WHEREAS, each State agency shall continue to conduct 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 while protecting the health, peace and safety of residents; and

WHEREAS, each State agency should continue to evaluate its administrative rules using any available and reliable data and performance metrics; and

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, 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 justifications 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 federal court 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 which are antiquated, redundant or otherwise no longer necessary for the operation of state government.
2. A State agency subject to this Order shall not publicize any directives, policy statements, documents or forms on its website unless such are explicitly authorized by Arizona Revised Statutes or Arizona Administrative Code.
3. A State agency subject to this Order and which issues occupational or professional licenses shall review the agency's rules and practices related to receiving and acting on substantive complaints about unlicensed individuals who are allegedly holding them-



selves out as licensed professionals for financial gain and are knowingly or recklessly providing or attempting to provide regulated services which the State agency director believes could cause immediate and/or significant harm to either the financial or physical health of unknowing consumers within the state. Agencies shall identify and execute on opportunities to improve its complaint intake process, documentation, tracking, enforcement actions and coordination with proper law enforcement channels to ensure those allegedly trying to defraud unsuspecting consumers and putting them at risk for immediate and/or significant harm to their financial or physical health are stopped and effectively diverted by the State agency to the proper law-enforcement agency for review. A written plan on the agency’s process shall be submitted to the Governor’s Office no later than May 31, 2019.

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 section 41-1001, Arizona Revised Statutes.

IN WITNESS THEREOF, 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 ninth day of January in the Year Two Thousand and Nineteen and of the Independence of the United States of America the Two Hundred and Forty-Third.

ATTEST:
Katie Hobbs
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

XN = Exempt new Section
 XM = Exempt amended Section
 XR = Exempt repealed Section
 X# = Exempt renumbered Section

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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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
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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
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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
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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.

Table with 3 columns: Deadline Date (paper only) Friday, 5:00 p.m., Register Publication Date, and Oral Proceeding may be scheduled on or after. Rows list dates from September 13, 2019 to April 3, 2020.



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 under A.R.S. § 41-1013(B)(15).

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 305, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit <http://grrc.az.gov>.

GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES FOR 2019

[M19-05]

DEADLINE FOR PLACEMENT ON AGENDA*	FINAL MATERIALS SUBMITTED TO COUNCIL	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
<i>Tuesday</i> January 22, 2019	<i>Tuesday</i> February 19, 2019	<i>Tuesday</i> February 26, 2019	<i>Tuesday</i> March 5, 2019
<i>Tuesday</i> February 19, 2019	<i>Tuesday</i> March 19, 2019	<i>Tuesday</i> March 26, 2019	<i>Tuesday</i> April 2, 2019
<i>Tuesday</i> March 19, 2019	<i>Tuesday</i> April 23, 2019	<i>Tuesday</i> April 30, 2019	<i>Tuesday</i> May 7, 2019
<i>Tuesday</i> April 23, 2019	<i>Tuesday</i> May 21, 2019	Wednesday May 29, 2019	<i>Tuesday</i> June 4, 2019
<i>Tuesday</i> May 21, 2019	<i>Tuesday</i> June 18, 2019	<i>Tuesday</i> June 25, 2019	<i>Tuesday</i> July 2, 2019
<i>Tuesday</i> June 18, 2019	<i>Tuesday</i> July 23, 2019	<i>Tuesday</i> July 30, 2019	<i>Tuesday</i> August 6, 2019
<i>Tuesday</i> July 23, 2019	<i>Tuesday</i> August 20, 2019	<i>Tuesday</i> August 27, 2019	Wednesday September 4, 2019
<i>Tuesday</i> August 20, 2019	<i>Tuesday</i> September 17, 2019	<i>Tuesday</i> September 24, 2019	<i>Tuesday</i> October 1, 2019
<i>Tuesday</i> September 17, 2019	<i>Tuesday</i> October 22, 2019	<i>Tuesday</i> October 29, 2019	<i>Tuesday</i> November 5, 2019
<i>Tuesday</i> October 22, 2019	<i>Tuesday</i> November 19, 2019	<i>Tuesday</i> November 26, 2019	<i>Tuesday</i> December 3, 2019
<i>Tuesday</i> November 19, 2019	<i>Tuesday</i> December 24, 2019	<i>Tuesday</i> January 7, 2020	<i>Tuesday</i> January 14, 2020
<i>Tuesday</i> December 24, 2019	<i>Tuesday</i> January 21, 2020	<i>Tuesday</i> January 28, 2020	<i>Tuesday</i> February 4, 2020

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



**GOVERNOR'S REGULATORY REVIEW COUNCIL
NOTICE OF ACTION TAKEN AT THE NOVEMBER 5, 2019 MEETING**

[M19-104]

1. CONSENT AGENDA ITEMS:

Rules:

1. DEPARTMENT OF PUBLIC SAFETY (R19-1007)

Title 13, Chapter 1, Article 4, Applicant Fingerprint Processing

Amend: R13-1-401, R13-1-402

2. DEPARTMENT OF HEALTH SERVICES (Expedited Rulemaking) (R19-1104)

Title 9, Chapter 10, Articles 1-11, 13-15, & 19, Health Care Institutions

Amend: R9-10-101, R9-10-104, R9-10-105, R9-10-110, R9-10-217, R9-10-228, R9-10-234, R9-10-322, R9-10-426, R9-10-518, R9-10-618, R9-10-720, R9-10-815, R9-10-818, R9-10-820, R9-10-918, R9-10-1018, R9-10-1019, R9-10-1025, R9-10-1029, R9-10-1117, R9-10-1315, R9-10-1317, R9-10-1416, R9-10-1514, R9-10-1910

New Section: R9-10-104.01

3. DEPARTMENT OF HEALTH SERVICES (Expedited Rulemaking) (R19-1102)

Title 9, Chapter 10, Article 12, Home Health Agencies

Amend: R9-10-1203, R9-10-1206

4. DEPARTMENT OF HEALTH SERVICES (R19-1105)

Title 9, Chapter 4, Articles 1-5, Noncommunicable Diseases

Amend: R9-4-101, R9-4-201, R9-4-202, R9-4-301, R9-4-302, R9-4-401, R9-4-402, R9-4-403, R9-4-404 R9-4-405, R9-4-501, R9-4-502, R9-4-503, R9-4-504

Five-Year Review Reports:

1. DEPARTMENT OF HEALTH SERVICES (F19-1103)

Title 9, Chapter 4, Articles 1-5, Noncommunicable Diseases

2. DEPARTMENT OF HEALTH SERVICES (F19-1104)

Title 9, Chapter 6, Article 4, AIDS Drug Assistance Program

3. WATER QUALITY APPEALS BOARD (F19-0905)

Title 2, Chapter 17, Article 1, Water Quality Appeals Board

4. DEPARTMENT OF CHILD SAFETY (F19-1005)

Title 21, Chapter 6, Articles 1-4, Department of Child Safety - Foster Home Licensing

COUNCIL ACTION: CONSENT AGENDA ITEMS APPROVED

2. CONSIDERATION AND DISCUSSION OF RULES:

1. DEPARTMENT OF ECONOMIC SECURITY (R19-1101)

Title 6, Chapter 7, Article 1, Child Support Enforcement

Amend: R6-7-103

COUNCIL ACTION: TABLED TO NOVEMBER 26, 2019 MEETING

2. CITIZENS CLEAN ELECTIONS COMMISSION (R19-1108)



Title 2, Chapter 20, Article 1, General Provisions and Article 7, Use of Funds and Repayment

Amend: R2-20-113, R2-20-702, R2-20-704

COUNCIL ACTION: R2-20-702 WAS RETURNED PURSUANT TO R1-6-206; R2-20-113 AND R2-20-704 WERE TABLED TO NOVEMBER 26, 2019 MEETING

3. CONSIDERATION AND DISCUSSION OF FIVE YEAR REVIEW REPORTS:

1. **DEPARTMENT OF HEALTH SERVICES (F19-1001)**

Title 9, Chapter 19, Department of Health Services - Vital Records and Statistics

COUNCIL ACTION: APPROVED

2. **DEPARTMENT OF ADMINISTRATION (F19-1107)**

Title 2, Chapter 15, Article 3, Materials Management

COUNCIL ACTION: APPROVED

3. **BOARD OF MASSAGE THERAPY (F19-1004)**

Title 4, Chapter 15, Articles 1-4, Board of Massage Therapy

COUNCIL ACTION: TABLED TO JANUARY 7, 2020 MEETING