

corporation holding a certificate of authority under Chapter 1751. of the Revised Code shall cancel or refuse to renew a policy, contract, certificate, or agreement or limit benefits provided under a policy, contract, certificate, or agreement solely because a policyholder, subscriber, or applicant for a policy, contract, certificate, or agreement has been exposed to diethylstilbestrol or other nonsteroidal synthetic estrogens.

Sec. 3705.30. (A) As used in this section:

(1) "Certified nurse-midwife," "clinical nurse specialist," and "certified nurse practitioner" have the same meanings as in section 4723.01 of the Revised Code.

(2) "Freestanding birthing center" has the same meaning as in section 3701.503 of the Revised Code.

~~(2)~~(3) "Hospital" has the same meaning as in section 3722.01 of the Revised Code.

~~(3)~~(4) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B) The director of health shall establish and, if funds for this purpose are available, implement a statewide birth defects information system for the collection of information concerning congenital anomalies, stillbirths, and abnormal conditions of newborns.

(C) If the system is implemented under division (B) of this section, all of the following apply:

(1) The director may require each physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, hospital, and freestanding birthing center to report to the system information concerning all patients under five years of age with a primary diagnosis of a congenital anomaly or abnormal condition. The director shall not require a hospital, freestanding birthing center, ~~or physician,~~ certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to report to the system any information that is reported to the director or department of health under another provision of the Revised Code or Administrative Code.

(2) On request, each physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, hospital, and freestanding birthing center shall give the director or authorized employees of the department of health access to the medical records of any patient described in division (C)(1) of this section. The department shall pay the costs of copying any medical records pursuant to this division.

(3) The director may review vital statistics records and shall consider expanding the list of congenital anomalies and abnormal conditions of newborns reported on birth certificates pursuant to section 3705.08 of the Revised Code.

(D) A physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, hospital, or freestanding birthing center that provides information to the system under division (C) of this section shall not be subject to criminal or civil liability for providing the information.

Sec. 3705.33. As used in this section, "local health department" means a health department

operated by the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code.

A child's parent or legal guardian who wants information concerning the child removed from the birth defects information system shall request from the local health department or the child's physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner a form prepared by the director of health. On request, a local health department-~~or, physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner~~ shall provide the form to the child's parent or legal guardian. The individual providing the form shall discuss with the child's parent or legal guardian the information contained in the system. If the child's parent or legal guardian signs the form, the department-~~or, physician, or nurse~~ shall forward it to the director. On receipt of the signed form, the director shall remove from the system any information that identifies the child.

Sec. 3705.35. Not later than one hundred eighty days after October 5, 2000, the director of health shall adopt rules in accordance with Chapter 119. of the Revised Code to do all of the following:

- (A) Implement the birth defects information system;
- (B) Specify the types of congenital anomalies and abnormal conditions of newborns to be reported to the system under section 3705.30 of the Revised Code;
- (C) Establish reporting requirements for information concerning diagnosed congenital anomalies and abnormal conditions of newborns;
- (D) Establish standards that must be met by persons or government entities that seek access to the system;
- (E) Establish a form for use by parents or legal guardians who seek to have information regarding their children removed from the system and a method of distributing the form to local health departments, as defined in section 3705.33 of the Revised Code, and to physicians, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners. The method of distribution must include making the form available on the internet.

Sec. 3707.08. When a person known to have been exposed to a communicable disease declared quarantinable by the board of health of a city or general health district or the department of health is reported within its jurisdiction, the board shall at once restrict such person to ~~his~~ the person's place of residence or other suitable place, prohibit entrance to or exit from such place without the board's written permission in such manner as to prevent effective contact with individuals not so exposed, and enforce such restrictive measures as are prescribed by the department.

When a person has, or is suspected of having, a communicable disease for which isolation is required by the board or the department, the board shall at once cause such person to be separated from susceptible persons in such places and under such circumstances as will prevent the conveyance of the infectious agents to susceptible persons, prohibit entrance to or exit from such

places without the board's written permission, and enforce such restrictive measures as are prescribed by the department.

When persons have, or are exposed to, a communicable disease for which placarding of premises is required by the board or the department, the board shall at once place in a conspicuous position on the premises where such a person is isolated or quarantined a placard having printed on it, in large letters, the name of the disease. No person shall remove, mar, deface, or destroy such placard, which shall remain in place until after the persons restricted have been released from isolation or quarantine.

Physicians, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners attending a person affected with a communicable disease shall use such precautionary measures to prevent its spread as are required by the board or the department.

No person isolated or quarantined by a board shall leave the premises to which ~~he the person~~ has been restricted without the written permission of such board until released from isolation or quarantine by it in ~~accordance~~ accordance with the rules and regulations of the department.

Sec. 3707.10. When a person affected with yellow fever, typhus fever, or diphtheria has recovered and is no longer liable to communicate the disease to others, or has died, the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner shall furnish a certificate of the recovery or death to the board of health of the city or general health district. As soon thereafter as the board considers it advisable, its health commissioner shall thoroughly disinfect and purify the house and contents of the house in which the affected person has been ill or has died, in accordance with the rules adopted by the department of health.

Sec. 3707.72. (A)(1) If a board of health establishes a fetal-infant mortality review board under section 3707.71 of the Revised Code, the board, by a majority vote of a quorum of its members, shall select the board's members. Members may include the following professionals or individuals representing the following constituencies:

- (a) Fetal-infant mortality review coordinators;
- (b) Physicians who are board-certified in obstetrics and gynecology by a certifying board recognized by the American board of medical specialties;
- (c) Key community leaders from the board of health's jurisdiction;
- (d) Health care providers;
- (e) Human services providers;
- (f) Consumer and advocacy groups;
- (g) Community action teams;
- (h) Certified nurse-midwives.

(2) A majority of the board members specified in division (A)(1) of this section may invite additional individuals to serve on the board. The additional members shall serve for a period of time determined by a majority of the board members specified in division (A)(1) of this section and shall have the same authority, duties, and responsibilities as members specified in that division.

(3) A board, by a majority vote of a quorum of its members, shall select an individual to serve as its chairperson.

(B) A vacancy on a board shall be filled in the same manner as the original appointment.

(C) A board member shall not receive any compensation for, and shall not be paid for any expenses incurred pursuant to, fulfilling the member's duties on the board.

(D) A board may work in conjunction with, or be a component of, a child fatality review board or regional child fatality review board created under section 307.621 of the Revised Code.

(E) A board shall convene at least once a year at the call of the board's chairperson.

Sec. 3709.11. Within thirty days after the appointment of the members of the board of health in a general health district, they shall organize by selecting one of the members as president and another member as president pro tempore. ~~The~~

The board shall appoint a health commissioner upon such terms, and for such period of time, not exceeding five years, as may be prescribed by the board. The person appointed as commissioner shall be one of the following: a licensed physician; a person who is licensed as a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner and who specializes in public health; a licensed dentist; a licensed veterinarian; a licensed podiatrist; a licensed chiropractor; or the holder of a master's degree in public health or an equivalent master's degree in a related health field as determined by the members of the board of health in a general health district. He Notice of such appointment shall be filed with the director of health.

The commissioner shall be secretary of the board, and shall devote such time to the duties of his office as may be fixed by contract with the board. ~~Notice of such appointment shall be filed with the director of health.~~ The commissioner shall be the executive officer of the board and shall carry out all orders of the board and of the department of health. ~~He~~ The commissioner shall be charged with the enforcement of all sanitary laws and regulations in the district. The commissioner shall keep the public informed in regard to all matters affecting the health of the district. ~~When~~

When the commissioner is not a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, the board shall provide for adequate medical direction of all personal health and nursing services by the employment of a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner as medical director on either a full-time or part-time basis. The medical director shall be responsible to the board of health.

Sec. 3709.13. In any general health district the board of health may, upon the recommendation of the health commissioner, appoint for full or part time service a public health nurse and a clerk and such additional public health nurses, physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, and other persons as are necessary for the proper conduct of its work. Such number of public health nurses may be employed as is necessary to provide adequate public health nursing service to all parts of the district. Employees of the board, other than the commissioner, shall be in the classified service of the state, and all employees of the board may be removed for cause by a majority of the board.

Sec. 3709.241. Notwithstanding any other provision of law, a minor may give consent for the diagnosis or treatment of any ~~venereal disease~~ sexually transmitted infection by a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner. Such consent is not subject to disaffirmance because of minority. The consent of the parent, parents, or guardian of a minor is not required for such diagnosis or treatment. The parent, parents, or guardian of a minor giving consent under this section are not liable for payment for any diagnostic or treatment service provided under this section without their consent.

Sec. 3710.07. (A) Prior to engaging in any asbestos hazard abatement project, an asbestos hazard abatement contractor shall do all of the following:

(1) Prepare a written respiratory protection program as defined by the director of environmental protection pursuant to rule, and make the program available to the environmental protection agency, and workers at the job site if the contractor is a public entity or prepare a written respiratory protection program, consistent with 29 C.F.R. 1910.134 and make the program available to the agency, and workers at the job site if the contractor is a business entity;

(2) Ensure that each worker who will be involved in any asbestos hazard abatement project has been examined within the preceding year and has been declared by a physician, clinical nurse specialist, or certified nurse practitioner to be physically capable of working while wearing a respirator;

(3) Ensure that each of the contractor's employees or agents who will come in contact with asbestos-containing materials or will be responsible for an asbestos hazard abatement project receives the appropriate certification or licensure required by this chapter and the following training:

(a) An initial course approved by the agency pursuant to section 3710.10 of the Revised Code, completed before engaging in any asbestos hazard abatement activity; and

(b) An annual review course approved by the agency pursuant to section 3710.10 of the Revised Code.

(B) After obtaining or renewing a license, an asbestos hazard abatement contractor shall notify the agency, on a form approved by the director, at least ten working days before beginning each asbestos hazard abatement project conducted during the term of the contractor's license.

(C) In addition to any other fee imposed under this chapter, an asbestos hazard abatement contractor shall pay, at the time of providing notice under division (B) of this section, the agency a fee of sixty-five dollars for each asbestos hazard abatement project conducted.

Sec. 3715.872. (A) As used in this section, "health care professional" means any of the following who provide medical, dental, or other health-related diagnosis, care, or treatment:

(1) Individuals authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(2) Registered nurses licensed under Chapter 4723. of the Revised Code, including advanced practice registered nurses, and licensed practical nurses licensed under ~~Chapter 4723. of the Revised Code~~ that chapter;

- (3) Physician assistants licensed under Chapter 4730. of the Revised Code;
- (4) Dentists and dental hygienists licensed under Chapter 4715. of the Revised Code;
- (5) Optometrists licensed under Chapter 4725. of the Revised Code;
- (6) Pharmacists licensed under Chapter 4729. of the Revised Code.

(B) For matters related to activities conducted under the drug repository program, all of the following apply:

(1) A pharmacy, drug manufacturer, health care facility, or other person or government entity that donates or gives drugs to the program, and any person or government entity that facilitates the donation or gift, shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property.

(2) A pharmacy, hospital, or nonprofit clinic that accepts or distributes drugs under the program shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property, unless an action or omission of the pharmacy, hospital, or nonprofit clinic constitutes willful and wanton misconduct.

(3) A health care professional who accepts, dispenses, or personally furnishes drugs under the program on behalf of a pharmacy, hospital, or nonprofit clinic participating in the program, and the pharmacy, hospital, or nonprofit clinic that employs or otherwise uses the services of the health care professional, shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property, unless an action or omission of the health care professional, pharmacy, hospital, or nonprofit clinic constitutes willful and wanton misconduct.

(4) The state board of pharmacy shall not be subject to liability in tort or other civil action for injury, death, or loss to person or property, unless an action or omission of the board constitutes willful and wanton misconduct.

(5) In addition to the civil immunity granted under division (B)(1) of this section, a pharmacy, drug manufacturer, health care facility, or other person or government entity that donates or gives drugs to the program, and any person or government entity that facilitates the donation or gift, shall not be subject to criminal prosecution for matters related to activities that it conducts or another party conducts under the program, unless an action or omission of the party that donates, gives, or facilitates the donation or gift of the drugs does not comply with the provisions of this chapter or the rules adopted under it.

(6) In the case of a drug manufacturer, the immunities from civil liability and criminal prosecution granted to another party under divisions (B)(1) and (5) of this section extend to the manufacturer when any drug it manufactures is the subject of an activity conducted under the program. This extension of immunities includes, but is not limited to, immunity from liability or prosecution for failure to transfer or communicate product or consumer information or the expiration date of a drug that is donated or given.

Sec. 3721.01. (A) As used in sections 3721.01 to 3721.09 and 3721.99 of the Revised Code:

(1)(a) "Home" means an institution, residence, or facility that provides, for a period of more

than twenty-four hours, whether for a consideration or not, accommodations to three or more unrelated individuals who are dependent upon the services of others, including a nursing home, residential care facility, home for the aging, and a veterans' home operated under Chapter 5907. of the Revised Code.

(b) "Home" also means both of the following:

(i) Any facility that a person, as defined in section 3702.51 of the Revised Code, proposes for certification as a skilled nursing facility or nursing facility under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and for which a certificate of need, other than a certificate to recategorize hospital beds as described in section 3702.521 of the Revised Code or division (R)(7)(d) of the version of section 3702.51 of the Revised Code in effect immediately prior to April 20, 1995, has been granted to the person under sections 3702.51 to 3702.62 of the Revised Code after August 5, 1989;

(ii) A county home or district home that is or has been licensed as a residential care facility.

(c) "Home" does not mean any of the following:

(i) Except as provided in division (A)(1)(b) of this section, a public hospital or hospital as defined in section 3701.01 or 5122.01 of the Revised Code;

(ii) A residential facility as defined in section 5119.34 of the Revised Code;

(iii) A residential facility as defined in section 5123.19 of the Revised Code;

(iv) A community addiction services provider as defined in section 5119.01 of the Revised Code;

(v) A facility licensed under section 5119.37 of the Revised Code to operate an opioid treatment program;

(vi) A facility providing services under contract with the department of developmental disabilities under section 5123.18 of the Revised Code;

(vii) A facility operated by a hospice care program licensed under section 3712.04 of the Revised Code that is used exclusively for care of hospice patients;

(viii) A facility operated by a pediatric respite care program licensed under section 3712.041 of the Revised Code that is used exclusively for the care of pediatric respite care patients or a location operated by a pediatric transition care program registered under section 3712.042 of the Revised Code that is used exclusively for the care of pediatric transition care patients;

(ix) A facility, infirmary, or other entity that is operated by a religious order, provides care exclusively to members of religious orders who take vows of celibacy and live by virtue of their vows within the orders as if related, and does not participate in the medicare program or the medicaid program if on January 1, 1994, the facility, infirmary, or entity was providing care exclusively to members of the religious order;

(x) A county home or district home that has never been licensed as a residential care facility.

(2) "Unrelated individual" means one who is not related to the owner or operator of a home or to the spouse of the owner or operator as a parent, grandparent, child, grandchild, brother, sister,

niece, nephew, aunt, uncle, or as the child of an aunt or uncle.

(3) "Mental impairment" does not mean mental illness, as defined in section 5122.01 of the Revised Code, or developmental disability, as defined in section 5123.01 of the Revised Code.

(4) "Skilled nursing care" means procedures that require technical skills and knowledge beyond those the untrained person possesses and that are commonly employed in providing for the physical, mental, and emotional needs of the ill or otherwise incapacitated. "Skilled nursing care" includes, but is not limited to, the following:

- (a) Irrigations, catheterizations, application of dressings, and supervision of special diets;
- (b) Objective observation of changes in the patient's condition as a means of analyzing and determining the nursing care required and the need for further medical diagnosis and treatment;
- (c) Special procedures contributing to rehabilitation;
- (d) Administration of medication by any method ordered by a physician, such as hypodermically, rectally, or orally, including observation of the patient after receipt of the medication;

(e) Carrying out other treatments prescribed by the physician that involve a similar level of complexity and skill in administration.

(5)(a) "Personal care services" means services including, but not limited to, the following:

- (i) Assisting residents with activities of daily living;
- (ii) Assisting residents with self-administration of medication, in accordance with rules adopted under section 3721.04 of the Revised Code;
- (iii) Preparing special diets, other than complex therapeutic diets, for residents pursuant to the instructions of a physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, certified nurse practitioner, or a licensed dietitian, in accordance with rules adopted under section 3721.04 of the Revised Code.

(b) "Personal care services" does not include "skilled nursing care" as defined in division (A)(4) of this section. A facility need not provide more than one of the services listed in division (A)(5)(a) of this section to be considered to be providing personal care services.

(6) "Nursing home" means a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care. A nursing home is licensed to provide personal care services and skilled nursing care.

(7) "Residential care facility" means a home that provides either of the following:

(a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment;

(b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or physical or mental impairment, and, to at least one of those individuals, any of the skilled

nursing care authorized by section 3721.011 of the Revised Code.

(8) "Home for the aging" means a home that provides services as a residential care facility and a nursing home, except that the home provides its services only to individuals who are dependent on the services of others by reason of both age and physical or mental impairment.

The part or unit of a home for the aging that provides services only as a residential care facility is licensed as a residential care facility. The part or unit that may provide skilled nursing care beyond the extent authorized by section 3721.011 of the Revised Code is licensed as a nursing home.

(9) "County home" and "district home" mean a county home or district home operated under Chapter 5155. of the Revised Code.

(10) "Change of operator" includes circumstances in which an entering operator becomes the operator of a nursing home in the place of the exiting operator.

(a) Actions that constitute a change of operator include the following:

(i) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;

(ii) A change in operational control of the nursing home, regardless of whether ownership of any or all of the real property or personal property associated with the nursing home is also transferred;

(iii) A lease of the nursing home to the entering operator or termination of the exiting operator's lease;

(iv) If the exiting operator is a partnership, dissolution of the partnership, a merger of the partnership into another person that is the survivor of the merger, or a consolidation of the partnership and at least one other person to form a new person;

(v) If the exiting operator is a limited liability company, dissolution of the limited liability company, a merger of the limited liability company into another person that is the survivor of the merger, or a consolidation of the limited liability company and at least one other person to form a new person;

(vi) If the exiting operator is a corporation, dissolution of the corporation, a merger of the corporation into another person that is the survivor of the merger, or a consolidation of the corporation and at least one other person to form a new person;

(vii) A contract for a person to assume operational control of a nursing home;

(viii) A change of fifty per cent or more in the ownership of the licensed operator that results in a change of operational control;

(ix) Any pledge, assignment, or hypothecation of or lien or other encumbrance on any of the legal or beneficial equity interests in the operator or a person with operational control.

(b) The following do not constitute a change of operator:

(i) Actions necessary to create an employee stock ownership plan under section 401(a) of the "Internal Revenue Code," 26 U.S.C. 401(a);

(ii) A change of ownership of real property or personal property associated with a nursing home;

(iii) If the operator is a corporation that has securities publicly traded in a marketplace, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator;

(iv) An initial public offering for which the securities and exchange commission has declared the registration statement effective, and the newly created public company remains the operator.

(11) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the entering operator.

(a) An individual who is a relative of an entering operator is a related party.

(b) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the entering operator and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the entering operator and another organization from which the entering operator purchases or leases real property.

(c) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(d) An individual or organization that supplies goods or services to an entering operator shall not be considered a related party if all of the following conditions are met:

(i) The supplier is a separate bona fide organization.

(ii) A substantial part of the supplier's business activity of the type carried on with the entering operator is transacted with others than the entering operator and there is an open, competitive market for the types of goods or services the supplier furnishes.

(iii) The types of goods or services are commonly obtained by other nursing homes from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by nursing homes.

(iv) The charge to the entering operator is in line with the charge for the goods or services in the open market and not more than the charge made under comparable circumstances to others by the supplier.

(12) "SFF list" means the list of nursing facilities created by the United States department of health and human services under the special focus facility program.

(13) "Special focus facility program" means the program conducted by the United States secretary of health and human services pursuant to section 1919(f)(10) of the "Social Security Act." 42 U.S.C. 1396r(f)(10).

(14) "Real and present danger" means immediate danger of serious physical or life-

threatening harm to one or more occupants of a home.

(15) "Operator" means a person or government entity responsible for the operational control of a nursing home and that holds both of the following:

(a) A license to operate the nursing home issued under section 3721.02 of the Revised Code, if such a license is required by section 3721.05 of the Revised Code;

(b) A medicaid provider agreement issued under section 5165.07 of the Revised Code, if applicable.

(16) "Entering operator" means the person or government entity that will become the operator of a nursing home when a change of operator occurs or following a license revocation.

(17) "Relative of entering operator" means an individual who is related to an entering operator of a nursing home by one of the following relationships:

(a) Spouse;

(b) Natural parent, child, or sibling;

(c) Adopted parent, child, or sibling;

(d) Stepparent, stepchild, stepbrother, or stepsister;

(e) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(f) Grandparent or grandchild;

(g) Foster caregiver, foster child, foster brother, or foster sister.

(18) "Exiting operator" means any of the following:

(a) An operator that will cease to be the operator of a nursing home on the effective date of a change of operator;

(b) An operator that will cease to be the operator of a nursing home on the effective date of a facility closure;

(c) An operator of a nursing home that is undergoing or has undergone a surrender of license;

(d) An operator of a nursing home that is undergoing or has undergone a license revocation.

(19) "Operational control" means having the ability to direct the overall operations and cash flow of a nursing home. "Operational control" may be exercised by one person or by multiple persons acting together or by a government entity, and may exist by means of any of the following:

(a) The person, persons, or government entity directly operating the nursing home;

(b) The person, persons, or government entity directly or indirectly owning fifty per cent or more of the operator of the nursing home;

(c) An agreement or other arrangement granting the person, persons, or government entity operational control of the nursing home.

(20) "Property owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in any of the following regarding a nursing home:

- (a) The land on which the nursing home is located;
- (b) The structure in which the nursing home is located;
- (c) Any mortgage, contract for deed, or other obligation secured in whole or in part by the land or structure on or in which the nursing home is located;
- (d) Any lease or sublease of the land or structure on or in which the nursing home is located.

"Property owner" does not include a holder of a debenture or bond related to the nursing home and purchased at public issue or a regulated lender that has made a loan related to the nursing home, unless the holder or lender operates the nursing home directly or through a subsidiary.

(21) "Person" has the same meaning as in section 1.59 of the Revised Code.

(B) The director of health may further classify homes. For the purposes of this chapter, any residence, institution, hotel, congregate housing project, or similar facility that meets the definition of a home under this section is such a home regardless of how the facility holds itself out to the public.

(C) For purposes of this chapter, personal care services or skilled nursing care shall be considered to be provided by a facility if they are provided by a person employed by or associated with the facility or by another person pursuant to an agreement to which neither the resident who receives the services nor the resident's sponsor is a party.

(D) Nothing in division (A)(4) of this section shall be construed to permit skilled nursing care to be imposed on an individual who does not require skilled nursing care.

Nothing in division (A)(5) of this section shall be construed to permit personal care services to be imposed on an individual who is capable of performing the activity in question without assistance.

(E) Division (A)(1)(c)(ix) of this section does not prohibit a facility, infirmary, or other entity described in that division from seeking licensure under sections 3721.01 to 3721.09 of the Revised Code or certification under Title XVIII or XIX of the "Social Security Act." However, such a facility, infirmary, or entity that applies for licensure or certification must meet the requirements of those sections or titles and the rules adopted under them and obtain a certificate of need from the director of health under section 3702.52 of the Revised Code.

(F) Nothing in this chapter, or rules adopted pursuant to it, shall be construed as authorizing the supervision, regulation, or control of the spiritual care or treatment of residents or patients in any home who rely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination.

Sec. 3721.011. (A) In addition to providing accommodations, supervision, and personal care services to its residents, a residential care facility may do the following:

(1) Provide the following skilled nursing care to its residents:

(a) Supervision of special diets;

(b) Application of dressings, in accordance with rules adopted under section 3721.04 of the Revised Code:

(c) Subject to division (B)(1) of this section, administration of medication.

(2) Subject to division (C) of this section, provide other skilled nursing care on a part-time, intermittent basis for not more than a total of one hundred twenty days in a twelve-month period;

(3) Provide skilled nursing care for more than one hundred twenty days in a twelve-month period to a resident when the requirements of division (D) of this section are met.

A residential care facility may not admit or retain an individual requiring skilled nursing care that is not authorized by this section. A residential care facility may not provide skilled nursing care beyond the limits established by this section.

(B)(1) A residential care facility may admit or retain an individual requiring medication, including biologicals, only if the individual's personal physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner has determined in writing that the individual is capable of self-administering the medication or the facility provides for the medication to be administered to the individual by a home health agency certified under Title XVIII of the "Social Security Act," 79 Stat. 620 (1965), 42 U.S.C. 1395, as amended; a hospice care program licensed under Chapter 3712. of the Revised Code; or a member of the staff of the residential care facility who is qualified to perform medication administration. Medication may be administered in a residential care facility only by the following persons authorized by law to administer medication:

(a) A registered nurse licensed under Chapter 4723. of the Revised Code, including a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner;

(b) A licensed practical nurse licensed under Chapter 4723. of the Revised Code who holds proof of successful completion of a course in medication administration approved by the board of nursing and who administers the medication only at the direction of a registered nurse or a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery;

(c) A medication aide certified under Chapter 4723. of the Revised Code;

(d) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(2) In assisting a resident with self-administration of medication, any member of the staff of a residential care facility may do the following:

(a) Remind a resident when to take medication and watch to ensure that the resident follows the directions on the container;

(b) Assist a resident by taking the medication from the locked area where it is stored, in accordance with rules adopted pursuant to section 3721.04 of the Revised Code, and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident.

(c) Assist a resident who is physically impaired but mentally alert, such as a resident with arthritis, cerebral palsy, or Parkinson's disease, in removing oral or topical medication from

containers and in consuming or applying the medication, upon request by or with the consent of the resident. If a resident is physically unable to place a dose of medicine to the resident's mouth without spilling it, a staff member may place the dose in a container and place the container to the mouth of the resident.

(C) Except as provided in division (D) of this section, a residential care facility may admit or retain individuals who require skilled nursing care beyond the supervision of special diets, application of dressings, or administration of medication, only if the care will be provided on a part-time, intermittent basis for not more than a total of one hundred twenty days in any twelve-month period. In accordance with Chapter 119. of the Revised Code, the director of health shall adopt rules specifying what constitutes the need for skilled nursing care on a part-time, intermittent basis. The director shall adopt rules that are consistent with rules pertaining to home health care adopted by the medicaid director for the medicaid program. Skilled nursing care provided pursuant to this division may be provided by a home health agency certified for participation in the medicare program, a hospice care program licensed under Chapter 3712. of the Revised Code, or a member of the staff of a residential care facility who is qualified to perform skilled nursing care.

A residential care facility that provides skilled nursing care pursuant to this division shall do both of the following:

(1) Evaluate each resident receiving the skilled nursing care at least once every seven days to determine whether the resident should be transferred to a nursing home;

(2) Meet the skilled nursing care needs of each resident receiving the care.

(D)(1) A residential care facility may admit or retain an individual who requires skilled nursing care for more than one hundred twenty days in any twelve-month period only if the facility has entered into a written agreement with each of the following:

(a) The individual or individual's sponsor;

(b) The individual's personal physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner;

(c) Unless the individual's personal physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner oversees the skilled nursing care, the provider of the skilled nursing care;

(d) If the individual is a hospice patient as defined in section 3712.01 of the Revised Code, a hospice care program licensed under Chapter 3712. of the Revised Code.

(2) The agreement required by division (D)(1) of this section shall include all of the following provisions:

(a) That the individual will be provided skilled nursing care in the facility only if a determination has been made that the individual's needs can be met at the facility;

(b) That the individual will be retained in the facility only if periodic redeterminations are made that the individual's needs are being met at the facility;

(c) That the redeterminations will be made according to a schedule specified in the

agreement;

(d) If the individual is a hospice patient, that the individual has been given an opportunity to choose the hospice care program that best meets the individual's needs;

(e) Unless the individual is a hospice patient, that the individual's personal physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined that the skilled nursing care the individual needs is routine.

(E) Notwithstanding any other provision of this chapter, a residential care facility in which residents receive skilled nursing care pursuant to this section is not a nursing home.

Sec. 3721.041. (A) As used in this section:

(1) "Advisory committee" means the advisory committee on immunization practices of the United States centers for disease control and prevention or a successor committee or agency.

(2) ~~"Home" has the same meaning as in section 3721.01~~ "Certified nurse-midwife," "clinical nurse specialist," and "certified nurse practitioner" have the same meanings as in section 4723.01 of the Revised Code.

(3) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B)(1) Each home shall, on an annual basis, offer to each resident, in accordance with guidelines issued by the advisory committee, vaccination against influenza, unless a physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner has determined that vaccination of the resident is medically inappropriate. The vaccine shall be of a form approved by the advisory committee for that calendar year. A resident may refuse vaccination.

(2) Each home shall obtain the influenza vaccine information sheet described in section 3701.138 of the Revised Code and post the sheet in a conspicuous location that is accessible to all residents, employees, and visitors. Not later than the first day of August each year, the home shall determine whether the information sheet it has posted is the most recent version available. If it is not, the home shall replace the information sheet with the updated version. Nothing in this division requires an older adult to be vaccinated against influenza.

Failure to comply with the requirement to post the information sheet shall not be taken into account when any survey or inspection of the home is conducted and shall not be used as the basis for imposing any penalty against the home.

(C) Each home shall offer to each resident, in accordance with guidelines issued by the advisory committee, vaccination against pneumococcal pneumonia, unless the resident has already received such vaccination or a physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner has determined that vaccination of the resident is medically inappropriate. Each vaccine shall be of a form approved by the advisory committee for that calendar year. A resident may refuse vaccination.

(D) The director of health may adopt rules under Chapter 119. of the Revised Code as the

director considers appropriate to implement this section.

Sec. 3721.21. As used in sections 3721.21 to 3721.34 of the Revised Code:

(A) "Long-term care facility" means either of the following:

- (1) A nursing home as defined in section 3721.01 of the Revised Code;
- (2) A facility or part of a facility that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act."

(B) "Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.

(C) "Abuse" means any of the following:

- (1) Physical abuse;
- (2) Psychological abuse;
- (3) Sexual abuse.

(D) "Neglect" means recklessly failing to provide a resident with any treatment, care, goods, or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident. "Neglect" does not include allowing a resident, at the resident's option, to receive only treatment by spiritual means through prayer in accordance with the tenets of a recognized religious denomination.

(E) "Exploitation" means taking advantage of a resident, regardless of whether the action was for personal gain, whether the resident knew of the action, or whether the resident was harmed.

(F) "Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of a resident by any means prohibited by the Revised Code, including violations of Chapter 2911. or 2913. of the Revised Code.

(G) "Resident" includes a resident, patient, former resident or patient, or deceased resident or patient of a long-term care facility or a residential care facility.

(H) "Physical abuse" means knowingly causing physical harm or recklessly causing serious physical harm to a resident through either of the following:

- (1) Physical contact with the resident;
- (2) The use of physical restraint, chemical restraint, medication that does not constitute a chemical restraint, or isolation, if the restraint, medication, or isolation is excessive, for punishment, for staff convenience, a substitute for treatment, or in an amount that precludes habilitation and treatment.

(I) "Psychological abuse" means knowingly or recklessly causing psychological harm to a resident, whether verbally or by action.

(J) "Sexual abuse" means sexual conduct or sexual contact with a resident, as those terms are defined in section 2907.01 of the Revised Code.

(K) "Physical restraint" has the same meaning as in section 3721.10 of the Revised Code.

(L) "Chemical restraint" has the same meaning as in section 3721.10 of the Revised Code.

(M) "Nursing and nursing-related services" means the personal care services and other

services not constituting skilled nursing care that are specified in rules the director of health shall adopt in accordance with Chapter 119. of the Revised Code.

(N) "Personal care services" has the same meaning as in section 3721.01 of the Revised Code.

(O)(1) Except as provided in division (O)(2) of this section, "nurse aide" means an individual who provides nursing and nursing-related services to residents in a long-term care facility, either as a member of the staff of the facility for monetary compensation or as a volunteer without monetary compensation.

(2) "Nurse aide" does not include either of the following:

(a) A licensed health professional practicing within the scope of the professional's license;

(b) An individual providing nursing and nursing-related services in a religious nonmedical health care institution, if the individual has been trained in the principles of nonmedical care and is recognized by the institution as being competent in the administration of care within the religious tenets practiced by the residents of the institution.

(P) "Licensed health professional" means all of the following:

(1) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;

(2) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;

(3) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(4) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;

(5) A registered nurse licensed under Chapter 4723. of the Revised Code, including an advanced practice registered nurse, or a licensed practical nurse licensed under Chapter 4723. of the Revised Code that chapter;

(6) A social worker or independent social worker licensed under Chapter 4757. of the Revised Code or a social work assistant registered under that chapter;

(7) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;

(8) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;

(9) An optometrist licensed under Chapter 4725. of the Revised Code;

(10) A pharmacist licensed under Chapter 4729. of the Revised Code;

(11) A psychologist licensed under Chapter 4732. of the Revised Code;

(12) A chiropractor licensed under Chapter 4734. of the Revised Code;

(13) A nursing home administrator licensed or temporarily licensed under Chapter 4751. of the Revised Code;

(14) A licensed professional counselor or licensed professional clinical counselor licensed

under Chapter 4757. of the Revised Code;

(15) A marriage and family therapist or independent marriage and family therapist licensed under Chapter 4757. of the Revised Code.

(Q) "Religious nonmedical health care institution" means an institution that meets or exceeds the conditions to receive payment under the medicare program established under Title XVIII of the "Social Security Act" for inpatient hospital services or post-hospital extended care services furnished to an individual in a religious nonmedical health care institution. as defined in section 1861(ss)(1) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395x(ss)(1), as amended.

(R) "Competency evaluation program" means a program through which the competency of a nurse aide to provide nursing and nursing-related services is evaluated.

(S) "Training and competency evaluation program" means a program of nurse aide training and evaluation of competency to provide nursing and nursing-related services.

Sec. 3727.09. (A) As used in this section and sections 3727.10 and 3727.101 of the Revised Code:

(1) "Trauma," "trauma care," "trauma center," "trauma patient," "pediatric," and "adult" have the same meanings as in section 4765.01 of the Revised Code.

(2) "Stabilize" and "transfer" have the same meanings as in section 1753.28 of the Revised Code.

(B) On and after November 3, 2002, each hospital in this state that is not a trauma center shall adopt protocols for adult and pediatric trauma care provided in or by that hospital; each hospital in this state that is an adult trauma center and not a level I or level II pediatric trauma center shall adopt protocols for pediatric trauma care provided in or by that hospital; each hospital in this state that is a pediatric trauma center and not a level I and II adult trauma center shall adopt protocols for adult trauma care provided in or by that hospital. In developing its trauma care protocols, each hospital shall consider the guidelines for trauma care established by the American college of surgeons, the American college of emergency physicians, American academy of emergency nurse practitioners, and the American academy of pediatrics. Trauma care protocols shall be written, comply with applicable federal and state laws, and include policies and procedures with respect to all of the following:

(1) Evaluation of trauma patients, including criteria for prompt identification of trauma patients who require a level of adult or pediatric trauma care that exceeds the hospital's capabilities;

(2) Emergency treatment and stabilization of trauma patients prior to transfer to an appropriate adult or pediatric trauma center;

(3) Timely transfer of trauma patients to appropriate adult or pediatric trauma centers based on a patient's medical needs. Trauma patient transfer protocols shall specify all of the following:

(a) Confirmation of the ability of the receiving trauma center to provide prompt adult or pediatric trauma care appropriate to a patient's medical needs;

(b) Procedures for selecting an appropriate alternative adult or pediatric trauma center to

receive a patient when it is not feasible or safe to transport the patient to a particular trauma center;

(c) Advance notification and appropriate medical consultation with the trauma center to which a trauma patient is being, or will be, transferred;

(d) Procedures for selecting an appropriate method of transportation and the hospital responsible for arranging or providing the transportation;

(e) Confirmation of the ability of the persons and vehicle that will transport a trauma patient to provide appropriate adult or pediatric trauma care;

(f) Assured communication with, and appropriate medical direction of, the persons transporting a trauma patient to a trauma center;

(g) Identification and timely transfer of appropriate medical records of the trauma patient being transferred;

(h) The hospital responsible for care of a patient in transit;

(i) The responsibilities of the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner attending a patient and, if different, the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who authorizes a transfer of the patient;

(j) Procedures for determining, in consultation with an appropriate adult or pediatric trauma center and the persons who will transport a trauma patient, when transportation of the patient to a trauma center may be delayed for either of the following reasons:

(i) Immediate transfer of the patient is unsafe due to adverse weather or ground conditions.

(ii) No trauma center is able to provide appropriate adult or pediatric trauma care to the patient without undue delay.

(4) Peer review and quality assurance procedures for adult and pediatric trauma care provided in or by the hospital.

(C)(1) On and after November 3, 2002, each hospital shall enter into all of the following written agreements unless otherwise provided in division (C)(2) of this section:

(a) An agreement with one or more adult trauma centers in each level of categorization as a trauma center higher than the hospital that governs the transfer of adult trauma patients from the hospital to those trauma centers;

(b) An agreement with one or more pediatric trauma centers in each level of categorization as a trauma center higher than the hospital that governs the transfer of pediatric trauma patients from the hospital to those trauma centers.

(2) A level I or level II adult trauma center is not required to enter into an adult trauma patient transfer agreement with another hospital. A level I or level II pediatric trauma center is not required to enter into a pediatric trauma patient transfer agreement with another hospital. A hospital is not required to enter into an adult trauma patient transfer agreement with a level III or level IV adult trauma center, or enter into a pediatric trauma patient transfer agreement with a level III or level IV pediatric trauma center, if no trauma center of that type is reasonably available to receive

trauma patients transferred from the hospital.

(3) A trauma patient transfer agreement entered into by a hospital under division (C)(1) of this section shall comply with applicable federal and state laws and contain provisions conforming to the requirements for trauma care protocols set forth in division (B) of this section.

(D) A hospital shall make trauma care protocols it adopts under division (B) of this section and trauma patient transfer agreements it adopts under division (C) of this section available for public inspection during normal working hours. A hospital shall furnish a copy of such documents upon request and may charge a reasonable and necessary fee for doing so, provided that upon request it shall furnish a copy of such documents to the director of health free of charge.

(E) A hospital that ceases to operate as an adult or pediatric trauma center under provisional status is not in violation of divisions (B) and (C) of this section during the time it develops different trauma care protocols and enters into different patient transfer agreements pursuant to division (D)(2)(c) of section 3727.101 of the Revised Code.

Sec. 3727.19. (A) As used in this section:

(1) "Advisory committee" means the advisory committee on immunization practices of the United States centers for disease control and prevention or its successor agency.

(2) "Certified nurse-midwife," "clinical nurse specialist," and "certified nurse practitioner" have the same meanings as in section 4723.01 of the Revised Code.

(3) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B) Each hospital shall offer to each patient who is admitted to the hospital, in accordance with guidelines issued by the advisory committee, vaccination against influenza, unless a physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner has determined that vaccination of the patient is medically inappropriate. The vaccine shall be of a form approved by the advisory committee for that calendar year. A patient may refuse vaccination.

(C) Each hospital shall offer to each patient who is admitted to the hospital, in accordance with guidelines issued by the advisory committee, vaccination against pneumococcal pneumonia, unless a physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner has determined that vaccination of the patient is medically inappropriate. Each vaccine shall be of a form approved by the advisory committee for that calendar year. A patient may refuse vaccination.

(D) The director of health may adopt rules under Chapter 119. of the Revised Code as the director considers appropriate to implement this section.

Sec. 3742.03. The director of health shall adopt rules in accordance with Chapter 119. of the Revised Code for the administration and enforcement of sections 3742.01 to 3742.19 and 3742.99 of the Revised Code. The rules shall specify all of the following:

(A) Procedures to be followed by a lead abatement contractor, lead abatement project

designer, lead abatement worker, lead inspector, or lead risk assessor licensed under section 3742.05 of the Revised Code for undertaking lead abatement activities and procedures to be followed by a clearance technician, lead inspector, or lead risk assessor in performing a clearance examination;

(B)(1) Requirements for training and licensure, in addition to those established under section 3742.08 of the Revised Code, to include levels of training and periodic refresher training for each class of worker, and to be used for licensure under section 3742.05 of the Revised Code. Except in the case of clearance technicians, these requirements shall include at least twenty-four classroom hours of training based on the Occupational Safety and Health Act training program for lead set forth in 29 C.F.R. 1926.62. For clearance technicians, the training requirements to obtain an initial license shall not exceed six hours and the requirements for refresher training shall not exceed two hours every four years. In establishing the training and licensure requirements, the director shall consider the core of information that is needed by all licensed persons, and establish the training requirements so that persons who would seek licenses in more than one area would not have to take duplicative course work.

(2) Persons certified by the American board of industrial hygiene as a certified industrial hygienist or as an industrial hygienist-in-training, and persons registered as a-an environmental health specialist or environmental health specialist in training under Chapter 3776. of the Revised Code, shall be exempt from any training requirements for initial licensure established under this chapter, but shall be required to take any examinations for licensure required under section 3742.05 of the Revised Code.

(C) Fees for licenses issued under section 3742.05 of the Revised Code and for their renewal;

(D) Procedures to be followed by lead inspectors, lead abatement contractors, environmental lead analytical laboratories, lead risk assessors, lead abatement project designers, and lead abatement workers to prevent public exposure to lead hazards and ensure worker protection during lead abatement projects;

(E)(1) Record-keeping and reporting requirements for clinical laboratories, environmental lead analytical laboratories, lead inspectors, lead abatement contractors, lead risk assessors, lead abatement project designers, and lead abatement workers for lead abatement projects and record-keeping and reporting requirements for clinical laboratories, environmental lead analytical laboratories, and clearance technicians for clearance examinations;

(2) Record-keeping and reporting requirements regarding lead poisoning for-to be followed by physicians, certified nurse-midwives if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialists, and certified nurse practitioners;

(3) Information that is required to be reported under rules based on divisions (E)(1) and (2) of this section and that is a medical record is not a public record under section 149.43 of the Revised Code and shall not be released, except in aggregate statistical form.

(F) Environmental sampling techniques for use in collecting samples of air, water, dust,

paint, and other materials;

(G) Requirements for a respiratory protection plan prepared in accordance with section 3742.07 of the Revised Code;

(H) Requirements under which a manufacturer of encapsulants must demonstrate evidence of the safety and durability of its encapsulants by providing results of testing from an independent laboratory indicating that the encapsulants meet the standards developed by the "E06.23.30 task group on encapsulants," which is the task group of the lead hazards associated with buildings subcommittee of the performance of buildings committee of the American society for testing and materials.

Sec. 3742.04. (A) The director of health shall do all of the following:

(1) Administer and enforce the requirements of sections 3742.01 to 3742.19 and 3742.99 of the Revised Code and the rules adopted pursuant to those sections;

(2) Examine records and reports submitted by lead inspectors, lead abatement contractors, lead risk assessors, lead abatement project designers, lead abatement workers, and clearance technicians in accordance with section 3742.05 of the Revised Code to determine whether the requirements of this chapter are being met;

(3) Examine records and reports submitted by physicians, certified nurse-midwives if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialists, and certified nurse practitioners pursuant to rules adopted under section 3742.03 of the Revised Code and by clinical laboratories and environmental lead analytical laboratories under section 3742.09 of the Revised Code;

(4) Issue approval to manufacturers of encapsulants that have done all of the following:

(a) Submitted an application for approval to the director on a form prescribed by the director;

(b) Paid the application fee established by the director;

(c) Submitted results from an independent laboratory indicating that the manufacturer's encapsulants satisfy the requirements established in rules adopted under division (H) of section 3742.03 of the Revised Code;

(d) Complied with rules adopted by the director regarding durability and safety to workers and residents.

(5) Establish liaisons and cooperate with the directors or agencies in states having lead abatement, licensing, accreditation, certification, and approval programs to promote consistency between the requirements of this chapter and those of other states in order to facilitate reciprocity of the programs among states;

(6) Establish a program to monitor and audit the quality of work of lead inspectors, lead risk assessors, lead abatement project designers, lead abatement contractors, lead abatement workers, and clearance technicians. The director may refer improper work discovered through the program to the attorney general for appropriate action.

(B) In addition to any other authority granted by this chapter, the director of health may do

any of the following:

(1) Employ persons who have received training from a program the director has determined provides the necessary background. The appropriate training may be obtained in a state that has an ongoing lead abatement program under which it conducts educational programs.

(2) Cooperate with the United States environmental protection agency in any joint oversight procedures the agency may propose for laboratories that offer lead analysis services and are accredited under the agency's laboratory accreditation program;

(3) Advise, consult, cooperate with, or enter into contracts or cooperative agreements with any person, government entity, interstate agency, or the federal government as the director considers necessary to fulfill the requirements of this chapter and the rules adopted under it.

Sec. 3742.07. (A) Prior to engaging in any lead abatement project on a residential unit, child care facility, or school, the lead abatement contractor primarily responsible for the project shall do all of the following:

(1) Prepare a written respiratory protection plan that meets requirements established by rule adopted under section 3742.03 of the Revised Code and make the plan available to the department of health and all lead abatement workers at the project site;

(2) Ensure that each lead abatement worker who is or will be involved in a lead abatement project has been examined ~~by a licensed physician~~ within the preceding calendar year by a physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner and has been declared by the physician or nurse to be physically capable of working while wearing a respirator;

(3) Ensure that each employee or agent who will come in contact with lead hazards or will be responsible for a lead abatement project receives a license and appropriate training as required by this chapter before engaging in a lead abatement project;

(4) At least ten days prior to the commencement of a project, notify the department of health, on a form prescribed by the director of health, of the date a lead abatement project will commence.

(B) During each lead abatement project, the lead abatement contractor primarily responsible for the project shall ensure that all persons involved in the project follow the worker protection standards established under 29 C.F.R. 1926.62 by the United States occupational safety and health administration.

Sec. 3742.32. (A) The director of health shall appoint an advisory council to assist in the ongoing development and implementation of the child lead poisoning prevention program created under section 3742.31 of the Revised Code. The advisory council shall consist of the following members:

- (1) A representative of the department of medicaid;
- (2) A representative of the bureau of child care in the department of job and family services;
- (3) A representative of the department of environmental protection;
- (4) A representative of the department of education and workforce;

- (5) A representative of the department of development;
- (6) A representative of the department of children and youth;
- (7) A representative of the Ohio apartment owner's association;
- (8) A representative of the Ohio healthy homes network;
- (9) A representative of the Ohio environmental health association;
- (10) An Ohio representative of the American coatings association;
- (11) A representative from Ohio realtors;
- (12) A representative of the Ohio housing finance agency;
- (13) A physician knowledgeable in the field of lead poisoning prevention;
- (14) A certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner knowledgeable in the field of lead poisoning prevention;

(15) A representative of the public.

(B) The advisory council shall do both of the following:

(1) Provide the director with advice regarding the policies the child lead poisoning prevention program should emphasize, preferred methods of financing the program, and any other matter relevant to the program's operation;

(2) Submit a report of the state's activities to the governor, president of the senate, and speaker of the house of representatives on or before the first day of March each year.

(C) The advisory council is not subject to sections 101.82 to 101.87 of the Revised Code.

Sec. 3901.56. An insurer may offer a wellness or health improvement program that provides rewards or incentives, including merchandise; gift cards; debit cards; premium discounts or rebates; contributions to a health savings account; modifications to copayment, deductible, or coinsurance amounts; or any combination of these incentives, to encourage participation or to reward participation in the program.

A wellness or health improvement program offered by an insurer under this section shall not be construed to violate division (E) of section 1751.31 or division (G) of section 3901.21 of the Revised Code if the program is disclosed in the policy or plan.

The insured may be required to provide verification, such as a statement from their the individual's physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, that a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness or health improvement program.

Nothing in this section shall prohibit an insurer from offering incentives or rewards to members for adherence to wellness or health improvement programs if otherwise allowed by federal law.

Nothing under division (C)(1) of section 3923.571 or section 3924.25 of the Revised Code shall be construed as prohibiting an insurer from offering a wellness or health improvement program or restricting the amount an employee is charged for coverage under a group policy after the application of any premium discounts or rebates, or modifying otherwise applicable copayments or

deductibles for adherence to wellness or health improvement programs.

For purposes of this section, "insurer" means a life insurance company, sickness and accident insurer, multiple employer welfare arrangement, public employee benefit plan, or health insuring corporation.

Sec. 3916.01. As used in this chapter:

(A) "Advertising" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the internet, or similar communications media, including, but not limited to, film strips, motion pictures, and videos, that is published, disseminated, circulated, or placed directly or indirectly before the public in this state for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a policy pursuant to a viatical settlement contract.

(B) "Business of viatical settlements" means an activity involved, but not limited to, in the offering, solicitation, negotiation, procurement, effectuation, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating or in any other manner acquiring an interest in a policy by means of viatical settlement contracts.

(C) "Chronically ill" means having been certified within the preceding twelve-month period by a licensed health professional as:

(1) Being unable to perform, without substantial assistance from another individual, at least two activities of daily living, including, but not limited to, eating, toileting, transferring, bathing, dressing, or continence for at least ninety days due to a loss of functional capacity; or

(2) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(3) Having a level of disability similar to that described in division (C)(1) of this section, as determined under regulations prescribed by the United States secretary of the treasury in consultation with the United States secretary of health and human services.

(D) "Escrow agent" means an independent third-party person who, pursuant to a written agreement signed by the viatical settlement provider and viator, provides escrow services related to the acquisition of a policy pursuant to a viatical settlement contract. "Escrow agent" does not include any person associated with, affiliated with, or under the control of a person licensed under this chapter or described in division (C) of section 3916.02 of the Revised Code.

(E)(1) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy from a viatical settlement provider, credit enhancer, or any other person that has a direct ownership interest in a policy that is the subject of a viatical settlement contract and to which both of the following apply:

(a) Its principal activity related to the transaction is providing funds to effect the business of viatical settlements or the purchase of one or more viaticated policies.

(b) It has an agreement in writing with one or more licensed viatical settlement providers to

finance the acquisition of viatical settlement contracts.

(2) "Financing entity" does not include a non-accredited investor or viatical settlement purchaser.

(F) "Recklessly" has the same meaning as in section 2901.22 of the Revised Code.

(G) "Defraud" has the same meaning as in section 2913.01 of the Revised Code.

(H) "Life expectancy" means an opinion or evaluation as to how long a particular person is going to live.

(I) Notwithstanding section 1.59 of the Revised Code, "person" means a natural person or a legal entity, including, but not limited to, an individual, partnership, limited liability company, limited liability partnership, association, trust, business trust, or corporation.

(J) "Policy" means an individual or group policy, group certificate, or other contract or arrangement of life insurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state.

(K) "Related provider trust" means a titling trust or any other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding ownership or beneficial interest in purchased policies in connection with a financing transaction, provided that the trust has a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the superintendent of insurance as if those records and files were maintained directly by the licensed viatical settlement provider.

(L) "Special purpose entity" means a corporation, partnership, trust, limited liability company or other similar entity formed solely for one of the following purposes:

(i) To provide access, either directly or indirectly, to institutional capital markets for a financing entity or licensed viatical settlement provider;

(ii) In connection with a transaction in which the securities in the special purpose entity are acquired by qualified institutional buyers.

(M) "Terminally ill" means certified by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner as having an illness or physical condition that can reasonably be expected to result in death in twenty-four months or less.

(N) "Viatical settlement broker" means a person that, on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers or viatical settlement brokers. "Viatical settlement broker" does not include an attorney, a certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator, whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

(O)(1) "Viatical settlement contract" means any of the following:

(a) A written agreement between a viator and a viatical settlement provider that establishes the terms under which compensation or anything of value, that is less than the expected death benefit of the policy is or will be paid in return for the viator's present or future assignment, transfer, sale, release, devise, or bequest of the death benefit or ownership of any portion of the policy or any beneficial interest in the policy or its ownership;

(b) The transfer or acquisition for compensation or anything of value for ownership or beneficial interest in a trust or an interest in another person that owns such a policy if the trust or other person was formed or availed of for the principal purpose of acquiring one or more life insurance policies;

(c) A premium finance loan made for a policy by a lender to a viator on, before, or after the date of issuance of the policy in either of the following situations:

(i) The viator or the insured receives a guarantee of the viatical settlement value of the policy.

(ii) The viator or the insured agrees on, before, or after the issuance of the policy to sell the policy or any portion of the policy's death benefit.

(2) "Viatical settlement contracts" include but are not limited to contracts that are commonly termed "life settlement contracts" and "senior settlement contracts."

(3) "Viatical settlement contract" does not include any of the following unless part of a plan, scheme, device, or artifice to avoid the application of this chapter:

(a) A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms whether issued with the original policy or a rider;

(b) Loan proceeds that are used solely to pay premiums for the policy and the costs of the loan including interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter of credit issuers;

(c) A loan made by a regulated financial institution in which the lender takes an interest in a policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, provided that neither the default itself nor the transfer is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(d) A premium finance loan made by a lender that does not violate sections 1321.71 to 1321.83 of the Revised Code, if the premium finance loan is not described in division (O)(1)(c) of this section;

(e) An agreement where all parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured, or are persons or trusts established primarily for the benefit of such parties;

(f) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life

insurance on the life of the employee as described in section 3911.091 of the Revised Code;

(g) Any business succession planning arrangement including, but not limited to all of the following if the arrangements are bona fide arrangements:

(i) An arrangement between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more persons or trusts established by its shareholders;

(ii) An arrangement between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners;

(iii) An arrangement between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members.

(h) An agreement entered into by a service recipient, a trust established by the service recipient and a service provider, or a trust established by the service provider who performs significant services for the service recipient's trade or business;

(i) An arrangement or agreement with a special purpose entity;

(j) Any other contract, transaction, or arrangement exempted from the definition of viatical settlement contract by rule adopted by the superintendent based on the superintendent's determination that the contract, transaction, or arrangement is not of the type regulated by this chapter.

(P)(1) "Viatical settlement provider" means a person, other than a viator, that enters into or effectuates a viatical settlement contract.

(2) "Viatical settlement provider" does not include any of the following:

(a) A bank, savings bank, savings and loan association, credit union, or other regulated financial institution that takes an assignment of a policy solely as a collateral for a loan;

(b) A premium finance company exempted under section 1321.72 of the Revised Code from the licensure requirements of section 3921.73 of the Revised Code that takes an assignment of a policy solely as collateral for a premium finance loan;

(c) The issuer of a policy;

(d) An individual who enters into or effectuates not more than one viatical settlement contract in any calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

(e) An authorized or eligible insurer that provides stop loss coverage or financial guarantee insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

(f) A financing entity;

(g) A special purpose entity;

(h) A related provider trust;

(i) A viatical settlement purchaser;

(j) Any other person the superintendent determines is not consistent with the definition of viatical settlement provider.

(Q) "Viaticated policy" means a policy that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

(R) "Viator" means the owner of a policy or a certificate holder under a group policy that has not previously been viaticated who, in return for compensation or anything of value that is less than the expected death benefit of the policy or certificate, assigns, transfers, sells, releases, devises, or bequests the death benefit or ownership of any portion of the policy or certificate of insurance. For the purposes of this chapter, a "viator" is not limited to an owner of a policy or a certificate holder under a group policy insuring the life of an individual who is terminally or chronically ill except where specifically addressed. "Viator" does not include any of the following:

- (1) A licensee under this chapter;
- (2) A qualified institutional buyer;
- (3) A financing entity;
- (4) A special purpose entity;
- (5) A related provider trust.

(S) "Viatical settlement purchaser" means a person who provides a sum of money as consideration for a policy or an interest in the death benefits of a policy from a viatical settlement provider that is the subject of a viatical settlement contract, or a person who owns, acquires, or is entitled to a beneficial interest in a trust or person that owns a viatical settlement contract or is the beneficiary of a policy that is the subject of a viatical settlement contract, for the purpose of deriving an economic benefit. "Viatical settlement purchaser" does not include any of the following:

- (1) A licensee under this chapter;
- (2) A qualified institutional buyer;
- (3) A financing entity;
- (4) A special purpose entity;
- (5) A related provider trust.

(T) "Qualified institutional buyer" has the same meaning as in 17 C.F.R. 230.144A as that regulation exists on September 11, 2008.

(U) "Licensee" means a person licensed as a viatical settlement provider or viatical settlement broker under this chapter.

(V) "NAIC" means the national association of insurance commissioners.

~~(X)~~(W) "Regulated financial institution" means a bank, a savings association, or credit union operating under authority granted by the superintendent of financial institutions, the regulatory authority of any other state of the United States, the national credit union administration, or the office of the comptroller of the currency.

~~(W)~~~~(H)~~~~(X)~~(1) "Stranger-originated life insurance," or "STOLI," means a practice, arrangement, or agreement initiated at or prior to the issuance of a policy that includes both of the

following:

(a) The purchase or acquisition of a policy primarily benefiting one or more persons who, at the time of issuance of the policy, lack insurable interest in the person insured under the policy;

(b) The transfer at any time of the legal or beneficial ownership of the policy or benefits of the policy or both, in whole or in part, including through an assumption or forgiveness of a loan to fund premiums.

(2) "Stranger-originated life insurance" also includes trusts or other persons that are created to give the appearance of insurable interest and are used to initiate one or more policies for investors but violate insurable interest laws and the prohibition against wagering on life.

(3) "Stranger-originated life insurance" does not include viatical settlement transactions specifically described in division (O)(3) of this section.

Sec. 3916.07. (A) A viatical settlement provider entering into a viatical settlement contract shall first obtain all of the following:

(1) If the viator is the insured, a written statement from an attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract. As used in this division, "physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(2) A document in which the insured consents in writing, as required by division (E) of section 3916.13 of the Revised Code, to the release of the insured's medical records to a viatical settlement provider or viatical settlement broker and to the insurance company that issued the policy covering the life of the insured.

(B) Within twenty days after a viator executes documents necessary to transfer any rights under a policy or within twenty days of entering any expressed or implied agreement, option, promise, or other form of understanding to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by division (C) of this section.

(C) The viatical settlement provider shall deliver a copy of the medical release required under division (A)(2) of this section, a copy of the viator's application for the viatical settlement contract, the notice required under division (B) of this section, and a request for verification of coverage to the insurer that issued the policy that is the subject of the viatical transaction. The viatical settlement provider shall use the NAIC's form for verification of coverage unless another form is developed or approved by the superintendent of insurance.

(D) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within thirty calendar days after the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at that time regarding

possible fraud or the validity of the life insurance policy that is the subject of the request. The insurer shall accept an original or facsimile or electronic copy of such request and any accompanying authorization signed by the viator.

(E) Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract and a full and complete understanding of the benefits of the policy, and acknowledges that the viator is entering into the viatical settlement contract freely and voluntarily and, for persons who are terminally or chronically ill, acknowledges that the insured is terminally or chronically ill and that the terminal or chronic illness was diagnosed after the policy was issued.

(F) If a viatical settlement broker performs any of the activities specified in this section on behalf of the viatical settlement provider, the viatical settlement provider is deemed to have fulfilled the requirements of this section.

(G) All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

Sec. 3916.16. (A)(1) It is a violation of this chapter for any person to enter into a viatical settlement contract prior to the application for or issuance of a policy that is the subject of the viatical settlement contract.

(2) It is a violation of this chapter for any person to issue, solicit, market, or otherwise promote the purchase of a policy for the purpose of or with an emphasis on selling the policy.

(B) It is a violation of this chapter for any person to enter into a viatical settlement contract within a five-year period commencing with the date of issuance of the policy unless the viator certifies to the viatical settlement provider that one or more of the following conditions have been met within five years after the issuance of the policy:

(1) The policy was issued upon the viator's exercise of conversion rights arising out of a group policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least sixty months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.

(2) The viator is a charitable organization with an insurable interest pursuant to division (B) of section 3911.09 the Revised Code that has received from the Internal Revenue Service a determination letter that is currently in effect, stating that the charitable organization is exempt from federal income taxation under subsection 501(a) and described in section 501(c)(3) of the "Internal Revenue Code."

(3) The viator certifies and submits independent evidence to the viatical settlement provider that one or more of the following conditions have arisen after the issuance of the policy:

(a) The viator or insured is terminally or chronically ill.

(b) The viator's spouse dies.

(c) The viator divorces the viator's spouse.

(d) The viator retires from full-time employment.

(e) The viator becomes physically or mentally disabled, and a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner determines that the disability prevents the viator from maintaining full-time employment.

(f) A court of competent jurisdiction enters a final order, judgment, or decree on the application of a creditor of the viator and adjudicates the viator bankrupt or insolvent or approves a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets.

(g) The sole beneficiary of the policy is a family member of the viator and the beneficiary dies.

(4) The viator enters into a viatical settlement contract more than two years after the date of issuance of a policy and certifies that all of the following are true:

(a) The viator has funded the policy using personal assets, which may include an interest in the life insurance policy being viaticated up to the cash surrender value of the policy or any financing agreement to fund the policy premiums entered into prior to policy issuance or within two years of policy issuance was provided to the insurer within thirty days of the date the agreement was executed and the financing agreement was secured with personal assets.

(b) The viator had no agreement or understanding with any other person to viaticate the policy or transfer the benefits of the policy, including through an assumption or forgiveness of a premium finance loan at any time prior to issuance of the policy or during the two years after the date of issuance of the policy.

(c) If requested by the insurer, the viator both disclosed to the insurer whether a person other than the insurer obtained a life expectancy evaluation for settlement purposes in connection with the application, underwriting, and issuance of the policy and provided a copy of any such life expectancy evaluation to the insurer at the time of application.

(d) The viator disclosed any financial arrangement, trust, or other arrangement, transaction, or device that conceals the ownership or beneficial interest of the policy to the insurer prior to the issuance of the policy.

(C) Copies of the independent evidence described in division (B)(3) of this section and documents required by section 3916.07 of the Revised Code shall be submitted to the insurer when the viatical settlement provider or any other party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(D) If the viatical settlement provider submits to the insurer a copy of the owner or insured's certification and independent evidence described in division (B)(3) of this section when the viatical settlement provider submits a request to the insurer to effect the transfer of the policy or certificate

to the viatical settlement provider, the copy conclusively establishes that the viatical settlement contract satisfies the requirements of this section, and the insurer shall timely respond to the request.

(E) No insurer, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, may require the viator, insured, viatical settlement provider, or viatical settlement broker to sign any form, disclosure, consent, or waiver form that has not been approved by the superintendent of insurance for use in connection with viatical settlement contracts.

(F) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within thirty calendar days to confirm that the insurer has made the change or specify reasons that the change cannot be processed. No insurer shall unreasonably delay effecting change in ownership or beneficiary or seek to interfere with any viatical settlement contract lawfully entered into in this state.

(G) A viatical settlement provider or viatical settlement broker that is party to a plan, transaction, or series of transactions to originate, renew, continue, or finance a policy with the insurer for the purpose of engaging in the business of viatical settlements at any time prior to or during the first five years after the insurer issues the policy shall fully disclose the plan, transaction, or series of transactions to the superintendent of insurance.

Sec. 3923.25. Every certificate furnished by an insurer in connection with, or pursuant to any provision of any group sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state, provided such policy was delivered, issued for delivery, or renewed on or after July 1, 1972, and every policy of sickness and accident insurance delivered, issued for delivery, renewed, or used in this state, provided such policy was delivered, issued for delivery, or renewed on or after July 1, 1972, which provides for kidney dialysis benefits, shall be deemed to include such benefits on an equal basis if the dialysis is performed on an out-patient basis. For purposes of this section, "out-patient basis" includes care rendered at any location whether or not at a hospital, upon approval by the attending physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner.

Sec. 3923.84. (A) Notwithstanding section 3901.71 of the Revised Code, each individual and group sickness and accident insurance policy that is delivered, issued for delivery, or renewed in this state shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder. A sickness and accident insurer shall not terminate an individual's coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder. Nothing in this section shall be applied to nongrandfathered plans in the individual and small group markets or to medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care, or other limited benefit hospital insurance policies. Except as otherwise provided in division (B) of this section, coverage under this section shall not be subject to dollar limits, deductibles, or

coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to substantially all medical and surgical benefits under the policy.

(B) Benefits provided under this section shall cover, at minimum, all of the following:

(1) For speech and language therapy or occupational therapy for an insured under the age of fourteen that is performed by a licensed therapist, twenty visits per year for each service;

(2) For clinical therapeutic intervention for an insured under the age of fourteen that is provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform such services in accordance with a health treatment plan, twenty hours per week;

(3) For mental or behavioral health outpatient services for an insured under the age of fourteen that are performed by ~~a licensed psychologist, psychiatrist, or physician~~ any of the following providing consultation, assessment, development, or oversight of treatment plans, thirty visits per year:

(a) A licensed psychologist;

(b) A licensed physician, including a psychiatrist;

(c) A clinical nurse specialist or certified nurse practitioner, including a psychiatric-mental health advanced practice registered nurse or a clinical nurse specialist or certified nurse practitioner specializing in pediatric or family health.

(C)(1) Except as provided in division (C)(2) of this section, this section shall not be construed as limiting benefits that are otherwise available to an insured under a policy.

(2) A policy of sickness and accident insurance shall stipulate that coverage provided under this section be contingent upon both of the following:

(a) The covered individual receiving prior authorization for the services in question;

(b) The services in question being prescribed or ordered by ~~either a developmental pediatrician or a psychologist trained in autism,~~ a developmental pediatrician, or a clinical nurse specialist or certified nurse practitioner specializing in pediatric health.

(D)(1) Except for inpatient services, if an insured is receiving treatment for an autism spectrum disorder, a sickness and accident insurer may review the treatment plan annually, unless the insurer and the insured's treating physician, clinical nurse specialist, certified nurse practitioner, or psychologist agree that a more frequent review is necessary.

(2) Any such agreement as described in division (D)(1) of this section shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorder by a physician, clinical nurse specialist, certified nurse practitioner, or psychologist.

(3) The insurer shall cover the cost of obtaining any review or treatment plan.

(E) This section shall not be construed as affecting any obligation to provide services to an insured under an individualized family service plan, an individualized education program, or an individualized service plan.

(F) As used in this section:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association available at the time an individual is first evaluated for suspected developmental delay.

(3) "Clinical therapeutic intervention" means therapies supported by empirical evidence, which include, but are not limited to, applied behavioral analysis, that satisfy both of the following:

(a) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the function of an individual;

(b) Are provided by or under the supervision of any of the following:

(i) A certified Ohio behavior analyst as defined in section 4783.01 of the Revised Code;

(ii) An individual licensed under Chapter 4732. of the Revised Code to practice psychology;

(iii) An individual licensed under Chapter 4757. of the Revised Code to practice professional counseling, social work, or marriage and family therapy.

(4) "Diagnosis of autism spectrum disorder" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

(5) "Pharmacy care" means prescribed medications ~~prescribed by a licensed physician~~ and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(6) "Psychiatric care" means direct or consultative services provided by a psychiatrist or psychiatric-mental health advanced practice registered nurse who is licensed in the state in which the psychiatrist or nurse practices.

(7) "Psychiatric-mental health advanced practice registered nurse" means an advanced practice registered nurse who is either of the following:

(a) A clinical nurse specialist who is certified as a psychiatric-mental health CNS. or the equivalent of such title, by the American nurses credentialing center;

(b) A certified nurse practitioner who is certified as a psychiatric-mental health NP. or the equivalent of such title, by the American nurses credentialing center or American academy of nurse practitioners certification board.

(8) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

~~(8)-(9)~~ "Therapeutic care" means services provided by a speech therapist, occupational therapist, or physical therapist licensed or certified in the state in which the person practices.

~~(9)-(10)~~ "Treatment for autism spectrum disorder" means evidence-based care and related

equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder, by a licensed physician who is a developmental pediatrician ~~or a~~ licensed psychologist trained in autism, clinical nurse specialist or certified nurse practitioner specializing in pediatric health, or clinical nurse specialist or certified nurse practitioner trained in autism who determines the care and related equipment to be medically necessary, including any of the following:

- (a) Clinical therapeutic intervention;
- (b) Pharmacy care;
- (c) Psychiatric care;
- (d) Psychological care;
- (e) Therapeutic care.

(G) If any provision of this section or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the section and the application of such remainder to other persons or circumstances shall not be affected thereby.

Sec. 3929.62. As used in sections 3929.62 to 3929.70 of the Revised Code and any rules adopted pursuant to those sections:

(A) "Applicant" means any licensed physician, podiatrist, or hospital, as those terms are defined in section 2305.113 of the Revised Code, or any certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner.

(B) "Medical liability underwriting association" means a nonprofit unincorporated underwriting association for medical liability insurance established under section 3929.63 of the Revised Code.

(C) "Medical liability insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service or related to the credentialing or accreditation of any medical professional or hospital by any licensed physician, podiatrist, or hospital, as those terms are defined in section 2305.113 of the Revised Code, any certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or any employee or agent acting within the scope of their duties for a physician, podiatrist, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or hospital.

Sec. 3929.63. (A) A medical liability underwriting association for medical liability insurance may be created for one or more classes of insurance by rule of the superintendent of insurance pursuant to Chapter 119. of the Revised Code upon a finding by the superintendent that both of the following circumstances exist:

(1) A substantial number of applicants for such class or classes of medical liability insurance have not been placed with insurers authorized to write medical liability insurance in this state, and are insurable risks. For purposes of this section, "insurable risk" means that the physician, podiatrist, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or hospital is licensed, certified, or accredited as required by law.

(2) The lack of such class or classes of medical liability insurance threatens the availability of health care for any group of individuals in this state.

(B) The medical liability underwriting association may:

(1) Issue or cause to be issued policies of insurance to applicants, including incidental coverages, subject to terms, conditions, exclusions, and limits, established by the medical liability underwriting association's board of governors subject to the superintendent's approval. Coverages under such policies may be made available as primary or excess protection, provided limits of primary protection under one policy shall not exceed one million dollars for each claim and three million dollars in any year unless otherwise provided for in the plan of operation.

(2) Underwrite the insurance and adjust and pay losses with respect thereto, or appoint service companies or associations to perform those functions;

(3) Assume reinsurance;

(4) Cede reinsurance.

Sec. 3929.64. (A)(1) A board of governors consisting of nine members shall govern the medical liability underwriting association. The members shall be appointed by the governor with the advice of the superintendent of insurance. Five shall be selected from insurers licensed to write and writing liability insurance in this state, at least two of which insurers must write medical liability insurance in this state. One shall be a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner and one shall be from a hospital operating in this state. One shall be an insurance agent licensed and writing medical liability insurance in this state. One shall represent the interests of consumers and shall neither be a member of, or associated with, a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company. The members of the board of governors shall serve without compensation but shall be reimbursed for their actual and necessary expenses incurred in the discharge of their official duties. The directors of the stabilization reserve fund shall serve as ex officio members of the medical liability underwriting association's board of governors.

(2) Of the initial member appointments made under division (A)(1) of this section, three shall be for terms of one year, three shall be for terms of two years, and three shall be for terms of three years, with the members' terms determined from the date the medical liability underwriting association is created under section 3929.63 of the Revised Code. Thereafter, terms of office for appointed members shall be for three years, each term ending on the same day of the same month of the year as did the term it succeeds. A vacancy shall be filled in the same manner as the original appointment. Members may be reappointed to the board of governors.

(B) The board of governors may employ, compensate, and prescribe the duties and powers of as many employees and consultants as are necessary to carry out the purposes of sections 3929.62 to 3929.70 of the Revised Code.

Sec. 3929.67. (A) A medical liability insurance policy that insures a physician-~~or~~ podiatrist, or advanced practice registered nurse, written by or on behalf of the medical liability underwriting

association pursuant to sections 3929.62 to 3929.70 of the Revised Code, may ~~only~~ be cancelled only during the term of the policy for one of the following reasons:

- (1) Nonpayment of premiums;
- (2) The license of the insured to practice medicine and surgery, osteopathic medicine and surgery, ~~or~~ podiatric medicine and surgery, or advanced practice registered nursing has been suspended or revoked;
- (3) The insured's failure to meet minimum eligibility and underwriting standards;
- (4) The occurrence of a change in the individual risk that substantially increases any hazard insured against after the coverage has been issued or renewed, except to the extent that the medical liability underwriting association reasonably should have foreseen the change or contemplated the risk in writing the policy;
- (5) Discovery of fraud or material misrepresentation in the procurement of insurance or with respect to any claim submitted thereunder.

(B) A medical liability insurance policy that insures a hospital, written by or on behalf of the medical liability underwriting association pursuant to sections 3929.62 to 3929.70 of the Revised Code, may only be cancelled during the term of the policy for one of the following reasons:

- (1) Nonpayment of premiums;
- (2) The hospital is not licensed under Chapter 3722. of the Revised Code;
- (3) An injunction against the hospital has been granted under section 3722.08 of the Revised Code;
- (4) The insured's failure to meet minimum eligibility and underwriting standards;
- (5) The occurrence of a change in the individual risk that substantially increases any hazard insured against after the coverage has been issued or renewed, except to the extent that the medical liability underwriting association reasonably should have foreseen the change or contemplated the risk in writing the policy;
- (6) Discovery of fraud or material misrepresentation in the procurement of insurance or with respect to any claim submitted thereunder.

Sec. 4113.23. (A) No employer ~~or~~, and no physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, other health care professional, hospital, or laboratory that contracts with the employer to provide medical information pertaining to employees, shall refuse upon written request of an employee, including a former employee, to furnish to the employee ~~or former employee or their the employee's~~ designated representative a copy of any medical report pertaining to the employee. The requirements of this section extend to any medical report arising out of any physical examination by a physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or other health care professional and any hospital or laboratory tests which examinations or tests are required by the employer as a condition of employment or arising out of any injury or disease related to the employee's employment. However, if a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner concludes that presentation of

all or any part of an employee's medical record directly to the employee will result in serious medical harm to the employee, ~~he~~ the physician or nurse shall so indicate on the medical record, in which case a copy thereof shall be given to a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner designated in writing by the employee.

(B) The employer may require the employee to pay the cost of furnishing copies of the medical reports described in division (A) of this section but in no case shall the employer charge more than twenty-five cents for each page of a report.

(C) As used in this section, "employer" has the same meaning as contained in the definition of that term found in section 4123.01 of the Revised Code.

(D) Any employer who refuses to furnish the reports to which an employee is entitled is guilty of a minor misdemeanor for each violation. The bureau of workers' compensation shall enforce this section.

Sec. 4121.121. (A) There is hereby created the bureau of workers' compensation, which shall be administered by the administrator of workers' compensation. A person appointed to the position of administrator shall possess significant management experience in effectively managing an organization or organizations of substantial size and complexity. A person appointed to the position of administrator also shall possess a minimum of five years of experience in the field of workers' compensation insurance or in another insurance industry, except as otherwise provided when the conditions specified in division (C) of this section are satisfied. The governor shall appoint the administrator as provided in section 121.03 of the Revised Code, and the administrator shall serve at the pleasure of the governor. The governor shall fix the administrator's salary on the basis of the administrator's experience and the administrator's responsibilities and duties under this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code. The governor shall not appoint to the position of administrator any person who has, or whose spouse has, given a contribution to the campaign committee of the governor in an amount greater than one thousand dollars during the two-year period immediately preceding the date of the appointment of the administrator.

The administrator shall hold no other public office and shall devote full time to the duties of administrator. Before entering upon the duties of the office, the administrator shall take an oath of office as required by sections 3.22 and 3.23 of the Revised Code, and shall file in the office of the secretary of state, a bond signed by the administrator and by surety approved by the governor, for the sum of fifty thousand dollars payable to the state, conditioned upon the faithful performance of the administrator's duties.

(B) The administrator is responsible for the management of the bureau and for the discharge of all administrative duties imposed upon the administrator in this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code, and in the discharge thereof shall do all of the following:

(1) Perform all acts and exercise all authorities and powers, discretionary and otherwise that

are required of or vested in the bureau or any of its employees in this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code, except the acts and the exercise of authority and power that is required of and vested in the bureau of workers' compensation board of directors or the industrial commission pursuant to those chapters. The treasurer of state shall honor all warrants signed by the administrator, or by one or more of the administrator's employees, authorized by the administrator in writing, or bearing the facsimile signature of the administrator or such employee under sections 4123.42 and 4123.44 of the Revised Code.

(2) Employ, direct, and supervise all employees required in connection with the performance of the duties assigned to the bureau by this chapter and Chapters 4123., 4125., 4127., 4131., 4133., and 4167. of the Revised Code, including an actuary, and may establish job classification plans and compensation for all employees of the bureau provided that this grant of authority shall not be construed as affecting any employee for whom the state employment relations board has established an appropriate bargaining unit under section 4117.06 of the Revised Code. All positions of employment in the bureau are in the classified civil service except those employees the administrator may appoint to serve at the administrator's pleasure in the unclassified civil service pursuant to section 124.11 of the Revised Code. The administrator shall fix the salaries of employees the administrator appoints to serve at the administrator's pleasure, including the chief operating officer, staff physicians, staff certified nurse-midwives, staff clinical nurse specialists, staff certified nurse practitioners, and other senior management personnel of the bureau and shall establish the compensation of staff attorneys of the bureau's legal section and their immediate supervisors, and take whatever steps are necessary to provide adequate compensation for other staff attorneys.

The administrator may appoint a person who holds a certified position in the classified service within the bureau to a position in the unclassified service within the bureau. A person appointed pursuant to this division to a position in the unclassified service shall retain the right to resume the position and status held by the person in the classified service immediately prior to the person's appointment in the unclassified service, regardless of the number of positions the person held in the unclassified service. An employee's right to resume a position in the classified service may only be exercised when the administrator demotes the employee to a pay range lower than the employee's current pay range or revokes the employee's appointment to the unclassified service. An employee who holds a position in the classified service and who is appointed to a position in the unclassified service on or after January 1, 2016, shall have the right to resume a position in the classified service under this division only within five years after the effective date of the employee's appointment in the unclassified service. An employee forfeits the right to resume a position in the classified service when the employee is removed from the position in the unclassified service due to incompetence, inefficiency, dishonesty, drunkenness, immoral conduct, insubordination, discourteous treatment of the public, neglect of duty, violation of this chapter or Chapter 124., 4123., 4125., 4127., 4131., 4133., or 4167. of the Revised Code, violation of the rules of the director of administrative services or the administrator, any other failure of good behavior, any other acts of

misfeasance, malfeasance, or nonfeasance in office, or conviction of a felony while employed in the civil service. An employee also forfeits the right to resume a position in the classified service upon transfer to a different agency.

Reinstatement to a position in the classified service shall be to a position substantially equal to that position in the classified service held previously, as certified by the department of administrative services. If the position the person previously held in the classified service has been placed in the unclassified service or is otherwise unavailable, the person shall be appointed to a position in the classified service within the bureau that the director of administrative services certifies is comparable in compensation to the position the person previously held in the classified service. Service in the position in the unclassified service shall be counted as service in the position in the classified service held by the person immediately prior to the person's appointment in the unclassified service. When a person is reinstated to a position in the classified service as provided in this division, the person is entitled to all rights, status, and benefits accruing to the position during the person's time of service in the position in the unclassified service.

(3) Reorganize the work of the bureau, its sections, departments, and offices to the extent necessary to achieve the most efficient performance of its functions and to that end may establish, change, or abolish positions and assign and reassign duties and responsibilities of every employee of the bureau. All persons employed by the commission in positions that, after November 3, 1989, are supervised and directed by the administrator under this section are transferred to the bureau in their respective classifications but subject to reassignment and reclassification of position and compensation as the administrator determines to be in the interest of efficient administration. The civil service status of any person employed by the commission is not affected by this section. Personnel employed by the bureau or the commission who are subject to Chapter 4117. of the Revised Code shall retain all of their rights and benefits conferred pursuant to that chapter as it presently exists or is hereafter amended and nothing in this chapter or Chapter 4123. of the Revised Code shall be construed as eliminating or interfering with Chapter 4117. of the Revised Code or the rights and benefits conferred under that chapter to public employees or to any bargaining unit.

(4) Provide offices, equipment, supplies, and other facilities for the bureau.

(5) Prepare and submit to the board information the administrator considers pertinent or the board requires, together with the administrator's recommendations, in the form of administrative rules, for the advice and consent of the board, for classifications of occupations or industries, for premium rates and contributions, for the amount to be credited to the surplus fund, for rules and systems of rating, rate revisions, and merit rating. The administrator shall obtain, prepare, and submit any other information the board requires for the prompt and efficient discharge of its duties.

(6) Keep the accounts required by division (A) of section 4123.34 of the Revised Code and all other accounts and records necessary to the collection, administration, and distribution of the workers' compensation funds and shall obtain the statistical and other information required by section 4123.19 of the Revised Code.

(7) Exercise the investment powers vested in the administrator by section 4123.44 of the Revised Code in accordance with the investment policy approved by the board pursuant to section 4121.12 of the Revised Code and in consultation with the chief investment officer of the bureau of workers' compensation. The administrator shall not engage in any prohibited investment activity specified by the board pursuant to division (F)(9) of section 4121.12 of the Revised Code and shall not invest in any type of investment specified in divisions (B)(1) to (10) of section 4123.442 of the Revised Code. All business shall be transacted, all funds invested, all warrants for money drawn and payments made, and all cash and securities and other property held, in the name of the bureau, or in the name of its nominee, provided that nominees are authorized by the administrator solely for the purpose of facilitating the transfer of securities, and restricted to the administrator and designated employees.

(8) In accordance with Chapter 125. of the Revised Code, purchase supplies, materials, equipment, and services.

(9) Prepare and submit to the board an annual budget for internal operating purposes for the board's approval. The administrator also shall, separately from the budget the industrial commission submits, prepare and submit to the director of budget and management a budget for each biennium. The budgets submitted to the board and the director shall include estimates of the costs and necessary expenditures of the bureau in the discharge of any duty imposed by law.

(10) As promptly as possible in the course of efficient administration, decentralize and relocate such of the personnel and activities of the bureau as is appropriate to the end that the receipt, investigation, determination, and payment of claims may be undertaken at or near the place of injury or the residence of the claimant and for that purpose establish regional offices, in such places as the administrator considers proper, capable of discharging as many of the functions of the bureau as is practicable so as to promote prompt and efficient administration in the processing of claims. All active and inactive lost-time claims files shall be held at the service office responsible for the claim. A claimant, at the claimant's request, shall be provided with information by telephone as to the location of the file pertaining to the claimant's claim. The administrator shall ensure that all service office employees report directly to the director for their service office.

(11) Provide a written binder on new coverage where the administrator considers it to be in the best interest of the risk. The administrator, or any other person authorized by the administrator, shall grant the binder upon submission of a request for coverage by the employer. A binder is effective for a period of thirty days from date of issuance and is nonrenewable. Payroll reports and premium charges shall coincide with the effective date of the binder.

(12) Set standards for the reasonable and maximum handling time of claims payment functions, ensure, by rules, the impartial and prompt treatment of all claims and employer risk accounts, and establish a secure, accurate method of time stamping all incoming mail and documents hand delivered to bureau employees.

(13) Ensure that all employees of the bureau follow the orders and rules of the commission

as such orders and rules relate to the commission's overall adjudicatory policy-making and management duties under this chapter and Chapters 4123., 4127., and 4131. of the Revised Code.

(14) Manage and operate a data processing system with a common data base for the use of both the bureau and the commission and, in consultation with the commission, using electronic data processing equipment, shall develop a claims tracking system that is sufficient to monitor the status of a claim at any time and that lists appeals that have been filed and orders or determinations that have been issued pursuant to section 4123.511 or 4123.512 of the Revised Code, including the dates of such filings and issuances.

(15) Establish and maintain a medical section within the bureau. The medical section shall do all of the following:

(a) Assist the administrator in establishing standard medical fees, approving medical procedures, and determining eligibility and reasonableness of the compensation payments for medical, hospital, and nursing services, and in establishing guidelines for payment policies which recognize usual, customary, and reasonable methods of payment for covered services;

(b) Provide a resource to respond to questions from claims examiners for employees of the bureau;

(c) Audit fee bill payments;

(d) Implement a program to utilize, to the maximum extent possible, electronic data processing equipment for storage of information to facilitate authorizations of compensation payments for medical, hospital, drug, and nursing services;

(e) Perform other duties assigned to it by the administrator.

(16) Appoint, as the administrator determines necessary, panels to review and advise the administrator on disputes arising over a determination that a health care service or supply provided to a claimant is not covered under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code or is medically unnecessary. If an individual health care provider is involved in the dispute, the panel shall consist of individuals licensed pursuant to the same section of the Revised Code as such health care provider.

(17) Pursuant to section 4123.65 of the Revised Code, approve applications for the final settlement of claims for compensation or benefits under this chapter and Chapters 4123., 4127., and 4131. of the Revised Code as the administrator determines appropriate, except in regard to the applications of self-insuring employers and their employees.

(18) Comply with section 3517.13 of the Revised Code, and except in regard to contracts entered into pursuant to the authority contained in section 4121.44 of the Revised Code, comply with the competitive bidding procedures set forth in the Revised Code for all contracts into which the administrator enters provided that those contracts fall within the type of contracts and dollar amounts specified in the Revised Code for competitive bidding and further provided that those contracts are not otherwise specifically exempt from the competitive bidding procedures contained in the Revised Code.

(19) Adopt, with the advice and consent of the board, rules for the operation of the bureau.

(20) Prepare and submit to the board information the administrator considers pertinent or the board requires, together with the administrator's recommendations, in the form of administrative rules, for the advice and consent of the board, for the health partnership program and the qualified health plan system, as provided in sections 4121.44, 4121.441, and 4121.442 of the Revised Code.

(C) The administrator, with the advice and consent of the senate, shall appoint a chief operating officer who has a minimum of five years of experience in the field of workers' compensation insurance or in another similar insurance industry if the administrator does not possess such experience. The chief operating officer shall not commence the chief operating officer's duties until after the senate consents to the chief operating officer's appointment. The chief operating officer shall serve in the unclassified civil service of the state.

Sec. 4121.31. (A) The administrator of workers' compensation and the industrial commission jointly shall adopt rules covering the following general topics with respect to this chapter and Chapter 4123. of the Revised Code:

(1) Rules that set forth any general policy and the principal operating procedures of the bureau of workers' compensation or commission, including but not limited to:

(a) Assignment to various operational units of any duties placed upon the administrator or the commission by statute;

(b) Procedures for decision-making;

(c) Procedures governing the appearances of a claimant, employer, or their representatives before the agency in a hearing;

(d) Procedures that inform claimants, on request, of the status of a claim and any actions necessary to maintain the claim;

(e) Time goals for activities of the bureau or commission;

(f) Designation of the person or persons authorized to issue directives with directives numbered and distributed from a central distribution point to persons on a list maintained for that purpose.

(2) A rule barring any employee of the bureau or commission from having a workers' compensation claims file in the employee's possession unless the file is necessary to the performance of the employee's duties.

(3) All claims, whether of a state fund or self-insuring employer, be processed in an orderly, uniform, and timely fashion.

(4) Rules governing the submission and sending of applications, notices, evidence, and other documents by electronic means. The rules shall provide that where this chapter or Chapter 4123., 4127., or 4131. of the Revised Code requires that a document be in writing or requires a signature, the administrator and the commission, to the extent of their respective jurisdictions, may approve of and provide for the electronic submission and sending of those documents, and the use of an electronic signature on those documents.

(5) Rules allowing a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to act in the same capacity as a physician for purposes of this chapter and Chapters 4123., 4127., and 4131. of the Revised Code, including the ability to complete and sign medical reports to support payment or nonpayment of disability, except that, in the case of a medical report completed by a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner that supports disability compensation for the time period that begins six weeks after the date of injury, the report shall be reviewed, approved, and signed by a physician.

(B) As used in this section:

(1) "Electronic" includes electrical, digital, magnetic, optical, electromagnetic, facsimile, or any other form of technology that entails capabilities similar to these technologies.

(2) "Electronic record" means a record generated, communicated, received, or stored by electronic means for use in an information system or for transmission from one information system to another.

(3) "Electronic signature" means a signature in electronic form attached to or logically associated with an electronic record.

Sec. 4121.32. (A) The rules covering operating procedure and criteria for decision-making that the administrator of workers' compensation and the industrial commission are required to adopt pursuant to section 4121.31 of the Revised Code shall be supplemented with operating manuals setting forth the procedural steps in detail for performing each of the assigned tasks of each section of the bureau of workers' compensation and commission. The administrator and commission jointly shall adopt such manuals. No employee may deviate from manual procedures without authorization of the section chief.

(B) Manuals shall set forth the procedure for the assignment and transfer of claims within sections and be designed to provide performance objectives and may require employees to record sufficient data to reasonably measure the efficiency of functions in all sections. The bureau shall perform periodic cost-effectiveness analyses that shall be made available to the general assembly, the governor, and to the public during normal working hours.

(C) The bureau and commission jointly shall develop, adopt, and use a policy manual setting forth the guidelines and bases for decision-making for any decision which is the responsibility of the bureau, district hearing officers, staff hearing officers, or the commission. Guidelines shall be set forth in the policy manual by the bureau and commission to the extent of their respective jurisdictions for deciding at least the following specific matters:

- (1) Reasonable ambulance services;
- (2) Relationship of drugs to injury;
- (3) Awarding lump-sum advances for creditors;
- (4) Awarding lump-sum advances for attorney's fees;
- (5) Placing a claimant into rehabilitation;
- (6) Transferring costs of a claim from employer costs to the statutory surplus fund pursuant

to section 4123.343 of the Revised Code;

(7) Utilization of physician or nurse specialist reports;

(8) Determining the percentage of permanent partial disability, temporary partial disability, temporary total disability, violations of specific safety requirements, an award under division (B) of section 4123.57 of the Revised Code, and permanent total disability.

(D) The bureau shall establish, adopt, and implement policy guidelines and bases for decisions involving reimbursement issues including, but not limited to, the adjustment of invoices, the reduction of payments for future services when an internal audit concludes that a health care provider was overpaid or improperly paid for past services, reimbursement fees, or other adjustments to payments. These policy guidelines and bases for decisions, and any changes to the guidelines and bases, shall be set forth in a reimbursement manual and provider bulletins.

Neither the policy guidelines nor the bases set forth in the reimbursement manual or provider bulletins referred to in this division is a rule as defined in section 119.01 of the Revised Code.

(E) With respect to any determination of disability under Chapter 4123. of the Revised Code, when the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner makes a determination based upon statements or information furnished by the claimant or upon subjective evidence, the physician or nurse shall clearly indicate this fact in the physician's or nurse's report.

(F) The administrator shall publish the manuals and make copies of all manuals available to interested parties at cost.

Sec. 4121.36. (A) The industrial commission shall adopt rules as to the conduct of all hearings before the commission and its staff and district hearing officers and the rendering of a decision and shall focus such rules on managing, directing, and otherwise ensuring a fair, equitable, and uniform hearing process. These rules shall provide for at least the following steps and procedures:

(1) Adequate notice to all parties and their representatives to ensure that no hearing is conducted unless all parties have the opportunity to be present and to present evidence and arguments in support of their positions or in rebuttal to the evidence or arguments of other parties;

(2) A public hearing;

(3) Written decisions;

(4) Impartial assignment of staff and district hearing officers and assignment of appeals from a decision of the administrator of workers' compensation to a district hearing officer located at the commission service office that is the closest in geographic proximity to the claimant's residence;

(5) Publication of a docket;

(6) The securing of the attendance or testimony of witnesses;

(7) Prehearing rules, including rules relative to discovery, the taking of depositions, and exchange of information relevant to a claim prior to the conduct of a hearing;

(8) The issuance of orders by the district or staff hearing officer who renders the decision.

(B) Every decision by a staff or district hearing officer or the commission shall be in writing and contain all of the following elements:

- (1) A concise statement of the order or award;
- (2) A notation as to notice provided and as to appearance of parties;
- (3) Signatures of each commissioner or appropriate hearing officer on the original copy of the decision only, verifying the commissioner's or hearing officer's vote;
- (4) Description of the part of the body and nature of the disability recognized in the claim.

(C) The commission shall adopt rules that require the regular rotation of district hearing officers with respect to the types of matters under consideration and that ensure that no district or staff hearing officer or the commission hears a claim unless all interested and affected parties have the opportunity to be present and to present evidence and arguments in support of their positions or in rebuttal to the evidence or arguments of other parties.

(D) All matters which, at the request of one of the parties or on the initiative of the administrator and any commissioner, are to be expedited, shall require at least forty-eight hours' notice, a public hearing, and a statement in any order of the circumstances that justified such expeditious hearings.

(E) All meetings of the commission and district and staff hearing officers shall be public with adequate notice, including if necessary, to the claimant, the employer, their representatives, and the administrator. Confidentiality of medical evidence presented at a hearing does not constitute a sufficient ground to relieve the requirement of a public hearing, but the presentation of privileged or confidential evidence shall not create any greater right of public inspection of evidence than presently exists.

(F) The commission shall compile all of its original memorandums, orders, and decisions in a journal and make the journal available to the public with sufficient indexing to allow orderly review of documents. The journal shall indicate the vote of each commissioner.

(G)(1) All original orders, rules, and memoranda, and decisions of the commission shall contain the signatures of two of the three commissioners and state whether adopted at a meeting of the commission or by circulation to individual commissioners. Any facsimile or secretarial signature, initials of commissioners, and delegated employees, and any printed record of the "yes" and "no" vote of a commission member or of a hearing officer on such original is invalid.

(2) Written copies of final decisions of district or staff hearing officers or the commission that are mailed to the administrator, employee, employer, and their respective representatives need not contain the signatures of the hearing officer or commission members if the hearing officer or commission members have complied with divisions (B)(3) and (G)(1) of this section.

(H) The commission shall do both of the following:

(1) Appoint an individual as a hearing officer trainer who is in the unclassified civil service of the state and who serves at the pleasure of the commission. The trainer shall be an attorney registered to practice law in this state and have experience in training or education, and the ability to

furnish the necessary training for district and staff hearing officers.

The hearing officer trainer shall develop and periodically update a training manual and such other training materials and courses as will adequately prepare district and staff hearing officers for their duties under this chapter and Chapter 4123. of the Revised Code. All district and staff hearing officers shall undergo the training courses developed by the hearing officer trainer, the cost of which the commission shall pay. The commission shall make the hearing officer manual and all revisions thereto available to the public at cost.

The commission shall have the final right of approval over all training manuals, courses, and other materials the hearing officer trainer develops and updates.

(2) Appoint a hearing administrator, who shall be in the classified civil service of the state, for each bureau service office, and sufficient support personnel for each hearing administrator, which support personnel shall be under the direct supervision of the hearing administrator. The hearing administrator shall do all of the following:

(a) Assist the commission in ensuring that district hearing officers comply with the time limitations for the holding of hearings and issuance of orders under section 4123.511 of the Revised Code. For that purpose, each hearing administrator shall prepare a monthly report identifying the status of all claims in its office and identifying specifically the claims which have not been decided within the time limits set forth in section 4123.511 of the Revised Code. The commission shall submit an annual report of all such reports to the standing committees of the house of representatives and of the state to which matters concerning workers' compensation are normally referred.

(b) Provide information to requesting parties or their representatives on the status of their claim;

(c) Issue compliance letters, upon a finding of good cause and without a formal hearing in all of the following areas:

- (i) Divisions (B) and (C) of section 4123.651 of the Revised Code;
- (ii) Requests for the taking of depositions of bureau and commission physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners;
- (iii) The issuance of subpoenas;
- (iv) The granting or denying of requests for continuances;
- (v) Matters involving section 4123.522 of the Revised Code;
- (vi) Requests for conducting telephone pre-hearing conferences;
- (vii) Any other matter that will cause a free exchange of information prior to the formal hearing.

(d) Ensure that claim files are reviewed by the district hearing officer prior to the hearing to ensure that there is sufficient information to proceed to a hearing;

(e) Ensure that for occupational disease claims under section 4123.68 of the Revised Code that require a medical examination the medical examination is conducted prior to the hearing;

(f) Take the necessary steps to prepare a claim to proceed to a hearing where the parties

agree and advise the hearing administrator that the claim is not ready for a hearing.

(I) The commission shall permit any person direct access to information contained in electronic data processing equipment regarding the status of a claim in the hearing process. The information shall indicate the number of days that the claim has been in process, the number of days the claim has been in its current location, and the number of days in the current point of the process within that location.

(J)(1) The industrial commission may establish an alternative dispute resolution process for workers' compensation claims that are within the commission's jurisdiction under Chapters 4121., 4123., 4127., and 4131. of the Revised Code when the commission determines that such a process is necessary. Notwithstanding sections 4121.34 and 4121.35 of the Revised Code, the commission may enter into personal service contracts with individuals who are qualified because of their education and experience to act as facilitators in the commission's alternative dispute resolution process.

(2) The parties' use of the alternative dispute resolution process is voluntary, and requires the agreement of all necessary parties. The use of the alternative dispute resolution process does not alter the rights or obligations of the parties, nor does it delay the timelines set forth in section 4123.511 of the Revised Code.

(3) The commission shall prepare monthly reports and submit those reports to the governor, the president of the senate, and the speaker of the house of representatives describing all of the following:

- (a) The names of each facilitator employed under a personal service contract;
- (b) The hourly amount of money and the total amount of money paid to each facilitator;
- (c) The number of disputed issues resolved during that month by each facilitator;
- (d) The number of decisions of each facilitator that were appealed by a party;
- (e) A certification by the commission that the alternative dispute resolution process did not delay any hearing timelines as set forth in section 4123.511 of the Revised Code for any disputed issue.

(4) The commission may adopt rules in accordance with Chapter 119. of the Revised Code for the administration of any alternative dispute resolution process that the commission establishes.

Sec. 4121.38. (A) The industrial commission shall:

(1) Implement a program of impairment evaluation training for its staff physicians, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners;

(2) Issue a manual of commission policy as to impairment evaluation so as to increase consistency of medical reports. This manual shall be available to the public at cost but shall be provided free to all physicians, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners who treat claimants or to whom claimants are referred for evaluation. The commission shall take steps to ensure that the manual receives the widest possible distribution to physicians, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners.

(3) Develop a method of peer review of medical reports prepared by the commission referral

~~doctors~~physicians;

(4) Issue a policy manual as to the basis upon which referrals to other than commission specialists will be made;

(5) Designate two hearing examiners and two medical staff members who shall be specially trained in medical-legal analysis. The specialists shall write evaluations of medical-legal problems upon assignment by other hearing examiners or the commission. The director of administrative services upon commission advice shall assign such employees to a salary schedule commensurate with expertise required of them.

(6) Require that prior to any examination, a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to whom a claimant is referred for examination receives all necessary medical information in the claim file about the claimant and a complete statement as to the purpose of the examination.

(B) The commission may establish a medical section within the commission to perform the duties assigned to the commission under this section.

Sec. 4121.45. (A) There is hereby created a workers' compensation ombudsperson system to assist claimants and employers in matters dealing with the bureau of workers' compensation and the industrial commission. The industrial commission nominating council shall appoint a chief ombudsperson. The chief ombudsperson, with the advice and consent of the nominating council, may appoint such assistant ombudspersons as the nominating council deems necessary. The position of chief ombudsperson is for a term of six years. A person appointed to the position of chief ombudsperson shall serve at the pleasure of the nominating council. The chief ombudsperson may not be transferred, demoted, or suspended during the person's tenure and may be removed by the nominating council only upon a vote of not fewer than nine members of the nominating council. The chief ombudsperson shall devote the chief ombudsperson's full time and attention to the duties of the ombudsperson's office. The administrator of workers' compensation shall furnish the chief ombudsperson with the office space, supplies, and clerical assistance that will enable the chief ombudsperson and the ombudsperson system staff to perform their duties effectively. The ombudsperson program shall be funded out of the budget of the bureau and the chief ombudsperson and the ombudsperson system staff shall be carried on the bureau payroll. The chief ombudsperson and the ombudsperson system shall be under the direction of the nominating council. The administrator and all employees of the bureau and the commission shall give the the ombudsperson system staff full and prompt cooperation in all matters relating to the duties of the chief ombudsperson.

(B) The ombudsperson system staff shall:

(1) Answer inquiries or investigate complaints made by employers or claimants under this chapter and Chapter 4123. of the Revised Code as they relate to the processing of a claim for workers' compensation benefits;

(2) Provide claimants and employers with information regarding problems which arise out of

the functions of the bureau, commission hearing officers, and the commission and the procedures employed in the processing of claims;

(3) Answer inquiries or investigate complaints of an employer as they relate to reserves established and premiums charged in connection with the employer's account;

(4) Comply with Chapter 102. and sections 2921.42 and 2921.43 of the Revised Code and the nominating council's human resource and ethics policies;

(5) Not express any opinions as to the merit of a claim or the correctness of a decision by the various officers or agencies as the decision relates to a claim for benefits or compensation.

For the purpose of carrying out the chief ombudsperson's duties, the chief ombudsperson or the ombudsperson system staff, notwithstanding sections 4123.27 and 4123.88 of the Revised Code, has the right at all reasonable times to examine the contents of a claim file and discuss with parties in interest the contents of the file as long as the ombudsperson does not divulge information that would tend to prejudice the case of either party to a claim or that would tend to compromise a privileged attorney-client ~~or doctor-patient relationship, physician-patient relationship, or advanced practice registered nurse-patient relationship.~~

(C) The chief ombudsperson shall:

(1) Assist any service office in its duties whenever it requires assistance or information that can best be obtained from central office personnel or records;

(2) Annually assemble reports from each assistant ombudsperson as to their activities for the preceding year together with their recommendations as to changes or improvements in the operations of the workers' compensation system. The chief ombudsperson shall prepare a written report summarizing the activities of the ombudsperson system together with a digest of recommendations. The chief ombudsperson shall transmit the report to the nominating council.

(3) Comply with Chapter 102. and sections 2921.42 and 2921.43 of the Revised Code and the nominating council's human resource and ethics policies.

(D) No ombudsperson or assistant ombudsperson shall:

(1) Represent a claimant or employer in claims pending before or to be filed with the administrator, a district or staff hearing officer, the commission, or the courts of the state, nor shall an ombudsperson or assistant ombudsperson undertake any such representation for a period of one year after the ombudsperson's or assistant ombudsperson's employment terminates or be eligible for employment by the bureau or the commission or as a district or staff hearing officer for one year;

(2) Express any opinions as to the merit of a claim or the correctness of a decision by the various officers or agencies as the decision relates to a claim for benefits or compensation.

(E) The chief ombudsperson and assistant ombudspersons shall receive compensation at a level established by the nominating council commensurate with the individual's background, education, and experience in workers' compensation or related fields. The chief ombudsperson and assistant ombudspersons are full-time permanent employees in the unclassified service of the state and are entitled to all benefits that accrue to such employees, including, without limitation, sick,

vacation, and personal leaves. Assistant ombudspersons serve at the pleasure of the chief ombudsperson.

(F) In the event of a vacancy in the position of chief ombudsperson, the nominating council may appoint a person to serve as acting chief ombudsperson until a chief ombudsperson is appointed. The acting chief ombudsperson shall be under the direction and control of the nominating council and may be removed by the nominating council with or without just cause.

Sec. 4123.19. The bureau of workers' compensation may make necessary expenditures to obtain statistical and other information to establish the classes provided for in section 4123.29 of the Revised Code.

The salaries and compensation of all of the actuaries, accountants, inspectors, examiners, experts, clerks, physicians, nurses, stenographers, and other assistants of the bureau, and all other expenses of the bureau, including the premium to be paid for the bond to be furnished by the treasurer of state pursuant to section 4123.42 of the Revised Code, shall be paid out of the workers' compensation fund pursuant to warrants signed by the administrator of workers' compensation.

Sec. 4123.511. (A) Within seven days after receipt of any claim under this chapter, the bureau of workers' compensation shall notify the claimant and the employer of the claimant of the receipt of the claim and of the facts alleged therein. If the bureau receives from a person other than the claimant written or facsimile information or information communicated verbally over the telephone indicating that an injury or occupational disease has occurred or been contracted which may be compensable under this chapter, the bureau shall notify the employee and the employer of the information. If the information is provided verbally over the telephone, the person providing the information shall provide written verification of the information to the bureau according to division (E) of section 4123.84 of the Revised Code. The receipt of the information in writing or facsimile, or if initially by telephone, the subsequent written verification, and the notice by the bureau shall be considered an application for compensation under section 4123.84 or 4123.85 of the Revised Code, provided that the conditions of division (E) of section 4123.84 of the Revised Code apply to information provided verbally over the telephone. Upon receipt of a claim, the bureau shall advise the claimant of the claim number assigned and the claimant's right to representation in the processing of a claim or to elect no representation. If the bureau determines that a claim is determined to be a compensable lost-time claim, the bureau shall notify the claimant and the employer of the availability of rehabilitation services. No bureau or industrial commission employee shall directly or indirectly convey any information in derogation of this right. This section shall in no way abrogate the bureau's responsibility to aid and assist a claimant in the filing of a claim and to advise the claimant of the claimant's rights under the law.

The administrator of workers' compensation shall assign all claims and investigations to the bureau service office from which investigation and determination may be made most expeditiously.

The bureau shall investigate the facts concerning an injury or occupational disease and ascertain such facts in whatever manner is most appropriate and may obtain statements ~~of~~ in

~~whatever manner is most appropriate from any of the following: employee; employer; attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner; and witnesses in whatever manner is most appropriate.~~

The administrator, with the advice and consent of the bureau of workers' compensation board of directors, may adopt rules that identify specified medical conditions that have a historical record of being allowed whenever included in a claim. The administrator may grant immediate allowance of any medical condition identified in those rules upon the filing of a claim involving that medical condition and may make immediate payment of medical bills for any medical condition identified in those rules that is included in a claim. If an employer contests the allowance of a claim involving any medical condition identified in those rules, and the claim is disallowed, payment for the medical condition included in that claim shall be charged to and paid from the surplus fund created under section 4123.34 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section, in claims other than those in which the employer is a self-insuring employer, if the administrator determines under division (A) of this section that a claimant is or is not entitled to an award of compensation or benefits, the administrator shall issue an order no later than twenty-eight days after the sending of the notice under division (A) of this section, granting or denying the payment of the compensation or benefits, or both as is appropriate to the claimant. Notwithstanding the time limitation specified in this division for the issuance of an order, if a medical examination of the claimant is required by statute, the administrator promptly shall schedule the claimant for that examination and shall issue an order no later than twenty-eight days after receipt of the report of the examination. The administrator shall notify the claimant and the employer of the claimant and their respective representatives in writing of the nature of the order and the amounts of compensation and benefit payments involved. The employer or claimant may appeal the order pursuant to division (C) of this section within fourteen days after the date of the receipt of the order. The employer and claimant may waive, in writing, their rights to an appeal under this division.

(2) Notwithstanding the time limitation specified in division (B)(1) of this section for the issuance of an order, if the employer certifies a claim for payment of compensation or benefits, or both, to a claimant, and the administrator has completed the investigation of the claim, the payment of benefits or compensation, or both, as is appropriate, shall commence upon the later of the date of the certification or completion of the investigation and issuance of the order by the administrator, provided that the administrator shall issue the order no later than the time limitation specified in division (B)(1) of this section.

(3) If an appeal is made under division (B)(1) or (2) of this section, the administrator shall forward the claim file to the appropriate district hearing officer within seven days of the appeal. In contested claims other than state fund claims, the administrator shall forward the claim within seven days of the administrator's receipt of the claim to the industrial commission, which shall refer the claim to an appropriate district hearing officer for a hearing in accordance with division (C) of this

section.

(C) If an employer or claimant timely appeals the order of the administrator issued under division (B) of this section or in the case of other contested claims other than state fund claims, the commission shall refer the claim to an appropriate district hearing officer according to rules the commission adopts under section 4121.36 of the Revised Code. The district hearing officer shall notify the parties and their respective representatives of the time and place of the hearing.

The district hearing officer shall hold a hearing on a disputed issue or claim within forty-five days after the filing of the appeal under this division and issue a decision within seven days after holding the hearing. The district hearing officer shall notify the parties and their respective representatives in writing of the order. Any party may appeal an order issued under this division pursuant to division (D) of this section within fourteen days after receipt of the order under this division.

(D) Upon the timely filing of an appeal of the order of the district hearing officer issued under division (C) of this section, the commission shall refer the claim file to an appropriate staff hearing officer according to its rules adopted under section 4121.36 of the Revised Code. The staff hearing officer shall hold a hearing within forty-five days after the filing of an appeal under this division and issue a decision within seven days after holding the hearing under this division. The staff hearing officer shall notify the parties and their respective representatives in writing of the staff hearing officer's order. Any party may appeal an order issued under this division pursuant to division (E) of this section within fourteen days after receipt of the order under this division.

(E) Upon the filing of a timely appeal of the order of the staff hearing officer issued under division (D) of this section, the commission or a designated staff hearing officer, on behalf of the commission, shall determine whether the commission will hear the appeal. If the commission or the designated staff hearing officer decides to hear the appeal, the commission or the designated staff hearing officer shall notify the parties and their respective representatives in writing of the time and place of the hearing. The commission shall hold the hearing within forty-five days after the filing of the notice of appeal and, within seven days after the conclusion of the hearing, the commission shall issue its order affirming, modifying, or reversing the order issued under division (D) of this section. The commission shall notify the parties and their respective representatives in writing of the order. If the commission or the designated staff hearing officer determines not to hear the appeal, within fourteen days after the expiration of the period in which an appeal of the order of the staff hearing officer may be filed as provided in division (D) of this section, the commission or the designated staff hearing officer shall issue an order to that effect and notify the parties and their respective representatives in writing of that order.

Except as otherwise provided in this chapter and Chapters 4121., 4127., and 4131. of the Revised Code, any party may appeal an order issued under this division to the court pursuant to section 4123.512 of the Revised Code within sixty days after receipt of the order, subject to the limitations contained in that section.

(F) Every notice of an appeal from an order issued under divisions (B), (C), (D), and (E) of this section shall state the names of the claimant and employer, the number of the claim, the date of the decision appealed from, and the fact that the appellant appeals therefrom.

(G) All of the following apply to the proceedings under divisions (C), (D), and (E) of this section:

(1) The parties shall proceed promptly and without continuances except for good cause;

(2) The parties, in good faith, shall engage in the free exchange of information relevant to the claim prior to the conduct of a hearing according to the rules the commission adopts under section 4121.36 of the Revised Code;

(3) The administrator is a party and may appear and participate at all administrative proceedings on behalf of the state insurance fund. However, in cases in which the employer is represented, the administrator shall neither present arguments nor introduce testimony that is cumulative to that presented or introduced by the employer or the employer's representative. The administrator may file an appeal under this section on behalf of the state insurance fund; however, except in cases arising under section 4123.343 of the Revised Code, the administrator only may appeal questions of law or issues of fraud when the employer appears in person or by representative.

(H) Except as provided in section 4121.63 of the Revised Code and division (K) of this section, payments of compensation to a claimant or on behalf of a claimant as a result of any order issued under this chapter shall commence upon the earlier of the following:

(1) Fourteen days after the date the administrator issues an order under division (B) of this section, unless that order is appealed;

(2) The date when the employer has waived the right to appeal a decision issued under division (B) of this section;

(3) If no appeal of an order has been filed under this section or to a court under section 4123.512 of the Revised Code, the expiration of the time limitations for the filing of an appeal of an order;

(4) The date of receipt by the employer of an order of a district hearing officer, a staff hearing officer, or the industrial commission issued under division (C), (D), or (E) of this section.

(I) Except as otherwise provided in division (B) of section 4123.66 of the Revised Code, payments of medical benefits payable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code shall commence upon the earlier of the following:

(1) The date of the issuance of the staff hearing officer's order under division (D) of this section;

(2) The date of the final administrative or judicial determination.

(J) The administrator shall charge the compensation payments made in accordance with division (H) of this section or medical benefits payments made in accordance with division (I) of this section to an employer's experience immediately after the employer has exhausted the employer's administrative appeals as provided in this section or has waived the employer's right to an

administrative appeal under division (B) of this section, subject to the adjustment specified in division (H) of section 4123.512 of the Revised Code.

(K) Upon the final administrative or judicial determination under this section or section 4123.512 of the Revised Code of an appeal of an order to pay compensation, if a claimant is found to have received compensation pursuant to a prior order which is reversed upon subsequent appeal, the claimant's employer, if a self-insuring employer, or the bureau, shall withhold from any amount to which the claimant becomes entitled pursuant to any claim, past, present, or future, under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, the amount of previously paid compensation to the claimant which, due to reversal upon appeal, the claimant is not entitled, pursuant to the following criteria:

(1) No withholding for the first twelve weeks of temporary total disability compensation pursuant to section 4123.56 of the Revised Code shall be made;

(2) Forty per cent of all awards of compensation paid pursuant to sections 4123.56 and 4123.57 of the Revised Code, until the amount overpaid is refunded;

(3) Twenty-five per cent of any compensation paid pursuant to section 4123.58 of the Revised Code until the amount overpaid is refunded;

(4) If, pursuant to an appeal under section 4123.512 of the Revised Code, the court of appeals or the supreme court reverses the allowance of the claim, then no amount of any compensation will be withheld.

The administrator and self-insuring employers, as appropriate, are subject to the repayment schedule of this division only with respect to an order to pay compensation that was properly paid under a previous order, but which is subsequently reversed upon an administrative or judicial appeal. The administrator and self-insuring employers are not subject to, but may utilize, the repayment schedule of this division, or any other lawful means, to collect payment of compensation made to a person who was not entitled to the compensation due to fraud as determined by the administrator or the industrial commission.

(L) If a staff hearing officer or the commission fails to issue a decision or the commission fails to refuse to hear an appeal within the time periods required by this section, payments to a claimant shall cease until the staff hearing officer or commission issues a decision or hears the appeal, unless the failure was due to the fault or neglect of the employer or the employer agrees that the payments should continue for a longer period of time.

(M) Except as otherwise provided in this section or section 4123.522 of the Revised Code, no appeal is timely filed under this section unless the appeal is filed with the time limits set forth in this section.

(N) No person who is not an employee of the bureau or commission or who is not by law given access to the contents of a claims file shall have a file in the person's possession.

(O) Upon application of a party who resides in an area in which an emergency or disaster is declared, the industrial commission and hearing officers of the commission may waive the time

frame within which claims and appeals of claims set forth in this section must be filed upon a finding that the applicant was unable to comply with a filing deadline due to an emergency or a disaster.

As used in this division:

(1) "Emergency" means any occasion or instance for which the governor of Ohio or the president of the United States publicly declares an emergency and orders state or federal assistance to save lives and protect property, the public health and safety, or to lessen or avert the threat of a catastrophe.

(2) "Disaster" means any natural catastrophe or fire, flood, or explosion, regardless of the cause, that causes damage of sufficient magnitude that the governor of Ohio or the president of the United States, through a public declaration, orders state or federal assistance to alleviate damage, loss, hardship, or suffering that results from the occurrence.

Sec. 4123.512. (A) The claimant or the employer may appeal an order of the industrial commission made under division (E) of section 4123.511 of the Revised Code in any injury or occupational disease case, other than a decision as to the extent of disability to the court of common pleas of the county in which the injury was inflicted or in which the contract of employment was made if the injury occurred outside the state, or in which the contract of employment was made if the exposure occurred outside the state. If no common pleas court has jurisdiction for the purposes of an appeal by the use of the jurisdictional requirements described in this division, the appellant may use the venue provisions in the Rules of Civil Procedure to vest jurisdiction in a court. If the claim is for an occupational disease, the appeal shall be to the court of common pleas of the county in which the exposure which caused the disease occurred. Like appeal may be taken from an order of a staff hearing officer made under division (D) of section 4123.511 of the Revised Code from which the commission has refused to hear an appeal. Except as otherwise provided in this division, the appellant shall file the notice of appeal with a court of common pleas within sixty days after the date of the receipt of the order appealed from or the date of receipt of the order of the commission refusing to hear an appeal of a staff hearing officer's decision under division (D) of section 4123.511 of the Revised Code. Either the claimant or the employer may file a notice of an intent to settle the claim within thirty days after the date of the receipt of the order appealed from or of the order of the commission refusing to hear an appeal of a staff hearing officer's decision. The claimant or employer shall file notice of intent to settle with the administrator of workers' compensation, and the notice shall be served on the opposing party and the party's representative. The filing of the notice of intent to settle extends the time to file an appeal to one hundred fifty days, unless the opposing party files an objection to the notice of intent to settle within fourteen days after the date of the receipt of the notice of intent to settle. The party shall file the objection with the administrator, and the objection shall be served on the party that filed the notice of intent to settle and the party's representative. The filing of the notice of the appeal with the court is the only act required to perfect the appeal.

If an action has been commenced in a court of a county other than a court of a county having

jurisdiction over the action, the court, upon notice by any party or upon its own motion, shall transfer the action to a court of a county having jurisdiction.

Notwithstanding anything to the contrary in this section, if the commission determines under section 4123.522 of the Revised Code that an employee, employer, or their respective representatives have not received written notice of an order or decision which is appealable to a court under this section and which grants relief pursuant to section 4123.522 of the Revised Code, the party granted the relief has sixty days from receipt of the order under section 4123.522 of the Revised Code to file a notice of appeal under this section.

(B) The notice of appeal shall state the names of the administrator of workers' compensation, the claimant, and the employer; the number of the claim; the date of the order appealed from; and the fact that the appellant appeals therefrom.

The administrator, the claimant, and the employer shall be parties to the appeal and the court, upon the application of the commission, shall make the commission a party. The party filing the appeal shall serve a copy of the notice of appeal on the administrator at the central office of the bureau of workers' compensation in Columbus. The administrator shall notify the employer that if the employer fails to become an active party to the appeal, then the administrator may act on behalf of the employer and the results of the appeal could have an adverse effect upon the employer's premium rates or may result in a recovery from the employer if the employer is determined to be a noncomplying employer under section 4123.75 of the Revised Code.

(C) The attorney general or one or more of the attorney general's assistants or special counsel designated by the attorney general shall represent the administrator and the commission. In the event the attorney general or the attorney general's designated assistants or special counsel are absent, the administrator or the commission shall select one or more of the attorneys in the employ of the administrator or the commission as the administrator's attorney or the commission's attorney in the appeal. Any attorney so employed shall continue the representation during the entire period of the appeal and in all hearings thereof except where the continued representation becomes impractical.

(D) Upon receipt of notice of appeal, the clerk of courts shall provide notice to all parties who are appellees and to the commission.

The claimant shall, within thirty days after the filing of the notice of appeal, file a petition containing a statement of facts in ordinary and concise language showing a cause of action to participate or to continue to participate in the fund and setting forth the basis for the jurisdiction of the court over the action. Further pleadings shall be had in accordance with the Rules of Civil Procedure, provided that service of summons on such petition shall not be required and provided that the claimant may not dismiss the complaint without the employer's consent if the employer is the party that filed the notice of appeal to court pursuant to this section. The clerk of the court shall, upon receipt thereof, transmit by certified mail a copy thereof to each party named in the notice of appeal other than the claimant. Any party may file with the clerk prior to the trial of the action a deposition of any physician, certified nurse-midwife, clinical nurse specialist, or certified nurse

practitioner taken in accordance with the provisions of the Revised Code, which deposition may be read in the trial of the action even though the physician or nurse is a resident of or subject to service in the county in which the trial is had. The bureau of workers' compensation shall pay the cost of the deposition filed in court and of copies of the deposition for each party from the surplus fund and charge the costs thereof against the unsuccessful party if the claimant's right to participate or continue to participate is finally sustained or established in the appeal. In the event the deposition is taken and filed, the physician or nurse whose deposition is taken is not required to respond to any subpoena issued in the trial of the action. The court, or the jury under the instructions of the court, if a jury is demanded, shall determine the right of the claimant to participate or to continue to participate in the fund upon the evidence adduced at the hearing of the action.

(E) The court shall certify its decision to the commission and the certificate shall be entered in the records of the court. Appeals from the judgment are governed by the law applicable to the appeal of civil actions.

(F) The cost of any legal proceedings authorized by this section, including an attorney's fee to the claimant's attorney to be fixed by the trial judge, based upon the effort expended, in the event the claimant's right to participate or to continue to participate in the fund is established upon the final determination of an appeal, shall be taxed against the employer or the commission if the commission or the administrator rather than the employer contested the right of the claimant to participate in the fund. The attorney's fee shall not exceed five thousand dollars.

(G) If the finding of the court or the verdict of the jury is in favor of the claimant's right to participate in the fund, the commission and the administrator shall thereafter proceed in the matter of the claim as if the judgment were the decision of the commission, subject to the power of modification provided by section 4123.52 of the Revised Code.

(H)(1) An appeal from an order issued under division (E) of section 4123.511 of the Revised Code or any action filed in court in a case in which an award of compensation or medical benefits has been made shall not stay the payment of compensation or medical benefits under the award, or payment for subsequent periods of total disability or medical benefits during the pendency of the appeal. If, in a final administrative or judicial action, it is determined that payments of compensation or benefits, or both, made to or on behalf of a claimant should not have been made, the amount thereof shall be charged to the surplus fund account under division (B) of section 4123.34 of the Revised Code. In the event the employer is a state risk, the amount shall not be charged to the employer's experience, and the administrator shall adjust the employer's account accordingly. In the event the employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code. If an employer is a state risk and has paid an assessment for a violation of a specific safety requirement, and, in a final administrative or judicial action, it is determined that the employer did not violate the specific safety requirement, the administrator shall reimburse the employer from the surplus fund account under division (B) of section 4123.34 of the

Revised Code for the amount of the assessment the employer paid for the violation.

(2)(a) Notwithstanding a final determination that payments of benefits made to or on behalf of a claimant should not have been made, the administrator or self-insuring employer shall award payment of medical or vocational rehabilitation services submitted for payment after the date of the final determination if all of the following apply:

(i) The services were approved and were rendered by the provider in good faith prior to the date of the final determination.

(ii) The services were payable under division (I) of section 4123.511 of the Revised Code prior to the date of the final determination.

(iii) The request for payment is submitted within the time limit set forth in section 4123.52 of the Revised Code.

(b) Payments made under division (H)(1) of this section shall be charged to the surplus fund account under division (B) of section 4123.34 of the Revised Code. If the employer of the employee who is the subject of a claim described in division (H)(2)(a) of this section is a state fund employer, the payments made under that division shall not be charged to the employer's experience. If that employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code.

(c) Division (H)(2) of this section shall apply only to a claim under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code arising on or after July 29, 2011.

(3) A self-insuring employer may elect to pay compensation and benefits under this section directly to an employee or an employee's dependents by filing an application with the bureau of workers' compensation not more than one hundred eighty days and not less than ninety days before the first day of the employer's next six-month coverage period. If the self-insuring employer timely files the application, the application is effective on the first day of the employer's next six-month coverage period, provided that the administrator shall compute the employer's assessment for the surplus fund account due with respect to the period during which that application was filed without regard to the filing of the application. On and after the effective date of the employer's election, the self-insuring employer shall pay directly to an employee or to an employee's dependents compensation and benefits under this section regardless of the date of the injury or occupational disease, and the employer shall receive no money or credits from the surplus fund account on account of those payments and shall not be required to pay any amounts into the surplus fund account on account of this section. The election made under this division is irrevocable.

(I) All actions and proceedings under this section which are the subject of an appeal to the court of common pleas or the court of appeals shall be preferred over all other civil actions except election causes, irrespective of position on the calendar.

This section applies to all decisions of the commission or the administrator on November 2, 1959, and all claims filed thereafter are governed by sections 4123.511 and 4123.512 of the Revised

Code.

Any action pending in common pleas court or any other court on January 1, 1986, under this section is governed by former sections 4123.514, 4123.515, 4123.516, and 4123.519 and section 4123.522 of the Revised Code.

Sec. 4123.54. (A) Except as otherwise provided in this division or divisions (I) and (K) of this section, every employee, who is injured or who contracts an occupational disease, and the dependents of each employee who is killed, or dies as the result of an occupational disease contracted in the course of employment, wherever the injury has occurred or occupational disease has been contracted, is entitled to receive the compensation for loss sustained on account of the injury, occupational disease, or death, and the medical, nurse, and hospital services and medicines, and the amount of funeral expenses in case of death, as are provided by this chapter. The compensation and benefits shall be provided, as applicable, directly from the employee's self-insuring employer as provided in section 4123.35 of the Revised Code or from the state insurance fund. An employee or dependent is not entitled to receive compensation or benefits under this division if the employee's injury or occupational disease is either of the following:

(1) Purposely self-inflicted;

(2) Caused by the employee being intoxicated, under the influence of a controlled substance not prescribed by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or under the influence of marihuana if being intoxicated, under the influence of a controlled substance not prescribed by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or under the influence of marihuana was the proximate cause of the injury.

(B) For the purpose of this section, provided that an employer has posted written notice to employees that the results of, or the employee's refusal to submit to, any chemical test described under this division may affect the employee's eligibility for compensation and benefits pursuant to this chapter and Chapter 4121. of the Revised Code, there is a rebuttable presumption that an employee is intoxicated, under the influence of a controlled substance not prescribed by the employee's physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or under the influence of marihuana and that being intoxicated, under the influence of a controlled substance not prescribed by the employee's physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or under the influence of marihuana is the proximate cause of an injury under either of the following conditions:

(1) When any one or more of the following is true:

(a) The employee, through a qualifying chemical test administered within eight hours of an injury, is determined to have an alcohol concentration level equal to or in excess of the levels established in divisions (A)(1)(b) to (i) of section 4511.19 of the Revised Code.

(b) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have a controlled substance not prescribed by the employee's physician,

certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner or marihuana in the employee's system at a level equal to or in excess of the cutoff concentration level for the particular substance as provided in section 40.87 of Title 49 of the Code of Federal Regulations, 49 C.F.R. 40.87, as amended.

(c) The employee, through a qualifying chemical test administered within thirty-two hours of an injury, is determined to have barbiturates, benzodiazepines, or methadone in the employee's system that tests above levels established by laboratories certified by the United States department of health and human services.

(2) When the employee refuses to submit to a requested chemical test, on the condition that that employee is or was given notice that the refusal to submit to any chemical test described in division (B)(1) of this section may affect the employee's eligibility for compensation and benefits under this chapter and Chapter 4121. of the Revised Code.

(C)(1) For purposes of division (B) of this section, a chemical test is a qualifying chemical test if it is administered to an employee after an injury under at least one of the following conditions:

(a) When the employee's employer had reasonable cause to suspect that the employee may be intoxicated, under the influence of a controlled substance not prescribed by the employee's physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or under the influence of marihuana;

(b) At the request of a police officer pursuant to section 4511.191 of the Revised Code, and not at the request of the employee's employer;

(c) At the request of a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who is not employed by the employee's employer, and not at the request of the employee's employer.

(2) As used in division (C)(1)(a) of this section, "reasonable cause" means, but is not limited to, evidence that an employee is or was using alcohol, a controlled substance, or marihuana drawn from specific, objective facts and reasonable inferences drawn from these facts in light of experience and training. These facts and inferences may be based on, but are not limited to, any of the following:

(a) Observable phenomena, such as direct observation of use, possession, or distribution of alcohol, a controlled substance, or marihuana, or of the physical symptoms of being under the influence of alcohol, a controlled substance, or marihuana, such as but not limited to slurred speech; dilated pupils; odor of alcohol, a controlled substance, or marihuana; changes in affect; or dynamic mood swings;

(b) A pattern of abnormal conduct, erratic or aberrant behavior, or deteriorating work performance such as frequent absenteeism, excessive tardiness, or recurrent accidents, that appears to be related to the use of alcohol, a controlled substance, or marihuana, and does not appear to be attributable to other factors;

(c) The identification of an employee as the focus of a criminal investigation into

unauthorized possession, use, or trafficking of a controlled substance or marihuana;

(d) A report of use of alcohol, a controlled substance, or marihuana provided by a reliable and credible source;

(e) Repeated or flagrant violations of the safety or work rules of the employee's employer, that are determined by the employee's supervisor to pose a substantial risk of physical injury or property damage and that appear to be related to the use of alcohol, a controlled substance, or marihuana and that do not appear attributable to other factors.

(D) Nothing in this section shall be construed to affect the rights of an employer to test employees for alcohol or controlled substance abuse.

(E) For the purpose of this section, laboratories certified by the United States department of health and human services or laboratories that meet or exceed the standards of that department for laboratory certification shall be used for processing the test results of a qualifying chemical test.

(F) The written notice required by division (B) of this section shall be the same size or larger than the proof of workers' compensation coverage furnished by the bureau of workers' compensation and shall be posted by the employer in the same location as the proof of workers' compensation coverage or the certificate of self-insurance.

(G) If a condition that pre-existed an injury is substantially aggravated by the injury, and that substantial aggravation is documented by objective diagnostic findings, objective clinical findings, or objective test results, no compensation or benefits are payable because of the pre-existing condition once that condition has returned to a level that would have existed without the injury.

(H)(1) Whenever, with respect to an employee of an employer who is subject to and has complied with this chapter, there is possibility of conflict with respect to the application of workers' compensation laws because the contract of employment is entered into and all or some portion of the work is or is to be performed in a state or states other than Ohio, the employer and the employee may agree to be bound by the laws of this state or by the laws of some other state in which all or some portion of the work of the employee is to be performed. The agreement shall be in writing and shall be filed with the bureau of workers' compensation within ten days after it is executed and shall remain in force until terminated or modified by agreement of the parties similarly filed. If the agreement is to be bound by the laws of this state and the employer has complied with this chapter, then the employee is entitled to compensation and benefits regardless of where the injury occurs or the disease is contracted and the rights of the employee and the employee's dependents under the laws of this state are the exclusive remedy against the employer on account of injury, disease, or death in the course of and arising out of the employee's employment. If the agreement is to be bound by the laws of another state and the employer has complied with the laws of that state, the rights of the employee and the employee's dependents under the laws of that state are the exclusive remedy against the employer on account of injury, disease, or death in the course of and arising out of the employee's employment without regard to the place where the injury was sustained or the disease contracted. If an employer and an employee enter into an agreement under this division, the fact that

the employer and the employee entered into that agreement shall not be construed to change the status of an employee whose continued employment is subject to the will of the employer or the employee, unless the agreement contains a provision that expressly changes that status.

(2) If an employee or the employee's dependents receive an award of compensation or benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for the same injury, occupational disease, or death for which the employee or the employee's dependents previously pursued or otherwise elected to accept workers' compensation benefits and received a decision on the merits as defined in section 4123.542 of the Revised Code under the laws of another state or recovered damages under the laws of another state, the claim shall be disallowed and the administrator or any self-insuring employer, by any lawful means, may collect from the employee or the employee's dependents any of the following:

(a) The amount of compensation or benefits paid to or on behalf of the employee or the employee's dependents by the administrator or a self-insuring employer pursuant to this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for that award;

(b) Any interest, attorney's fees, and costs the administrator or the self-insuring employer incurs in collecting that payment.

(3) If an employee or the employee's dependents receive an award of compensation or benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code and subsequently pursue or otherwise elect to accept workers' compensation benefits or damages under the laws of another state for the same injury, occupational disease, or death the claim under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code shall be disallowed. The administrator or a self-insuring employer, by any lawful means, may collect from the employee or the employee's dependents or other-states' insurer any of the following:

(a) The amount of compensation or benefits paid to or on behalf of the employee or the employee's dependents by the administrator or the self-insuring employer pursuant to this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for that award;

(b) Any interest, costs, and attorney's fees the administrator or the self-insuring employer incurs in collecting that payment;

(c) Any costs incurred by an employer in contesting or responding to any claim filed by the employee or the employee's dependents for the same injury, occupational disease, or death that was filed after the original claim for which the employee or the employee's dependents received a decision on the merits as described in section 4123.542 of the Revised Code.

(4) If the employee's employer pays premiums into the state insurance fund, the administrator shall not charge the amount of compensation or benefits the administrator collects pursuant to division (H)(2) or (3) of this section to the employer's experience. If the administrator collects any costs incurred by an employer in contesting or responding to any claim pursuant to division (H)(2) or (3) of this section, the administrator shall forward the amount collected to that employer. If the employee's employer is a self-insuring employer, the self-insuring employer shall

deduct the amount of compensation or benefits the self-insuring employer collects pursuant to this division from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code.

(5) If an employee is a resident of a state other than this state and is insured under the workers' compensation law or similar laws of a state other than this state, the employee and the employee's dependents are not entitled to receive compensation or benefits under this chapter, on account of injury, disease, or death arising out of or in the course of employment while temporarily within this state, and the rights of the employee and the employee's dependents under the laws of the other state are the exclusive remedy against the employer on account of the injury, disease, or death.

(6) An employee, or the dependent of an employee, who elects to receive compensation and benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for a claim may not receive compensation and benefits under the workers' compensation laws of any state other than this state for that same claim. For each claim submitted by or on behalf of an employee, the administrator or, if the employee is employed by a self-insuring employer, the self-insuring employer, shall request the employee or the employee's dependent to sign an election that affirms the employee's or employee's dependent's acceptance of electing to receive compensation and benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code for that claim that also affirmatively waives and releases the employee's or the employee's dependent's right to file for and receive compensation and benefits under the laws of any state other than this state for that claim. The employee or employee's dependent shall sign the election form within twenty-eight days after the administrator or self-insuring employer submits the request or the administrator or self-insuring employer shall dismiss that claim.

In the event a workers' compensation claim has been filed in another jurisdiction on behalf of an employee or the dependents of an employee, and the employee or dependents subsequently elect to receive compensation, benefits, or both under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code, the employee or dependent shall withdraw or refuse acceptance of the workers' compensation claim filed in the other jurisdiction in order to pursue compensation or benefits under the laws of this state. If the employee or dependents were awarded workers' compensation benefits or had recovered damages under the laws of the other state, any compensation and benefits awarded under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code shall be paid only to the extent to which those payments exceed the amounts paid under the laws of the other state. If the employee or dependent fails to withdraw or to refuse acceptance of the workers' compensation claim in the other jurisdiction within twenty-eight days after a request made by the administrator or a self-insuring employer, the administrator or self-insuring employer shall dismiss the employee's or employee's dependents' claim made in this state.

(I) If an employee who is covered under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., is injured or contracts an occupational disease or dies as a result of an injury or occupational disease, and if that employee's or that

employee's dependents' claim for compensation or benefits for that injury, occupational disease, or death is subject to the jurisdiction of that act, the employee or the employee's dependents are not entitled to apply for and shall not receive compensation or benefits under this chapter and Chapter 4121. of the Revised Code. The rights of such an employee and the employee's dependents under the federal "Longshore and Harbor Workers' Compensation Act," 98 Stat. 1639, 33 U.S.C. 901 et seq., are the exclusive remedy against the employer for that injury, occupational disease, or death.

(J) Compensation or benefits are not payable to a claimant or a dependent during the period of confinement of the claimant or dependent in any state or federal correctional institution, or in any county jail in lieu of incarceration in a state or federal correctional institution, whether in this or any other state for conviction of violation of any state or federal criminal law.

(K) An employer, upon the approval of the administrator, may provide for workers' compensation coverage for the employer's employees who are professional athletes and coaches by submitting to the administrator proof of coverage under a league policy issued under the laws of another state under either of the following circumstances:

(1) The employer administers the payroll and workers' compensation insurance for a professional sports team subject to a collective bargaining agreement, and the collective bargaining agreement provides for the uniform administration of workers' compensation benefits and compensation for professional athletes.

(2) The employer is a professional sports league, or is a member team of a professional sports league, and all of the following apply:

(a) The professional sports league operates as a single entity, whereby all of the players and coaches of the sports league are employees of the sports league and not of the individual member teams.

(b) The professional sports league at all times maintains workers' compensation insurance that provides coverage for the players and coaches of the sports league.

(c) Each individual member team of the professional sports league, pursuant to the organizational or operating documents of the sports league, is obligated to the sports league to pay to the sports league any workers' compensation claims that are not covered by the workers' compensation insurance maintained by the sports league.

If the administrator approves the employer's proof of coverage submitted under division (K) of this section, a professional athlete or coach who is an employee of the employer and the dependents of the professional athlete or coach are not entitled to apply for and shall not receive compensation or benefits under this chapter and Chapter 4121. of the Revised Code. The rights of such an athlete or coach and the dependents of such an athlete or coach under the laws of the state where the policy was issued are the exclusive remedy against the employer for the athlete or coach if the athlete or coach suffers an injury or contracts an occupational disease in the course of employment, or for the dependents of the athlete or the coach if the athlete or coach is killed as a result of an injury or dies as a result of an occupational disease, regardless of the location where the

injury was suffered or the occupational disease was contracted.

Sec. 4123.56. (A) Except as provided in division (D) of this section, in the case of temporary disability, an employee shall receive sixty-six and two-thirds per cent of the employee's average weekly wage so long as such disability is total, not to exceed a maximum amount of weekly compensation which is equal to the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code, and not less than a minimum amount of compensation which is equal to thirty-three and one-third per cent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code unless the employee's wage is less than thirty-three and one-third per cent of the minimum statewide average weekly wage, in which event the employee shall receive compensation equal to the employee's full wages; provided that for the first twelve weeks of total disability the employee shall receive seventy-two per cent of the employee's full weekly wage, but not to exceed a maximum amount of weekly compensation which is equal to the lesser of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code or one hundred per cent of the employee's net take-home weekly wage. In the case of a self-insuring employer, payments shall be for a duration based upon the medical reports of the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner. If the employer disputes the attending physician's or attending nurse's report, payments may be terminated only upon application and hearing by a district hearing officer pursuant to division (C) of section 4123.511 of the Revised Code. Payments shall continue pending the determination of the matter, however payment shall not be made for the period when any employee has returned to work, when an employee's treating physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has made a written statement that the employee is capable of returning to the employee's former position of employment, when work within the physical capabilities of the employee is made available by the employer or another employer, or when the employee has reached the maximum medical improvement. Where the employee is capable of work activity, but the employee's employer is unable to offer the employee any employment, the employee shall register with the director of job and family services, who shall assist the employee in finding suitable employment. The termination of temporary total disability, whether by order or otherwise, does not preclude the commencement of temporary total disability at another point in time if the employee again becomes temporarily totally disabled.

After two hundred weeks of temporary total disability benefits, the bureau of workers' compensation may schedule the claimant for an examination for an evaluation to determine whether or not the temporary disability has become permanent. A self-insuring employer shall notify the bureau immediately after payment of two hundred weeks of temporary total disability. The self-insuring employer may request that the bureau schedule the claimant for an examination to determine whether the temporary disability has become permanent.

When the employee is awarded compensation for temporary total disability for a period for which the employee has received benefits under Chapter 4141. of the Revised Code, the bureau shall

pay an amount equal to the amount received from the award to the director of job and family services and the director shall credit the amount to the accounts of the employers to whose accounts the payment of benefits was charged or is chargeable to the extent it was charged or is chargeable.

If any compensation under this section has been paid for the same period or periods for which temporary nonoccupational accident and sickness insurance is or has been paid pursuant to an insurance policy or program to which the employer has made the entire contribution or payment for providing insurance or under a nonoccupational accident and sickness program fully funded by the employer, except as otherwise provided in this division compensation paid under this section for the period or periods shall be paid only to the extent by which the payment or payments exceeds the amount of the nonoccupational insurance or program paid or payable. Offset of the compensation shall be made only upon the prior order of the bureau or industrial commission or agreement of the claimant. If an employer provides supplemental sick leave benefits in addition to temporary total disability compensation paid under this section, and if the employer and an employee agree in writing to the payment of the supplemental sick leave benefits, temporary total disability benefits may be paid without an offset for those supplemental sick leave benefits.

As used in this division, "net take-home weekly wage" means the amount obtained by dividing an employee's total remuneration, as defined in section 4141.01 of the Revised Code, paid to or earned by the employee during the first four of the last five completed calendar quarters which immediately precede the first day of the employee's entitlement to benefits under this division, by the number of weeks during which the employee was paid or earned remuneration during those four quarters, less the amount of local, state, and federal income taxes deducted for each such week.

(B)(1) If an employee in a claim allowed under this chapter suffers a wage loss as a result of returning to employment other than the employee's former position of employment due to an injury or occupational disease, the employee shall receive compensation at sixty-six and two-thirds per cent of the difference between the employee's average weekly wage and the employee's present earnings not to exceed the statewide average weekly wage. The payments may continue for up to a maximum of two hundred weeks, but the payments shall be reduced by the corresponding number of weeks in which the employee receives payments pursuant to division (A)(2) of section 4121.67 of the Revised Code.

(2) If an employee in a claim allowed under this chapter suffers a wage loss as a result of being unable to find employment consistent with the employee's disability resulting from the employee's injury or occupational disease, the employee shall receive compensation at sixty-six and two-thirds per cent of the difference between the employee's average weekly wage and the employee's present earnings, not to exceed the statewide average weekly wage. The payments may continue for up to a maximum of fifty-two weeks. The first twenty-six weeks of payments under division (B)(2) of this section shall be in addition to the maximum of two hundred weeks of payments allowed under division (B)(1) of this section. If an employee in a claim allowed under this chapter receives compensation under division (B)(2) of this section in excess of twenty-six weeks,

the number of weeks of compensation allowable under division (B)(1) of this section shall be reduced by the corresponding number of weeks in excess of twenty-six, and up to fifty-two, that is allowable under division (B)(1) of this section.

(3) The number of weeks of wage loss payable to an employee under divisions (B)(1) and (2) of this section shall not exceed two hundred and twenty-six weeks in the aggregate.

(C) In the event an employee of a professional sports franchise domiciled in this state is disabled as the result of an injury or occupational disease, the total amount of payments made under a contract of hire or collective bargaining agreement to the employee during a period of disability is deemed an advanced payment of compensation payable under sections 4123.56 to 4123.58 of the Revised Code. The employer shall be reimbursed the total amount of the advanced payments out of any award of compensation made pursuant to sections 4123.56 to 4123.58 of the Revised Code.

(D) If an employee receives temporary total disability benefits pursuant to division (A) of this section and social security retirement benefits pursuant to the "Social Security Act," the weekly benefit amount under division (A) of this section shall not exceed sixty-six and two-thirds per cent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code.

(E) If an employee is eligible for compensation under division (A) of this section, but the employee's full weekly wage has not been determined at the time payments are to commence under division (H) of section 4123.511 of the Revised Code, the employee shall receive thirty-three and one-third per cent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code. On determination of the employee's full weekly wage, the compensation an employee receives shall be adjusted pursuant to division (A) of this section.

If the amount of compensation an employee receives under this division is greater than the adjusted amount the employee receives under division (A) of this section that is based on the employee's full weekly wage, the excess amount shall be recovered in the manner provided in division (K) of section 4123.511 of the Revised Code. If the amount of compensation an employee receives under this division is less than the adjusted amount the employee receives under that division that is based on the employee's full weekly wage, the employee shall receive the difference between those two amounts.

(F) If an employee is unable to work or suffers a wage loss as the direct result of an impairment arising from an injury or occupational disease, the employee is entitled to receive compensation under this section, provided the employee is otherwise qualified. If an employee is not working or has suffered a wage loss as the direct result of reasons unrelated to the allowed injury or occupational disease, the employee is not eligible to receive compensation under this section. It is the intent of the general assembly to supersede any previous judicial decision that applied the doctrine of voluntary abandonment to a claim brought under this section.

Sec. 4123.57. Partial disability compensation shall be paid as follows.

Except as provided in this section, not earlier than twenty-six weeks after the date of

termination of the latest period of payments under section 4123.56 of the Revised Code or twenty-six weeks after the termination of wages in lieu of those payments, or not earlier than twenty-six weeks after the date of the injury or contraction of an occupational disease in the absence of payments under section 4123.56 of the Revised Code or wages in lieu of those payments, the employee may file an application with the bureau of workers' compensation for the determination of the percentage of the employee's permanent partial disability resulting from an injury or occupational disease.

Whenever the application is filed, the bureau shall send a copy of the application to the employee's employer or the employer's representative and shall schedule the employee for a medical examination by the bureau medical section. The bureau shall send a copy of the report of the medical examination to the employee, the employer, and their representatives. Thereafter, the administrator of workers' compensation shall review the employee's claim file and make a tentative order as the evidence before the administrator at the time of the making of the order warrants. If the administrator determines that there is a conflict of evidence, the administrator shall send the application, along with the claimant's file, to the district hearing officer who shall set the application for a hearing.

If an employee fails to respond to an attempt to schedule a medical examination by the bureau medical section, or fails to attend a medical examination scheduled under this section without notice or explanation, the employee's application for a finding shall be dismissed without prejudice. The employee may refile the application. A dismissed application does not toll the continuing jurisdiction of the industrial commission under section 4123.52 of the Revised Code. The administrator shall adopt rules addressing the manner in which an employee will be notified of a possible dismissal and how an employee may refile an application for a determination.

The administrator shall notify the employee, the employer, and their representatives, in writing, of the tentative order and of the parties' right to request a hearing. Unless the employee, the employer, or their representative notifies the administrator, in writing, of an objection to the tentative order within twenty days after receipt of the notice thereof, the tentative order shall go into effect and the employee shall receive the compensation provided in the order. In no event shall there be a reconsideration of a tentative order issued under this division.

If the employee, the employer, or their representatives timely notify the administrator of an objection to the tentative order, the matter shall be referred to a district hearing officer who shall set the application for hearing with written notices to all interested persons. Upon referral to a district hearing officer, the employer may obtain a medical examination of the employee, pursuant to rules of the industrial commission.

(A) The district hearing officer, upon the application, shall determine the percentage of the employee's permanent disability, except as is subject to division (B) of this section, based upon that condition of the employee resulting from the injury or occupational disease and causing permanent impairment evidenced by medical or clinical findings reasonably demonstrable. The employee shall

receive sixty-six and two-thirds per cent of the employee's average weekly wage, but not more than a maximum of thirty-three and one-third per cent of the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code, per week regardless of the average weekly wage, for the number of weeks which equals the percentage of two hundred weeks. Except on application for reconsideration, review, or modification, which is filed within ten days after the date of receipt of the decision of the district hearing officer, in no instance shall the former award be modified unless it is found from medical or clinical findings that the condition of the claimant resulting from the injury has so progressed as to have increased the percentage of permanent partial disability. A staff hearing officer shall hear an application for reconsideration filed and the staff hearing officer's decision is final. An employee may file an application for a subsequent determination of the percentage of the employee's permanent disability. If such an application is filed, the bureau shall send a copy of the application to the employer or the employer's representative. No sooner than sixty days from the date of the mailing of the application to the employer or the employer's representative, the administrator shall review the application. The administrator may require a medical examination or medical review of the employee. The administrator shall issue a tentative order based upon the evidence before the administrator, provided that if the administrator requires a medical examination or medical review, the administrator shall not issue the tentative order until the completion of the examination or review.

The employer may obtain a medical examination of the employee and may submit medical evidence at any stage of the process up to a hearing before the district hearing officer, pursuant to rules of the commission. The administrator shall notify the employee, the employer, and their representatives, in writing, of the nature and amount of any tentative order issued on an application requesting a subsequent determination of the percentage of an employee's permanent disability. An employee, employer, or their representatives may object to the tentative order within twenty days after the receipt of the notice thereof. If no timely objection is made, the tentative order shall go into effect. In no event shall there be a reconsideration of a tentative order issued under this division. If an objection is timely made, the application for a subsequent determination shall be referred to a district hearing officer who shall set the application for a hearing with written notice to all interested persons. No application for subsequent percentage determinations on the same claim for injury or occupational disease shall be accepted for review by the district hearing officer unless supported by substantial evidence of new and changed circumstances developing since the time of the hearing on the original or last determination.

No award shall be made under this division based upon a percentage of disability which, when taken with all other percentages of permanent disability, exceeds one hundred per cent. If the percentage of the permanent disability of the employee equals or exceeds ninety per cent, compensation for permanent partial disability shall be paid for two hundred weeks.

Compensation payable under this division accrues and is payable to the employee from the date of last payment of compensation, or, in cases where no previous compensation has been paid,

from the date of the injury or the date of the diagnosis of the occupational disease.

When an award under this division has been made prior to the death of an employee, all unpaid installments accrued or to accrue under the provisions of the award are payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee, and if there are no children surviving, then to other dependents as the administrator determines.

(B) For purposes of this division, "payable per week" means the seven-consecutive-day period in which compensation is paid in installments according to the schedule associated with the applicable injury as set forth in this division.

Compensation paid in weekly installments according to the schedule described in this division may only be commuted to one or more lump sum payments pursuant to the procedure set forth in section 4123.64 of the Revised Code.

In cases included in the following schedule the compensation payable per week to the employee is the statewide average weekly wage as defined in division (C) of section 4123.62 of the Revised Code per week and shall be paid in installments according to the following schedule:

For the loss of a first finger, commonly known as a thumb, sixty weeks.

For the loss of a second finger, commonly called index finger, thirty-five weeks.

For the loss of a third finger, thirty weeks.

For the loss of a fourth finger, twenty weeks.

For the loss of a fifth finger, commonly known as the little finger, fifteen weeks.

The loss of a second, or distal, phalange of the thumb is considered equal to the loss of one half of such thumb; the loss of more than one half of such thumb is considered equal to the loss of the whole thumb.

The loss of the third, or distal, phalange of any finger is considered equal to the loss of one-third of the finger.

The loss of the middle, or second, phalange of any finger is considered equal to the loss of two-thirds of the finger.

The loss of more than the middle and distal phalanges of any finger is considered equal to the loss of the whole finger. In no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

For the loss of the metacarpal bone (bones of the palm) for the corresponding thumb, or fingers, add ten weeks to the number of weeks under this division.

For ankylosis (total stiffness of) or contractures (due to scars or injuries) which makes any of the fingers, thumbs, or parts of either useless, the same number of weeks apply to the members or parts thereof as given for the loss thereof.

If the claimant has suffered the loss of two or more fingers by amputation or ankylosis and the nature of the claimant's employment in the course of which the claimant was working at the time of the injury or occupational disease is such that the impairment or disability resulting from the loss of fingers, or loss of use of fingers, exceeds the normal impairment or disability resulting from the

loss of fingers, or loss of use of fingers, the administrator may take that fact into consideration and increase the award of compensation accordingly, but the award made shall not exceed the amount of compensation for loss of a hand.

For the loss of a hand, one hundred seventy-five weeks.

For the loss of an arm, two hundred twenty-five weeks.

For the loss of a great toe, thirty weeks.

For the loss of one of the toes other than the great toe, ten weeks.

The loss of more than two-thirds of any toe is considered equal to the loss of the whole toe.

The loss of less than two-thirds of any toe is considered no loss, except as to the great toe; the loss of the great toe up to the interphalangeal joint is co-equal to the loss of one-half of the great toe; the loss of the great toe beyond the interphalangeal joint is considered equal to the loss of the whole great toe.

For the loss of a foot, one hundred fifty weeks.

For the loss of a leg, two hundred weeks.

For the loss of the sight of an eye, one hundred twenty-five weeks.

For the permanent partial loss of sight of an eye, the portion of one hundred twenty-five weeks as the administrator in each case determines, based upon the percentage of vision actually lost as a result of the injury or occupational disease, but, in no case shall an award of compensation be made for less than twenty-five per cent loss of uncorrected vision. "Loss of uncorrected vision" means the percentage of vision actually lost as the result of the injury or occupational disease.

For the permanent and total loss of hearing of one ear, twenty-five weeks; but in no case shall an award of compensation be made for less than permanent and total loss of hearing of one ear.

For the permanent and total loss of hearing, one hundred twenty-five weeks; but, except pursuant to the next preceding paragraph, in no case shall an award of compensation be made for less than permanent and total loss of hearing.

In case an injury or occupational disease results in serious facial or head disfigurement which either impairs or may in the future impair the opportunities to secure or retain employment, the administrator shall make an award of compensation as it deems proper and equitable, in view of the nature of the disfigurement, and not to exceed the sum of ten thousand dollars. For the purpose of making the award, it is not material whether the employee is gainfully employed in any occupation or trade at the time of the administrator's determination.

When an award under this division has been made prior to the death of an employee all unpaid installments accrued or to accrue under the provisions of the award shall be payable to the surviving spouse, or if there is no surviving spouse, to the dependent children of the employee and if there are no such children, then to such dependents as the administrator determines.

When an employee has sustained the loss of a member by severance, but no award has been made on account thereof prior to the employee's death, the administrator shall make an award in accordance with this division for the loss which shall be payable to the surviving spouse, or if there

is no surviving spouse, to the dependent children of the employee and if there are no such children, then to such dependents as the administrator determines.

(C) Compensation for partial impairment under divisions (A) and (B) of this section is in addition to the compensation paid the employee pursuant to section 4123.56 of the Revised Code. A claimant may receive compensation under divisions (A) and (B) of this section.

In all cases arising under division (B) of this section, if it is determined by any one of the following: (1) the amputee clinic at University hospital, Ohio state university; (2) the opportunities for Ohioans with disabilities agency; (3) an amputee clinic or prescribing physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner approved by the administrator or the administrator's designee, that an injured or disabled employee is in need of an artificial appliance, or in need of a repair thereof, regardless of whether the appliance or its repair will be serviceable in the vocational rehabilitation of the injured employee, and regardless of whether the employee has returned to or can ever again return to any gainful employment, the bureau shall pay the cost of the artificial appliance or its repair out of the surplus created by division (B) of section 4123.34 of the Revised Code.

In those cases where an opportunities for Ohioans with disabilities agency's recommendation that an injured or disabled employee is in need of an artificial appliance would conflict with their state plan, adopted pursuant to the "Rehabilitation Act of 1973," 87 Stat. 355, 29 U.S.C.A. 701, the administrator or the administrator's designee or the bureau may obtain a recommendation from an amputee clinic or prescribing physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner that they determine appropriate.

(D) If an employee of a state fund employer makes application for a finding and the administrator finds that the employee has contracted silicosis as defined in division (Y), or coal miners' pneumoconiosis as defined in division (Z), or asbestosis as defined in division (BB) of section 4123.68 of the Revised Code, and that a change of such employee's occupation is medically advisable in order to decrease substantially further exposure to silica dust, asbestos, or coal dust and if the employee, after the finding, has changed or shall change the employee's occupation to an occupation in which the exposure to silica dust, asbestos, or coal dust is substantially decreased, the administrator shall allow to the employee an amount equal to fifty per cent of the statewide average weekly wage per week for a period of thirty weeks, commencing as of the date of the discontinuance or change, and for a period of one hundred weeks immediately following the expiration of the period of thirty weeks, the employee shall receive sixty-six and two-thirds per cent of the loss of wages resulting directly and solely from the change of occupation but not to exceed a maximum of an amount equal to fifty per cent of the statewide average weekly wage per week. No such employee is entitled to receive more than one allowance on account of discontinuance of employment or change of occupation and benefits shall cease for any period during which the employee is employed in an occupation in which the exposure to silica dust, asbestos, or coal dust is not substantially less than the exposure in the occupation in which the employee was formerly employed or for any period

during which the employee may be entitled to receive compensation or benefits under section 4123.68 of the Revised Code on account of disability from silicosis, asbestosis, or coal miners' pneumoconiosis. An award for change of occupation for a coal miner who has contracted coal miners' pneumoconiosis may be granted under this division even though the coal miner continues employment with the same employer, so long as the coal miner's employment subsequent to the change is such that the coal miner's exposure to coal dust is substantially decreased and a change of occupation is certified by the claimant as permanent. The administrator may accord to the employee medical and other benefits in accordance with section 4123.66 of the Revised Code.

(E) If a firefighter or police officer makes application for a finding and the administrator finds that the firefighter or police officer has contracted a cardiovascular and pulmonary disease as defined in division (W) of section 4123.68 of the Revised Code, and that a change of the firefighter's or police officer's occupation is medically advisable in order to decrease substantially further exposure to smoke, toxic gases, chemical fumes, and other toxic vapors, and if the firefighter, or police officer, after the finding, has changed or changes occupation to an occupation in which the exposure to smoke, toxic gases, chemical fumes, and other toxic vapors is substantially decreased, the administrator shall allow to the firefighter or police officer an amount equal to fifty per cent of the statewide average weekly wage per week for a period of thirty weeks, commencing as of the date of the discontinuance or change, and for a period of seventy-five weeks immediately following the expiration of the period of thirty weeks the administrator shall allow the firefighter or police officer sixty-six and two-thirds per cent of the loss of wages resulting directly and solely from the change of occupation but not to exceed a maximum of an amount equal to fifty per cent of the statewide average weekly wage per week. No such firefighter or police officer is entitled to receive more than one allowance on account of discontinuance of employment or change of occupation and benefits shall cease for any period during which the firefighter or police officer is employed in an occupation in which the exposure to smoke, toxic gases, chemical fumes, and other toxic vapors is not substantially less than the exposure in the occupation in which the firefighter or police officer was formerly employed or for any period during which the firefighter or police officer may be entitled to receive compensation or benefits under section 4123.68 of the Revised Code on account of disability from a cardiovascular and pulmonary disease. The administrator may accord to the firefighter or police officer medical and other benefits in accordance with section 4123.66 of the Revised Code.

(F) An order issued under this section is appealable pursuant to section 4123.511 of the Revised Code but is not appealable to court under section 4123.512 of the Revised Code.

Sec. 4123.651. ~~(A)-(A)(1)~~ The employer of a claimant who is injured or disabled in the course of the claimant's employment may require, without the approval of the administrator or the industrial commission, that the claimant be examined by ~~a physician~~ any of the following of the employer's choice one time ~~upon~~:

(a) A physician;

(b) A certified nurse midwife;

(c) A clinical nurse specialist;

(d) A certified nurse practitioner.

(2) The examination described in division (A)(1) of this section shall be for the purpose of any issue asserted by the employee or a physician-any of the practitioners listed in divisions (A)(1) (a) to (d) of this section of the employee's choice or for the purpose of any issue which is to be considered by the commission. ~~Any~~

(3) Any further requests for medical examinations shall be made to the commission, which shall consider and rule on the request. The employer shall pay the cost of any examinations initiated by the employer.

(B) The bureau of workers' compensation shall prepare or adopt a form for the release of medical information, records, and reports relative to the issues necessary for the administration of a claim under this chapter. The claimant promptly shall provide a current signed form, or an equivalent form such as the standard form under section 3798.10 of the Revised Code, for the release of the information, records, and reports when requested by the employer. The employer promptly shall provide copies of all medical information, records, and reports to the bureau and to the claimant or the claimant's representative upon request.

Medical information, records, and reports shall be related causally or historically to physical, psychological, or psychiatric injuries relevant to the claimant's workers' compensation claim.

(C) If, without good cause, an employee refuses to submit to any examination scheduled under this section or refuses to release or execute a release for any medical information, record, or report that is required to be released under this section and involves an issue pertinent to the condition alleged in the claim, the employee's right to have the employee's claim for compensation or benefits considered, if the employee's claim is pending before the administrator, commission, or a district or staff hearing officer, or to receive any payment for compensation or benefits previously granted, is suspended during the period of refusal.

(D) No bureau or commission employee shall alter any medical report obtained from a health care provider the bureau or commission has selected or cause or request the health care provider to alter or change a report. The bureau and commission shall make any request for clarification of a health care provider's report in writing and shall provide a copy of the request to the affected parties and their representatives at the time of making the request.

Sec. 4123.71. Every physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner in this state attending on or called in to visit a patient whom the physician or nurse believes to have an occupational disease as defined in section 4123.68 of the Revised Code shall, within forty-eight hours from the time of making such diagnosis, send to the bureau of workers' compensation a report stating:

(A) Name, address, and occupation of patient;

(B) Name and address of business in which employed;

(C) Nature of disease;

(D) Name and address of employer of patient;

(E) Such other information as is reasonably required by the bureau.

The reports shall be made on blanks to be furnished by the bureau. A physician or nurse who sends the report within the time stated to the bureau is in compliance with this section.

Reports made under this section shall not be evidence of the facts therein stated in any action arising out of a disease therein reported.

The bureau shall, within twenty-four hours after the receipt of the report, send a copy thereof to the employer of the patient named in the report.

Sec. 4123.84. (A) In all cases of injury or death, claims for compensation or benefits for the specific part or parts of the body injured shall be forever barred unless, within one year after the injury or death:

(1) Written or facsimile notice of the specific part or parts of the body claimed to have been injured has been made to the industrial commission or the bureau of workers' compensation;

(2) The employer, with knowledge of a claimed compensable injury or occupational disease, has paid wages in lieu of compensation for total disability;

(3) In the event the employer is a self-insuring employer, one of the following has occurred:

(a) Written or facsimile notice of the specific part or parts of the body claimed to have been injured has been given to the commission or bureau or the employer has furnished treatment by a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner in the employ of an employer, provided, however, that the furnishing of such treatment shall not constitute a recognition of a claim as compensable, but shall do no more than satisfy the requirements of this section;

(b) Compensation or benefits have been paid or furnished equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code.

(4) Written or facsimile notice of death has been given to the commission or bureau.

(B) The bureau shall provide printed notices quoting in full division (A) of this section, and every self-insuring employer shall post and maintain at all times one or more of the notices in conspicuous places in the workshop or places of employment.

(C) The commission has continuing jurisdiction as set forth in section 4123.52 of the Revised Code over a claim which meets the requirement of this section, including jurisdiction to award compensation or benefits for loss or impairment of bodily functions developing in a part or parts of the body not specified pursuant to division (A)(1) of this section, if the commission finds that the loss or impairment of bodily functions was due to and a result of or a residual of the injury to one of the parts of the body set forth in the written notice filed pursuant to division (A)(1) of this section.

(D) Any claim pending before the administrator, the commission, or a court on December 11, 1967, in which the remedy is affected by this section is governed by this section.

(E) Notwithstanding the requirement that the notice required to be given to the bureau,

commission, or employer under this section is to be in writing or facsimile, the bureau may accept, assign a claim number, and process a claim when notice is provided verbally over the telephone. Immediately upon receipt of notice provided verbally over the telephone, the bureau shall send a written or facsimile notice to the employer of the bureau's receipt of the verbal notice. Within fifteen days after receipt of the bureau's written or facsimile notice, the employer may in writing or facsimile either verify or not verify the verbal notice. If the bureau does not receive the written or facsimile notification from the employer or receives a written or facsimile notification verifying the verbal notice within such time period, the claim is validly filed and such verbal notice tolls the statute of limitations in regard to the claim filed and is considered to meet the requirements of written or facsimile notice required by this section.

(F) As used in division (A)(3)(b) of this section, "benefits" means payments by a self-insuring employer to, or on behalf of, an employee for any of the following: a hospital bill; a medical bill to a licensed physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or hospital; or an orthopedic or prosthetic device.

Sec. 4123.85. In all cases of occupational disease, or death resulting from occupational disease, claims for compensation or benefits are forever barred unless, within one year after the disability due to the disease began, or within such longer period as does not exceed six months after diagnosis of the occupational disease by a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner or within one year after death occurs, application is made to the industrial commission or the bureau of workers' compensation or to the employer if the employer is a self-insuring employer.

Sec. 4506.07. (A) An applicant for a commercial driver's license, restricted commercial driver's license, or a commercial driver's license temporary instruction permit, or a duplicate of such a license or permit, shall submit an application upon a form approved and furnished by the registrar of motor vehicles. Except as provided in section 4506.24 of the Revised Code in regard to a restricted commercial driver's license, the applicant shall sign the application which shall contain the following information:

(1) The applicant's name, date of birth, social security account number, sex, general description including height, weight, and color of hair and eyes, current residence, duration of residence in this state, state of domicile, country of citizenship, and occupation;

(2) Whether the applicant previously has been licensed to operate a commercial motor vehicle or any other type of motor vehicle in another state or a foreign jurisdiction and, if so, when, by what state, and whether the license or driving privileges currently are suspended or revoked in any jurisdiction, or the applicant otherwise has been disqualified from operating a commercial motor vehicle, or is subject to an out-of-service order issued under this chapter or any similar law of another state or a foreign jurisdiction and, if so, the date of, locations involved, and reason for the suspension, revocation, disqualification, or out-of-service order;

(3) Whether the applicant has any physical or mental disability or disease that prevents the

applicant from exercising reasonable and ordinary control over a motor vehicle while operating it upon a highway or is or has been subject to any condition resulting in episodic impairment of consciousness or loss of muscular control and, if so, the nature and extent of the disability, disease, or condition, and the names and addresses of the physicians, certified nurse-midwives if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialists, or certified nurse practitioners attending the applicant;

(4) Whether the applicant has obtained a medical examiner's certificate as required by this chapter and, beginning January 30, 2012, the applicant, prior to or at the time of applying, has self-certified to the registrar the applicable status of the applicant under division (A)(1) of section 4506.10 of the Revised Code;

(5) Whether the applicant has pending a citation for violation of any motor vehicle law or ordinance except a parking violation and, if so, a description of the citation, the court having jurisdiction of the offense, and the date when the offense occurred;

(6) If an applicant has not certified the applicant's willingness to make an anatomical gift under section 2108.05 of the Revised Code, whether the applicant wishes to certify willingness to make such an anatomical gift, which shall be given no consideration in the issuance of a license;

(7) Whether the applicant has executed a valid durable power of attorney for health care pursuant to sections 1337.11 to 1337.17 of the Revised Code or has executed a declaration governing the use or continuation, or the withholding or withdrawal, of life-sustaining treatment pursuant to sections 2133.01 to 2133.15 of the Revised Code and, if the applicant has executed either type of instrument, whether the applicant wishes the license issued to indicate that the applicant has executed the instrument;

(8) Whether the applicant is a veteran, active duty, or reservist of the armed forces of the United States and, if the applicant is such, whether the applicant wishes the license issued to indicate that the applicant is a veteran, active duty, or reservist of the armed forces of the United States by a military designation on the license.

(B) Every applicant shall certify, on a form approved and furnished by the registrar, all of the following:

(1) That the motor vehicle in which the applicant intends to take the driving skills test is representative of the type of motor vehicle that the applicant expects to operate as a driver;

(2) That the applicant is not subject to any disqualification or out-of-service order, or license suspension, revocation, or cancellation, under the laws of this state, of another state, or of a foreign jurisdiction and does not have more than one driver's license issued by this or another state or a foreign jurisdiction;

(3) Any additional information, certification, or evidence that the registrar requires by rule in order to ensure that the issuance of a commercial driver's license or commercial driver's license temporary instruction permit to the applicant is in compliance with the law of this state and with federal law.

(C) Every applicant shall execute a form, approved and furnished by the registrar, under which the applicant consents to the release by the registrar of information from the applicant's driving record.

(D) The registrar or a deputy registrar, in accordance with section 3503.11 of the Revised Code, shall register as an elector any applicant for a commercial driver's license or for a renewal or duplicate of such a license under this chapter, if the applicant is eligible and wishes to be registered as an elector. The decision of an applicant whether to register as an elector shall be given no consideration in the decision of whether to issue the applicant a license or a renewal or duplicate.

(E) The registrar or a deputy registrar, in accordance with section 3503.11 of the Revised Code, shall offer the opportunity of completing a notice of change of residence or change of name to any applicant for a commercial driver's license or for a renewal or duplicate of such a license who is a resident of this state, if the applicant is a registered elector who has changed the applicant's residence or name and has not filed such a notice.

(F) In considering any application submitted pursuant to this section, the bureau of motor vehicles may conduct any inquiries necessary to ensure that issuance or renewal of a commercial driver's license would not violate any provision of the Revised Code or federal law.

(G) In addition to any other information it contains, the form approved and furnished by the registrar of motor vehicles for an application for a commercial driver's license, restricted commercial driver's license, or a commercial driver's license temporary instruction permit or an application for a duplicate of such a license or permit shall inform applicants that the applicant must present a copy of the applicant's DD-214 or an equivalent document in order to qualify to have the license, or permit, or duplicate indicate that the applicant is a veteran, active duty, or reservist of the armed forces of the United States based on a request made pursuant to division (A)(8) of this section.

Sec. 4507.06. (A)(1) Every application for a driver's license, motorcycle operator's license or endorsement, or motor-driven cycle or motor scooter license or endorsement, or duplicate of any such license or endorsement, shall be made upon the approved form furnished by the registrar of motor vehicles and shall be signed by the applicant.

Every application shall state the following:

(a) The applicant's name, date of birth, social security number if such has been assigned, sex, general description, including height, weight, color of hair, and eyes, residence address, including county of residence, duration of residence in this state, and country of citizenship;

(b) Whether the applicant previously has been licensed as an operator, chauffeur, driver, commercial driver, or motorcycle operator and, if so, when, by what state, and whether such license is suspended or canceled at the present time and, if so, the date of and reason for the suspension or cancellation;

(c) Whether the applicant is now or ever has been afflicted with epilepsy, or whether the applicant now has any physical or mental disability or disease and, if so, the nature and extent of the disability or disease, giving the names and addresses of physicians, certified nurse-midwives if

authorized as described in section 4723.438 of the Revised Code, clinical nurse specialists, or certified nurse practitioners then or previously in attendance upon the applicant;

(d) Whether an applicant for a duplicate driver's license, duplicate license containing a motorcycle operator endorsement, or duplicate license containing a motor-driven cycle or motor scooter endorsement has pending a citation for violation of any motor vehicle law or ordinance, a description of any such citation pending, and the date of the citation;

(e) If an applicant has not certified the applicant's willingness to make an anatomical gift under section 2108.05 of the Revised Code, whether the applicant wishes to certify willingness to make such an anatomical gift, which shall be given no consideration in the issuance of a license or endorsement;

(f) Whether the applicant has executed a valid durable power of attorney for health care pursuant to sections 1337.11 to 1337.17 of the Revised Code or has executed a declaration governing the use or continuation, or the withholding or withdrawal, of life-sustaining treatment pursuant to sections 2133.01 to 2133.15 of the Revised Code and, if the applicant has executed either type of instrument, whether the applicant wishes the applicant's license to indicate that the applicant has executed the instrument;

(g) Whether the applicant is a veteran, active duty, or reservist of the armed forces of the United States and, if the applicant is such, whether the applicant wishes the applicant's license to indicate that the applicant is a veteran, active duty, or reservist of the armed forces of the United States by a military designation on the license.

(2) Every applicant for a driver's license applying in person at a deputy registrar office shall be photographed at the time the application for the license is made. The application shall state any additional information that the registrar requires.

(B) The registrar or a deputy registrar, in accordance with section 3503.11 of the Revised Code, shall register as an elector any person who applies for a license or endorsement under division (A) of this section, or for a renewal or duplicate of the license or endorsement, if the applicant is eligible and wishes to be registered as an elector. The decision of an applicant whether to register as an elector shall be given no consideration in the decision of whether to issue the applicant a license or endorsement, or a renewal or duplicate.

(C) The registrar or a deputy registrar, in accordance with section 3503.11 of the Revised Code, shall offer the opportunity of completing a notice of change of residence or change of name to any applicant for a driver's license or endorsement under division (A) of this section, or for a renewal or duplicate of the license or endorsement, if the applicant is a registered elector who has changed the applicant's residence or name and has not filed such a notice.

(D) In addition to any other information it contains, the approved form furnished by the registrar of motor vehicles for an application for a license or endorsement or an application for a duplicate of any such license or endorsement shall inform applicants that the applicant must present a copy of the applicant's DD-214 or an equivalent document in order to qualify to have the license or

duplicate indicate that the applicant is a veteran, active duty, or reservist of the armed forces of the United States based on a request made pursuant to division (A)(1)(g) of this section.

Sec. 4507.08. (A) No probationary license shall be issued to any person under the age of eighteen who has been adjudicated an unruly or delinquent child or a juvenile traffic offender for having committed any act that if committed by an adult would be a drug abuse offense, as defined in section 2925.01 of the Revised Code, a violation of division (B) of section 2917.11, or a violation of division (A) of section 4511.19 of the Revised Code, unless the person has been required by the court to attend a drug abuse or alcohol abuse education, intervention, or treatment program specified by the court and has satisfactorily completed the program.

(B) No temporary instruction permit or driver's license shall be issued to any person whose license has been suspended, during the period for which the license was suspended, nor to any person whose license has been canceled, under Chapter 4510. or any other provision of the Revised Code.

(C) No temporary instruction permit or driver's license shall be issued to any person whose commercial driver's license is suspended under Chapter 4510. or any other provision of the Revised Code during the period of the suspension.

No temporary instruction permit or driver's license shall be issued to any person when issuance is prohibited by division (A) of section 4507.091 of the Revised Code.

(D) No temporary instruction permit or driver's license shall be issued to, or retained by, any of the following persons:

(1) Any person who has alcoholism, or is addicted to the use of controlled substances to the extent that the use constitutes an impairment to the person's ability to operate a motor vehicle with the required degree of safety;

(2) Any person who is under the age of eighteen and has been adjudicated an unruly or delinquent child or a juvenile traffic offender for having committed any act that if committed by an adult would be a drug abuse offense, as defined in section 2925.01 of the Revised Code, a violation of division (B) of section 2917.11, or a violation of division (A) of section 4511.19 of the Revised Code, unless the person has been required by the court to attend a drug abuse or alcohol abuse education, intervention, or treatment program specified by the court and has satisfactorily completed the program;

(3) Any person who, in the opinion of the registrar, has a physical or mental disability or disease that prevents the person from exercising reasonable and ordinary control over a motor vehicle while operating the vehicle upon the highways, except that a restricted license effective for six months may be issued to any person otherwise qualified who is or has been subject to any condition resulting in episodic impairment of consciousness or loss of muscular control and whose condition, in the opinion of the registrar, is dormant or is sufficiently under medical control that the person is capable of exercising reasonable and ordinary control over a motor vehicle. A restricted license effective for six months shall be issued to any person who otherwise is qualified and who is

subject to any condition that causes episodic impairment of consciousness or a loss of muscular control if the person presents a statement from a licensed physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner that the person's condition is under effective medical control and the period of time for which the control has been continuously maintained, unless, thereafter, a medical examination is ordered and, pursuant thereto, cause for denial is found.

A person to whom a six-month restricted license has been issued shall give notice of the person's medical condition to the registrar on forms provided by the registrar and signed by the licensee's physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner. The notice shall be sent to the registrar six months after the issuance of the license. Subsequent restricted licenses issued to the same individual shall be effective for six months.

(4) Any person who is unable to understand highway warnings or traffic signs or directions given in the English language;

(5) Any person making an application whose driver's license or driving privileges are under cancellation, revocation, or suspension in the jurisdiction where issued or any other jurisdiction, until the expiration of one year after the license was canceled or revoked or until the period of suspension ends. Any person whose application is denied under this division may file a petition in the municipal court or county court in whose jurisdiction the person resides agreeing to pay the cost of the proceedings and alleging that the conduct involved in the offense that resulted in suspension, cancellation, or revocation in the foreign jurisdiction would not have resulted in a suspension, cancellation, or revocation had the offense occurred in this state. If the petition is granted, the petitioner shall notify the registrar by a certified copy of the court's findings and a license shall not be denied under this division.

(6) Any person who is under a class one or two suspension imposed for a violation of section 2903.01, 2903.02, 2903.04, 2903.06, 2903.08, 2903.11, 2921.331, or 2923.02 of the Revised Code or whose driver's or commercial driver's license or permit was permanently revoked prior to January 1, 2004, for a substantially equivalent violation pursuant to section 4507.16 of the Revised Code;

(7) Any person who is not a resident or temporary resident of this state.

(E) No person whose driver's license or permit has been suspended under Chapter 4510. of the Revised Code or any other provision of the Revised Code shall have driving privileges reinstated if the registrar determines that a warrant has been issued in this state or any other state for the person's arrest and that warrant is an active warrant.

Sec. 4507.081. (A) Upon the expiration of a restricted license issued under division (D)(3) of section 4507.08 of the Revised Code and submission of a statement as provided in division (C) of this section, the registrar of motor vehicles may issue a driver's license to the person to whom the restricted license was issued. A driver's license issued under this section, unless otherwise suspended or canceled, shall be effective for one year.

(B) A driver's license issued under this section may be renewed annually, for no more than

three consecutive years, whenever the person to whom the license has been issued submits to the registrar no sooner than thirty days prior to the expiration date of the license or renewal thereof, a statement as provided in division (C) of this section. A renewal of a driver's license, unless the license is otherwise suspended or canceled, shall be effective for one year following the expiration date of the license or renewal thereof.

(C) No person may be issued a driver's license under this section, and no such driver's license may be renewed, unless the person presents a signed statement from a licensed physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner that the person's condition either is dormant or is under effective medical control, that the control has been maintained continuously for at least one year prior to the date on which application for the license is made, and that, if continued medication is prescribed to control the condition, the person may be depended upon to take the medication.

The statement shall be made on a form provided by the registrar and shall contain any other information the registrar considers necessary.

(D) Whenever the registrar receives a statement indicating that the condition of a person to whom a driver's license has been issued under this section no longer is dormant or under effective medical control, the registrar shall cancel the person's driver's license.

(E) Nothing in this section shall require a person submitting a signed statement from a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to obtain a medical examination prior to the submission of the statement.

(F) Any person whose driver's license has been canceled under this section may apply for a subsequent restricted license according to the provisions of section 4507.08 of the Revised Code.

Sec. 4507.141. (A) Any hearing-impaired person may apply to the registrar of motor vehicles for an identification card identifying the person as hearing-impaired. The application for a hearing-impaired identification card shall be accompanied by a statement, signed statement from by the applicant's personal physician, certified nurse-midwife if authorized as described in section 4723.438 of the Revised Code, clinical nurse specialist, or certified nurse practitioner, certifying that the applicant is hearing-impaired. Upon receipt of the application ~~for the identification card and the signed statement from the applicant's personal physician~~, and upon presentation by the applicant of the applicant's driver's or commercial driver's license or motorcycle operator's license, the registrar shall issue the applicant an identification card. A hearing-impaired person may also apply for a hearing-impaired identification card at the time the person applies for a driver's or commercial driver's license or motorcycle operator's license or endorsement. Every hearing-impaired identification card shall expire on the same date that the cardholder's driver's or commercial driver's license or motorcycle operator's license expires.

(B) The hearing-impaired identification card shall be rectangular in shape, approximately the same size as an average motor vehicle sun visor, as determined by the registrar, to enable the identification card to be attached to a sun visor in a motor vehicle. The identification card shall

contain the heading "Identification Card for the Hearing-impaired Driver" in boldface type, the name and signature of the hearing-impaired person to whom it is issued, an identifying number, and instructions on the actions the hearing-impaired person should take and the actions the person should refrain from taking in the event the person is stopped by a law enforcement officer while operating the motor vehicle. The registrar shall determine the preferred manner in which a hearing-impaired motorcycle operator should carry or display the hearing-impaired identification card, and the color and composition of, and any other information to be included on, the identification card.

(C) As used in this section, "hearing-impaired" means a hearing loss of forty decibels or more in one or both ears.

Sec. 4507.30. No person shall do any of the following:

(A) Display, or cause or permit to be displayed, or possess any identification card, driver's or commercial driver's license, temporary instruction permit, or commercial driver's license temporary instruction permit knowing the same to be fictitious, or to have been canceled, suspended, or altered;

(B) Lend to a person not entitled thereto, or knowingly permit a person not entitled thereto to use any identification card, driver's or commercial driver's license, temporary instruction permit, or commercial driver's license temporary instruction permit issued to the person so lending or permitting the use thereof;

(C) Display, or represent as one's own, any identification card, driver's or commercial driver's license, temporary instruction permit, or commercial driver's license temporary instruction permit not issued to the person so displaying the same;

(D) Fail to surrender to the registrar of motor vehicles, upon the registrar's demand, any identification card, driver's or commercial driver's license, temporary instruction permit, or commercial driver's license temporary instruction permit that has been suspended or canceled;

(E) In any application for an identification card, driver's or commercial driver's license, temporary instruction permit, or commercial driver's license temporary instruction permit, or any renewal, reprint, or duplicate thereof, knowingly conceal a material fact, or present any ~~physician's~~ statement required under section 4507.08 or 4507.081 of the Revised Code when knowing the same to be false or fictitious.

(F) Whoever violates any division of this section is guilty of a misdemeanor of the first degree.

Sec. 4511.81. (A) When any child who is in either or both of the following categories is being transported in a motor vehicle, other than a taxicab or public safety vehicle as defined in section 4511.01 of the Revised Code, that is required by the United States department of transportation to be equipped with seat belts at the time of manufacture or assembly, the operator of the motor vehicle shall have the child properly secured in accordance with the manufacturer's instructions in a child restraint system that meets federal motor vehicle safety standards:

(1) A child who is less than four years of age;

(2) A child who weighs less than forty pounds.

(B) When any child who is in either or both of the following categories is being transported in a motor vehicle, other than a taxicab, that is owned, leased, or otherwise under the control of a nursery school or child care center, the operator of the motor vehicle shall have the child properly secured in accordance with the manufacturer's instructions in a child restraint system that meets federal motor vehicle safety standards:

- (1) A child who is less than four years of age;
- (2) A child who weighs less than forty pounds.

(C) When any child who is less than eight years of age and less than four feet nine inches in height, who is not required by division (A) or (B) of this section to be secured in a child restraint system, is being transported in a motor vehicle, other than a taxicab or public safety vehicle as defined in section 4511.01 of the Revised Code or a vehicle that is regulated under section 5104.015 of the Revised Code, that is required by the United States department of transportation to be equipped with seat belts at the time of manufacture or assembly, the operator of the motor vehicle shall have the child properly secured in accordance with the manufacturer's instructions on a booster seat that meets federal motor vehicle safety standards.

(D) When any child who is at least eight years of age but not older than fifteen years of age, and who is not otherwise required by division (A), (B), or (C) of this section to be secured in a child restraint system or booster seat, is being transported in a motor vehicle, other than a taxicab or public safety vehicle as defined in section 4511.01 of the Revised Code, that is required by the United States department of transportation to be equipped with seat belts at the time of manufacture or assembly, the operator of the motor vehicle shall have the child properly restrained either in accordance with the manufacturer's instructions in a child restraint system that meets federal motor vehicle safety standards or in an occupant restraining device as defined in section 4513.263 of the Revised Code.

(E) Notwithstanding any provision of law to the contrary, no law enforcement officer shall cause an operator of a motor vehicle being operated on any street or highway to stop the motor vehicle for the sole purpose of determining whether a violation of division (C) or (D) of this section has been or is being committed or for the sole purpose of issuing a ticket, citation, or summons for a violation of division (C) or (D) of this section or causing the arrest of or commencing a prosecution of a person for a violation of division (C) or (D) of this section, and absent another violation of law, a law enforcement officer's view of the interior or visual inspection of a motor vehicle being operated on any street or highway may not be used for the purpose of determining whether a violation of division (C) or (D) of this section has been or is being committed.

(F) The director of public safety shall adopt such rules as are necessary to carry out this section.

(G) The failure of an operator of a motor vehicle to secure a child in a child restraint system, a booster seat, or an occupant restraining device as required by this section is not negligence imputable to the child, is not admissible as evidence in any civil action involving the rights of the

child against any other person allegedly liable for injuries to the child, is not to be used as a basis for a criminal prosecution of the operator of the motor vehicle other than a prosecution for a violation of this section, and is not admissible as evidence in any criminal action involving the operator of the motor vehicle other than a prosecution for a violation of this section.

(H) This section does not apply when an emergency exists that threatens the life of any person operating or occupying a motor vehicle that is being used to transport a child who otherwise would be required to be restrained under this section. This section does not apply to a person operating a motor vehicle who has an affidavit signed by a physician licensed to practice in this state under Chapter 4731. of the Revised Code, a clinical nurse specialist or certified nurse practitioner licensed to practice in this state under Chapter 4723. of the Revised Code, or a chiropractor licensed to practice in this state under Chapter 4734. of the Revised Code that states that the child who otherwise would be required to be restrained under this section has a physical impairment that makes use of a child restraint system, booster seat, or an occupant restraining device impossible or impractical, provided that the person operating the vehicle has safely and appropriately restrained the child in accordance with any recommendations of the physician, nurse, or chiropractor as noted on the affidavit.

(I) There is hereby created in the state treasury the child highway safety fund, consisting of fines imposed pursuant to division (L)(1) of this section for violations of divisions (A), (B), (C), and (D) of this section. The money in the fund shall be used by the department of health only to defray the cost of designating hospitals as pediatric trauma centers under section 3727.081 of the Revised Code and to establish and administer a child highway safety program. The purpose of the program shall be to educate the public about child restraint systems and booster seats and the importance of their proper use. The program also shall include a process for providing child restraint systems and booster seats to persons who meet the eligibility criteria established by the department, and a toll-free telephone number the public may utilize to obtain information about child restraint systems and booster seats, and their proper use.

(J) The director of health, in accordance with Chapter 119. of the Revised Code, shall adopt any rules necessary to carry out this section, including rules establishing the criteria a person must meet in order to receive a child restraint system or booster seat under the department's child highway safety program; provided that rules relating to the verification of pediatric trauma centers shall not be adopted under this section.

(K) Nothing in this section shall be construed to require any person to carry with the person the birth certificate of a child to prove the age of the child, but the production of a valid birth certificate for a child showing that the child was not of an age to which this section applies is a defense against any ticket, citation, or summons issued for violating this section.

(L)(1) Whoever violates division (A), (B), (C), or (D) of this section shall be punished as follows, provided that the failure of an operator of a motor vehicle to secure more than one child in a child restraint system, booster seat, or occupant restraining device as required by this section that

occurred at the same time, on the same day, and at the same location is deemed to be a single violation of this section:

(a) Except as otherwise provided in division (L)(1)(b) of this section, the offender is guilty of a minor misdemeanor and shall be fined not less than twenty-five dollars nor more than seventy-five dollars.

(b) If the offender previously has been convicted of or pleaded guilty to a violation of division (A), (B), (C), or (D) of this section or of a municipal ordinance that is substantially similar to any of those divisions, the offender is guilty of a misdemeanor of the fourth degree.

(2) All fines imposed pursuant to division (L)(1) of this section shall be forwarded to the treasurer of state for deposit in the child highway safety fund created by division (I) of this section.

Sec. 4723.36. (A) A certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist may determine and pronounce an individual's death, ~~but only if the individual's respiratory and circulatory functions are not being artificially sustained and, at the time the determination and pronouncement of death is made, either or both of the following apply:~~

~~(1) The individual was receiving care in one of the following:~~

~~(a) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision under section 3721.09 of the Revised Code;~~

~~(b) A residential care facility or home for the aging licensed under Chapter 3721. of the Revised Code;~~

~~(c) A county home or district home operated pursuant to Chapter 5155. of the Revised Code;~~

~~(d) A residential facility licensed under section 5123.19 of the Revised Code.~~

~~(2) The certified nurse practitioner or clinical nurse specialist is providing or supervising the individual's care through a hospice care program licensed under Chapter 3712. of the Revised Code or any other entity that provides palliative care.~~

~~(B)(B)(1)~~ A registered nurse who is not described in division (A) of this section may determine and pronounce an individual's death, but only if the individual's respiratory and circulatory functions are not being artificially sustained and, at the time the determination and pronouncement of death is made, the registered nurse is providing or supervising the individual's care through a hospice care program licensed under Chapter 3712. of the Revised Code or any other entity that provides palliative care.

~~(C) If a certified nurse practitioner, clinical nurse specialist, or (2)~~ A registered nurse who determines and pronounces an individual's death, ~~the nurse~~ under division (B)(1) of this section shall comply with both of the following:

~~(1)(a)~~ The nurse shall not complete any portion of the individual's death certificate.

~~(2)(b)~~ The nurse shall notify the individual's attending physician, certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist of the determination and pronouncement of death in order for the physician, certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist to fulfill the physician's, certified nurse-midwife's, certified nurse practitioner's, or

clinical nurse specialist's duties under section 3705.16 of the Revised Code. The nurse shall provide the notification within a period of time that is reasonable but not later than twenty-four hours following the determination and pronouncement of the individual's death.

Sec. 4723.431. (A)(1) An advanced practice registered nurse who is designated as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may practice only in accordance with a standard care arrangement entered into with each physician or podiatrist with whom the nurse collaborates. A copy of the standard care arrangement shall be retained on file by the nurse's employer. Prior approval of the standard care arrangement by the board of nursing is not required, but the board may periodically review it for compliance with this section.

A clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may enter into a standard care arrangement with one or more collaborating physicians or podiatrists. If a collaborating physician or podiatrist enters into standard care arrangements with more than five nurses, the physician or podiatrist shall not collaborate at the same time with more than five nurses in the prescribing component of their practices.

Not later than thirty days after first engaging in the practice of nursing as a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, the nurse shall submit to the board the name and business address of each collaborating physician or podiatrist. Thereafter, the nurse shall notify the board of any additions or deletions to the nurse's collaborating physicians or podiatrists. Except as provided in division (D) of this section, the notice must be provided not later than thirty days after the change takes effect.

(2) All of the following conditions apply with respect to the practice of a collaborating physician or podiatrist with whom a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner may enter into a standard care arrangement:

(a) The physician or podiatrist must be authorized to practice in this state.

(b) Except as provided in division (A)(2)(c) of this section, the physician or podiatrist must be practicing in a specialty that is the same as or similar to the nurse's nursing specialty.

(c) If the nurse is a clinical nurse specialist who is certified as a psychiatric-mental health CNS or the equivalent of such title by the American nurses credentialing center or a certified nurse practitioner who is certified as a psychiatric-mental health NP or the equivalent of such title by the American nurses credentialing center or American academy of nurse practitioners certification board, the nurse may enter into a standard care arrangement with a physician but not a podiatrist and the collaborating physician must be practicing in one of the following specialties:

(i) Psychiatry;

(ii) Pediatrics;

(iii) Primary care or family practice.

(B) A standard care arrangement shall be in writing and shall contain all of the following:

(1) Criteria for referral of a patient by the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner to a collaborating physician or podiatrist or another physician or

podiatrist;

(2) A process for the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner to obtain a consultation with a collaborating physician or podiatrist or another physician or podiatrist;

(3) A plan for coverage in instances of emergency or planned absences of either the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner or a collaborating physician or podiatrist that provides the means whereby a physician or podiatrist is available for emergency care;

(4) The process for resolution of disagreements regarding matters of patient management between the clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner and a collaborating physician or podiatrist;

(5) Any other criteria required by rule of the board adopted pursuant to section 4723.07 or 4723.50 of the Revised Code.

(C) A standard care arrangement entered into pursuant to this section may permit a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner to do any of the following:

(1) Supervise services provided by a home health agency as defined in section 3740.01 of the Revised Code;

(2) Admit a patient to a hospital in accordance with section 3727.06 of the Revised Code;

(3) Sign any document relating to the admission, treatment, or discharge of an inpatient receiving psychiatric or other behavioral health care services, but only if the conditions of section 4723.436 of the Revised Code have been met.

(D)(1) Except as provided in division (D)(2) of this section, if a physician or podiatrist terminates the collaboration between the physician or podiatrist and a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist before their standard care arrangement expires, all of the following apply:

(a) The physician or podiatrist must give the nurse written or electronic notice of the termination.

(b) Once the nurse receives the termination notice, the nurse must notify the board of nursing of the termination as soon as practicable by submitting to the board a copy of the physician's or podiatrist's termination notice.

(c) Notwithstanding the requirement of section 4723.43 of the Revised Code that the nurse practice in collaboration with a physician or podiatrist, the nurse may continue to practice under the existing standard care arrangement without a collaborating physician or podiatrist for not more than one hundred twenty days after submitting to the board a copy of the termination notice.

(2) In the event that the collaboration between a physician or podiatrist and a certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist terminates because of the physician's or podiatrist's death, the nurse must notify the board of the death as soon as practicable. The nurse may continue to practice under the existing standard care arrangement without a collaborating

physician or podiatrist for not more than one hundred twenty days after notifying the board of the physician's or podiatrist's death.

~~(E)~~(1) Nothing in this section prohibits a hospital from hiring a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner as an employee and negotiating standard care arrangements on behalf of the employee as necessary to meet the requirements of this section. A standard care arrangement between the hospital's employee and the employee's collaborating physician is subject to approval by the medical staff and governing body of the hospital prior to implementation of the arrangement at the hospital.

(2) Nothing in this section prohibits a standard care arrangement from specifying actions that a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner is authorized to take, or is prohibited from taking, as part of the nurse's practice in collaboration with a physician or podiatrist. In specifying such actions, the standard care arrangement shall not authorize the nurse to take any action that is otherwise prohibited by the Revised Code or rule of the board.

Sec. 4723.437. (A) As used in this section, "fetal death" has the same meaning as in section 3705.01 of the Revised Code, except that it does not include either of the following:

(1) The product of human conception of at least twenty weeks of gestation;

(2) The purposeful termination of a pregnancy, as described in section 2919.11 of the Revised Code.

(B) If a woman who is in the process of experiencing a fetal death or who is with the product of human conception as a result of a fetal death presents herself to a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner and is not referred to a hospital, the nurse shall provide the woman with all of the following:

(1) A written statement, not longer than one page in length, that confirms that the woman was pregnant and that she subsequently suffered a miscarriage that resulted in a fetal death;

(2) Notice of the right of the woman to apply for a fetal death certificate pursuant to section 3705.20 of the Revised Code;

(3) A short, general description of the nurse's procedures for disposing of the product of a fetal death.

The nurse may present the notice and description required by divisions (B)(2) and (3) of this section through oral or written means. The nurse shall document in the woman's medical record that all of the items required by this division were provided to the woman and shall place in the record a copy of the statement required by division (B)(1) of this section.

(C) A certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner is immune from civil or criminal liability or professional disciplinary action with regard to any action taken in good faith compliance with this section.

Sec. 4723.438. For purposes of sections 173.521, 173.542, 3701.162, 3721.01, 3721.011, 3721.041, 3727.19, 3742.03, 3742.04, 3742.07, 3923.25, 4506.07, 4507.06, 4507.08, 4507.081, and 4507.141 of the Revised Code, a certified nurse-midwife may sign documents or take related actions

under those sections only if the nurse's scope of practice, as determined in accordance with section 4723.43 of the Revised Code and standards established by the board of nursing, authorizes the nurse to practice in the manner described in those sections.

Sec. 4723.4812. (A) A certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who has established a protocol that meets the requirements of section 4729.284 of the Revised Code and the rules adopted under that section may authorize one or more pharmacists to use the protocol for the purpose of dispensing nicotine replacement therapy under section 4729.284 of the Revised Code.

(B) The board of nursing shall adopt rules establishing standards and procedures to be followed by a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner when prescribing a drug that may be administered by a pharmacist pursuant to section 4729.45 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code and in consultation with the state board of pharmacy.

(C) A certified nurse-midwife, clinical nurse specialist or certified nurse practitioner who has established a protocol that meets the requirements specified by the state board of pharmacy in rules adopted under section 4729.47 of the Revised Code may authorize one or more pharmacists and any of the pharmacy interns supervised by the pharmacist or pharmacists to use the protocol for the purpose of dispensing epinephrine under section 4729.47 of the Revised Code.

Sec. 4729.284. (A) As used in this section, "nicotine replacement therapy" means a drug, including a dangerous drug, that delivers small doses of nicotine to an individual for the purpose of aiding in tobacco cessation or smoking cessation.

(B) Subject to division (C) of this section, if use of a protocol that has been developed under this section has been authorized under section 4723.4812 or 4731.90 of the Revised Code, a pharmacist may dispense nicotine replacement therapy in accordance with that protocol to individuals who are eighteen years old or older and seeking to quit using tobacco-containing products.

(C) For a pharmacist to be authorized to dispense nicotine replacement therapy under this section, the pharmacist shall do both of the following:

(1) Successfully complete a course on nicotine replacement therapy that is taught by a provider that is accredited by the accreditation council for pharmacy education, or another provider approved by the state board of pharmacy, and that meets requirements established in rules adopted under this section;

(2) Practice in accordance with a protocol that meets the requirements of division (D) of this section.

(D) All of the following apply with respect to the protocol required by this section:

(1) The protocol shall be established by a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner licensed under Chapter 4723.

of the Revised Code.

(2) The protocol shall specify a definitive set of treatment guidelines and the locations at which a pharmacist may dispense nicotine replacement therapy under this section.

(3) The protocol shall include provisions for implementation of the following requirements:

(a) Use by the pharmacist of a screening procedure, recommended by the United States centers for disease control and prevention or another organization approved by the board, to determine if an individual is a good candidate to receive nicotine replacement therapy dispensed as authorized by this section;

(b) A requirement that the pharmacist refer high-risk individuals or individuals with contraindications to a primary care provider or, as appropriate, to another type of provider;

(c) A requirement that the pharmacist develop and implement a follow-up care plan in accordance with guidelines specified in rules adopted under this section, including a recommendation by the pharmacist that the individual seek additional assistance with behavior change, including assistance from the Ohio tobacco quit line made available by the department of health.

(4) The protocol shall satisfy any additional requirements established in rules adopted under this section.

(E)(1) Documentation related to screening, dispensing, and follow-up care plans shall be maintained in the records of the pharmacy where the pharmacist practices for at least three years. Dispensing of nicotine replacement therapy may be documented on a prescription form, and the form may be assigned a number for recordkeeping purposes.

(2) Not later than seventy-two hours after a screening is conducted under this section, the pharmacist shall provide notice to the individual's primary care provider, if known, or to the individual if the primary care provider is unknown. The notice shall include results of the screening, and if applicable, the dispensing record and follow-up care plan.

A copy of the documentation identified in division (E)(1) of this section shall also be provided to the individual or the individual's primary care provider on request.

(F) This section does not affect the authority of a pharmacist to do any of the following:

(1) Fill or refill prescriptions for nicotine replacement therapy;

(2) Sell nicotine replacement therapy that does not require a prescription.

(G) No pharmacist shall do either of the following:

(1) Dispense nicotine replacement therapy in accordance with a protocol unless the requirements of division (C) of this section have been met;

(2) Delegate to any person the pharmacist's authority to engage in or supervise the dispensing of nicotine replacement therapy.

(H)(1) The board shall adopt rules to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code and shall include all of the following:

(a) Provisions specifying the nicotine replacement therapy that may be dispensed in

accordance with a protocol;

(b) Requirements for courses on nicotine replacement therapy including requirements that are consistent with any standards established for such courses by the United States centers for disease control and prevention;

(c) Requirements for protocols to be followed by pharmacists in dispensing nicotine replacement therapy;

(d) Guidelines for follow-up care plans.

(2) Prior to adopting rules regarding requirements for protocols to be followed by pharmacists in dispensing of nicotine replacement therapy, the state board of pharmacy shall consult with the state medical board, board of nursing, and the department of health.

(1) A physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who in good faith authorizes a pharmacist to dispense nicotine replacement therapy in accordance with a protocol developed pursuant to rules adopted under division (H) of this section is not liable for or subject to any of the following for any action or omission of the individual to whom the nicotine replacement therapy is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

Sec. 4729.41. (A)(1) A pharmacist licensed under this chapter who meets the requirements of division (B) of this section, a pharmacy intern licensed under this chapter who meets the requirements of division (B) of this section and is working under the direct supervision of a pharmacist who meets the requirements of that division, and a certified pharmacy technician or a registered pharmacy technician who meets the requirements of division (B) of this section and is working under the direct supervision of a pharmacist who meets the requirements of that division, may administer to an individual who is five years of age or older: an immunization for any disease, including an immunization for influenza or COVID-19.

(2) As part of engaging in the administration of immunizations or supervising a pharmacy intern's, certified pharmacy technician's, or registered pharmacy technician's administration of immunizations, a pharmacist may administer epinephrine or diphenhydramine, or both, to individuals in emergency situations resulting from adverse reactions to the immunizations administered by the pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician.

(B) For a pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician to be authorized to engage in the administration of immunizations, the pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician shall do all of the following:

(1) Successfully complete a course in the administration of immunizations that meets the requirements established in rules adopted under this section for such courses;

(2) Receive and maintain certification to perform basic life-support procedures by successfully completing a basic life-support training course that is certified by the American red

cross or American heart association or approved by the state board of pharmacy;

(3) Practice in accordance with a protocol that meets the requirements of division (C) of this section.

(C) All of the following apply with respect to the protocol required by division (B)(3) of this section:

(1) The protocol shall be established by a physician authorized under Chapter 4731, of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery or a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner licensed under Chapter 4723, of the Revised Code.

(2) The protocol shall specify a definitive set of treatment guidelines and the locations at which a pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician may engage in the administration of immunizations.

(3) The protocol shall satisfy the requirements established in rules adopted under this section for protocols.

(4) The protocol shall include provisions for implementation of the following requirements:

(a) The pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician who administers an immunization shall observe the individual who receives the immunization to determine whether the individual has an adverse reaction to the immunization. The length of time and location of the observation shall comply with the rules adopted under this section establishing requirements for protocols. The protocol shall specify procedures to be followed by a pharmacist when administering epinephrine or diphenhydramine, or both, to an individual who has an adverse reaction to an immunization administered by the pharmacist or by a pharmacy intern, certified pharmacy technician, or registered pharmacy technician.

(b) For each immunization administered to an individual by a pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician, other than an immunization for influenza administered to an individual eighteen years of age or older, the pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician shall notify the individual's primary care provider or, if the individual has no primary care provider, the board of health of the health district in which the individual resides or the authority having the duties of a board of health for that district under section 3709.05 of the Revised Code. The notice shall be given not later than thirty days after the immunization is administered.

(c) For each immunization administered by a pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician to an individual younger than eighteen years of age, the pharmacist, a pharmacy intern, certified pharmacy technician, or registered pharmacy technician shall obtain permission from the individual's parent or legal guardian in accordance with the procedures specified in rules adopted under this section.

(d) For each immunization administered by a pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician to an individual who is younger than

eighteen years of age, the pharmacist, pharmacy intern, certified pharmacy technician, or registered pharmacy technician shall inform the individual's parent or legal guardian of the importance of well child visits with a pediatrician or other primary care provider and shall refer patients when appropriate.

(D)(1) No pharmacist shall do either of the following:

(a) Engage in the administration of immunizations unless the requirements of division (B) of this section have been met;

(b) Delegate to any person the pharmacist's authority to engage in or supervise the administration of immunizations.

(2) No pharmacy intern shall engage in the administration of immunizations unless the requirements of division (B) of this section have been met.

(3) No certified pharmacy technician or registered pharmacy technician shall engage in the administration of immunizations unless the requirements of division (B) of this section have been met.

(E)(1) The state board of pharmacy shall adopt rules to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code and shall include the following:

(a) Requirements for courses in administration of immunizations, including requirements that are consistent with any standards established for such courses by the centers for disease control and prevention;

(b) Requirements for protocols to be followed by pharmacists, pharmacy interns, certified pharmacy technicians, and registered pharmacy technicians in engaging in the administration of immunizations;

(c) Procedures to be followed by pharmacists, pharmacy interns, certified pharmacy technicians, and registered pharmacy technicians in obtaining from the individual's parent or legal guardian permission to administer immunizations to an individual younger than eighteen years of age.

(2) Prior to adopting rules regarding requirements for protocols to be followed by pharmacists, pharmacy interns, certified pharmacy technicians, and registered pharmacy technicians in engaging in the administration of immunizations, the state board of pharmacy shall consult with the state medical board and the board of nursing.

Sec. 4729.45. (A) As used in this section, "~~physician~~":

(1) "Certified nurse-midwife," "clinical nurse specialist," and "certified nurse practitioner" have the same meanings as in section 4723.01 of the Revised Code.

(2) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(B)(1) Subject to division (C) of this section, a pharmacist licensed under this chapter may administer by injection any of the following drugs as long as the drug that is to be administered has

been prescribed by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner and the individual to whom the drug was prescribed has an ongoing physician-patient or nurse-patient relationship with the physician or nurse:

- (a) An addiction treatment drug administered in a long-acting or extended-release form;
- (b) An antipsychotic drug administered in a long-acting or extended-release form;
- (c) Hydroxyprogesterone caproate;
- (d) Medroxyprogesterone acetate;
- (e) Cobalamin.

(2) As part of engaging in the administration of drugs by injection pursuant to this section, a pharmacist may administer epinephrine or diphenhydramine, or both, to an individual in an emergency situation resulting from an adverse reaction to a drug administered by the pharmacist.

(C) To be authorized to administer drugs pursuant to this section, a pharmacist must do all of the following:

(1) Successfully complete a course in the administration of drugs that satisfies the requirements established by the state board of pharmacy in rules adopted under division (H)(1)(a) of this section;

(2) Receive and maintain certification to perform basic life-support procedures by successfully completing a basic life-support training course that is certified by the American red cross or American heart association or approved by the state board of pharmacy;

(3) Practice in accordance with a protocol that meets the requirements of division (F) of this section.

(D) Each time a pharmacist administers a drug pursuant to this section, the pharmacist shall do all of the following:

(1) Obtain permission in accordance with the procedures specified in rules adopted under division (H) of this section and comply with the following requirements:

(a) Except as provided in division (D)(1)(c) of this section, for each drug administered by a pharmacist to an individual who is eighteen years of age or older, the pharmacist shall obtain permission from the individual.

(b) For each drug administered by a pharmacist to an individual who is under eighteen years of age, the pharmacist shall obtain permission from the individual's parent or other person having care or charge of the individual.

(c) For each drug administered by a pharmacist to an individual who lacks the capacity to make informed health care decisions, the pharmacist shall obtain permission from the person authorized to make such decisions on the individual's behalf.

(2) In the case of an addiction treatment drug described in division (B)(1)(a) of this section, obtain in accordance with division (E) of this section test results indicating that it is appropriate to administer the drug to the individual if either of the following is to be administered:

- (a) The initial dose of the drug;

(b) Any subsequent dose, if the administration occurs more than thirty days after the previous dose of the drug was administered.

(3) Observe the individual to whom the drug is administered to determine whether the individual has an adverse reaction to the drug;

(4) Notify the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who prescribed the drug that the drug has been administered to the individual.

(E) A pharmacist may obtain the test results described in division (D)(2) of this section in either of the following ways:

(1) From the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner;

(2) By ordering blood and urine tests for the individual to whom the drug is to be administered.

If a pharmacist orders blood and urine tests, the pharmacist shall evaluate the results of the tests to determine whether they indicate that it is appropriate to administer the drug. A pharmacist's authority to evaluate test results under this division does not authorize the pharmacist to make a diagnosis.

(F) All of the following apply with respect to the protocol required by division (C)(3) of this section:

(1) The protocol must be established by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who has a scope of practice that includes treatment of the condition for which the individual has been prescribed the drug to be administered.

(2) The protocol must satisfy the requirements established in rules adopted under division (H)(1)(b) of this section.

(3) The protocol must do all of the following:

(a) Specify a definitive set of treatment guidelines;

(b) Specify the locations at which a pharmacist may engage in the administration of drugs pursuant to this section;

(c) Include provisions for implementing the requirements of division (D) of this section, including for purposes of division (D)(3) of this section provisions specifying the length of time and location at which a pharmacist must observe an individual who receives a drug to determine whether the individual has an adverse reaction to the drug;

(d) Specify procedures to be followed by a pharmacist when administering epinephrine, diphenhydramine, or both, to an individual who has an adverse reaction to a drug administered by the pharmacist.

(G) A pharmacist shall not do either of the following:

(1) Engage in the administration of drugs pursuant to this section unless the requirements of division (C) of this section have been met;

(2) Delegate to any person the pharmacist's authority to engage in the administration of

drugs pursuant to this section.

(H)(1) The state board of pharmacy shall adopt rules to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code and include all of the following:

- (a) Requirements for courses in administration of drugs;
- (b) Requirements for protocols to be followed by pharmacists in administering drugs pursuant to this section;
- (c) Procedures to be followed by a pharmacist in obtaining permission to administer a drug to an individual.

(2) The board shall consult with the state medical board and board of nursing before adopting rules regarding requirements for protocols under this section.

Sec. 4729.47. (A) As used in this section:

(1) "Board of health" means a board of health of a city or general health district or an authority having the duties of a board of health under section 3709.05 of the Revised Code.

(2) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(B) If use of a protocol that has been developed pursuant to rules adopted under division (G) of this section has been authorized under section 3707.60, 4723.4812, or 4731.961 of the Revised Code, a pharmacist or pharmacy intern may dispense epinephrine without a prescription in accordance with that protocol to either of the following individuals so long as the individual is at least eighteen years of age:

(1) An individual who there is reason to believe is experiencing or at risk of experiencing anaphylaxis if the pharmacy affiliated with the pharmacist or intern has a record of previously dispensing epinephrine to the individual in accordance with a prescription issued by a licensed health professional authorized to prescribe drugs;

(2) An individual acting on behalf of a qualified entity, as defined in section 3728.01 of the Revised Code.

(C)(1) A pharmacist or pharmacy intern who dispenses epinephrine under this section shall instruct the individual to whom epinephrine is dispensed to summon emergency services as soon as practicable either before or after administering epinephrine.

(2) A pharmacist or pharmacy intern who dispenses epinephrine to an individual identified in division (B)(1)(a) of this section shall provide notice of the dispensing to the individual's primary care provider, if known, or to the prescriber who issued the individual the initial prescription for epinephrine.

(D) A pharmacist may document the dispensing of epinephrine by the pharmacist or a pharmacy intern supervised by the pharmacist on a prescription form. The form may be assigned a number for record-keeping purposes.

(E) This section does not affect the authority of a pharmacist or pharmacy intern to fill or

refill a prescription for epinephrine.

(F) A board of health that in good faith authorizes a pharmacist or pharmacy intern to dispense epinephrine without a prescription in accordance with a protocol developed pursuant to rules adopted under division (G) of this section is not liable for or subject to any of the following for any action or omission of the individual to whom the epinephrine is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

A physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who in good faith authorizes a pharmacist or pharmacy intern to dispense epinephrine without a prescription in accordance with a protocol developed pursuant to rules adopted under division (G) of this section is not liable for or subject to any of the following for any action or omission of the individual to whom the epinephrine is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

A pharmacist or pharmacy intern authorized under this section to dispense epinephrine without a prescription who does so in good faith is not liable for or subject to any of the following for any action or omission of the individual to whom the epinephrine is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

(G) ~~Not later than ninety days after the effective date of this section, the~~ The state board of pharmacy shall, after consulting with the state medical board and board of nursing, adopt rules to implement this section. The rules shall specify minimum requirements for protocols established by physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners under which pharmacists or pharmacy interns may dispense epinephrine without a prescription.

All rules adopted under this section shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5120.17. (A) As used in this section:

(1) "Mental illness" means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

(2) "Person with a mental illness subject to hospitalization" means a person with a mental illness to whom any of the following applies because of the person's mental illness:

(a) The person represents a substantial risk of physical harm to the person as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm.

(b) The person represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness.

(c) The person represents a substantial and immediate risk of serious physical impairment or injury to the person as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that

appropriate provision for those needs cannot be made immediately available in the correctional institution in which the inmate is currently housed.

(d) The person would benefit from treatment in a hospital for the person's mental illness and is in need of treatment in a hospital as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.

(3) "Psychiatric hospital" means all or part of a facility that is operated and managed by the department of mental health and addiction services to provide psychiatric hospitalization services in accordance with the requirements of this section pursuant to an agreement between the directors of rehabilitation and correction and mental health and addiction services or, is licensed by the department of mental health and addiction services pursuant to section 5119.33 of the Revised Code as a psychiatric hospital and is accredited by a health care accrediting organization approved by the department of mental health and addiction services and the psychiatric hospital is any of the following:

(a) Operated and managed by the department of rehabilitation and correction within a facility that is operated by the department of rehabilitation and correction;

(b) Operated and managed by a contractor for the department of rehabilitation and correction within a facility that is operated by the department of rehabilitation and correction;

(c) Operated and managed in the community by an entity that has contracted with the department of rehabilitation and correction to provide psychiatric hospitalization services in accordance with the requirements of this section.

(4) "Inmate patient" means an inmate who is admitted to a psychiatric hospital.

(5) "Admitted" to a psychiatric hospital means being accepted for and staying at least one night at the psychiatric hospital.

(6) "Treatment plan" means a written statement of reasonable objectives and goals for an inmate patient that is based on the needs of the inmate patient and that is established by the treatment team, with the active participation of the inmate patient and with documentation of that participation. "Treatment plan" includes all of the following:

(a) The specific criteria to be used in evaluating progress toward achieving the objectives and goals;

(b) The services to be provided to the inmate patient during the inmate patient's hospitalization;

(c) The services to be provided to the inmate patient after discharge from the hospital, including, but not limited to, housing and mental health services provided at the state correctional institution to which the inmate patient returns after discharge or community mental health services.

(7) "Emergency transfer" means the transfer of an inmate with a mental illness to a psychiatric hospital when the inmate presents an immediate danger to self or others and requires hospital-level care.

(8) "Uncontested transfer" means the transfer of an inmate with a mental illness to a

psychiatric hospital when the inmate has the mental capacity to, and has waived, the hearing required by division (B) of this section.

(9)(a) "Independent decision-maker" means a person who is employed or retained by the department of rehabilitation and correction and is appointed by the chief or chief clinical officer of mental health services as a hospitalization hearing officer to conduct due process hearings.

(b) An independent decision-maker who presides over any hearing or issues any order pursuant to this section shall be a psychiatrist, psychiatric-mental health advanced practice registered nurse, psychologist, or attorney, shall not be specifically associated with the institution in which the inmate who is the subject of the hearing or order resides at the time of the hearing or order, and previously shall not have had any treatment relationship with nor have represented in any legal proceeding the inmate who is the subject of the order.

(10) "Psychiatric-mental health advanced practice registered nurse" means an advanced practice registered nurse, as defined in section 4723.01 of the Revised Code, who is either of the following:

(a) A clinical nurse specialist who is certified as a psychiatric-mental health CNS, or the equivalent of such title, by the American nurses credentialing center;

(b) A certified nurse practitioner who is certified as a psychiatric-mental health NP, or the equivalent of such title, by the American nurses credentialing center or American academy of nurse practitioners certification board.

(B)(1) Except as provided in division (C) of this section, if the warden of a state correctional institution or the warden's designee believes that an inmate should be transferred from the institution to a psychiatric hospital, the department shall hold a hearing to determine whether the inmate is a person with a mental illness subject to hospitalization. The department shall conduct the hearing at the state correctional institution in which the inmate is confined, and the department shall provide qualified independent assistance to the inmate for the hearing. An independent decision-maker provided by the department shall preside at the hearing and determine whether the inmate is a person with a mental illness subject to hospitalization.

(2) Except as provided in division (C) of this section, prior to the hearing held pursuant to division (B)(1) of this section, the warden or the warden's designee shall give written notice to the inmate that the department is considering transferring the inmate to a psychiatric hospital, that it will hold a hearing on the proposed transfer at which the inmate may be present, that at the hearing the inmate has the rights described in division (B)(3) of this section, and that the department will provide qualified independent assistance to the inmate with respect to the hearing. The department shall not hold the hearing until the inmate has received written notice of the proposed transfer and has had sufficient time to consult with the person appointed by the department to provide assistance to the inmate and to prepare for a presentation at the hearing.

(3) At the hearing held pursuant to division (B)(1) of this section, the department shall disclose to the inmate the evidence that it relies upon for the transfer and shall give the inmate an

opportunity to be heard. Unless the independent decision-maker finds good cause for not permitting it, the inmate may present documentary evidence and the testimony of witnesses at the hearing and may confront and cross-examine witnesses called by the department.

(4) If the independent decision-maker does not find clear and convincing evidence that the inmate is a person with a mental illness subject to hospitalization, the department shall not transfer the inmate to a psychiatric hospital but shall continue to confine the inmate in the same state correctional institution or in another state correctional institution that the department considers appropriate. If the independent decision-maker finds clear and convincing evidence that the inmate is a person with a mental illness subject to hospitalization, the decision-maker shall order that the inmate be transported to a psychiatric hospital for observation and treatment for a period of not longer than thirty days. After the hearing, the independent decision-maker shall submit to the department a written decision that states one of the findings described in division (B)(4) of this section, the evidence that the decision-maker relied on in reaching that conclusion, and, if the decision is that the inmate should be transferred, the reasons for the transfer.

(C)(1) The department may transfer an inmate to a psychiatric hospital under an emergency transfer order if a determination is made that the inmate has a mental illness, presents an immediate danger to self or others, and requires hospital-level care. To qualify, the determination shall be made as follows: by the chief clinical officer of mental health services of the department or that officer's designee and either a psychiatrist or psychiatric-mental health advanced practice registered nurse employed or retained by the department or, in the absence of a psychiatrist or psychiatric-mental health advanced practice registered nurse, a psychologist employed or retained by the department ~~determines that the inmate has a mental illness, presents an immediate danger to self or others, and requires hospital-level care.~~

(2) The department may transfer an inmate to a psychiatric hospital under an uncontested transfer order if both of the following apply:

(a) A psychiatrist or psychiatric-mental health advanced practice registered nurse employed or retained by the department determines all of the following apply:

(i) The inmate has a mental illness or is a person with a mental illness subject to hospitalization.

(ii) The inmate requires hospital care to address the mental illness.

(iii) The inmate has the mental capacity to make a reasoned choice regarding the inmate's transfer to a hospital.

(b) The inmate agrees to a transfer to a hospital.

(3) The written notice and the hearing required under divisions (B)(1) and (2) of this section are not required for an emergency transfer or uncontested transfer under division (C)(1) or (2) of this section.

(4) After an emergency transfer under division (C)(1) of this section, the department shall hold a hearing for continued hospitalization within five working days after admission of the

transferred inmate to the psychiatric hospital. The department shall hold subsequent hearings pursuant to division (F) of this section at the same intervals as required for inmate patients who are transported to a psychiatric hospital under division (B)(4) of this section.

(5) After an uncontested transfer under division (C)(2) of this section, the inmate may withdraw consent to the transfer in writing at any time. Upon the inmate's withdrawal of consent, the hospital shall discharge the inmate, or, within five working days, the department shall hold a hearing for continued hospitalization. The department shall hold subsequent hearings pursuant to division (F) of this section at the same time intervals as required for inmate patients who are transported to a psychiatric hospital under division (B)(4) of this section.

(D)(1) If an independent decision-maker, pursuant to division (B)(4) of this section, orders an inmate transported to a psychiatric hospital or if an inmate is transferred pursuant to division (C)(1) or (2) of this section, the staff of the psychiatric hospital shall examine the inmate patient when admitted to the psychiatric hospital as soon as practicable after the inmate patient arrives at the hospital and no later than twenty-four hours after the time of arrival. The attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner responsible for the inmate patient's care shall give the inmate patient all information necessary to enable the patient to give a fully informed, intelligent, and knowing consent to the treatment the inmate patient will receive in the hospital. The attending physician or attending nurse shall tell the inmate patient the expected physical and medical consequences of any proposed treatment and shall give the inmate patient the opportunity to consult with another psychiatrist or psychiatric-mental health advanced practice registered nurse at the hospital and with the inmate advisor.

(2) No inmate patient who is transported or transferred pursuant to division (B)(4) or (C)(1) or (2) of this section to a psychiatric hospital within a facility that is operated by the department of rehabilitation and correction shall be subjected to any of the following procedures:

- (a) Convulsive therapy;
- (b) Major aversive interventions;
- (c) Any unusually hazardous treatment procedures;
- (d) Psychosurgery.

(E) The department of rehabilitation and correction shall ensure that an inmate patient hospitalized pursuant to this section receives or has all of the following:

(1) Receives sufficient professional care within twenty days of admission to ensure that an evaluation of the inmate patient's current status, differential diagnosis, probable prognosis, and description of the current treatment plan have been formulated and are stated on the inmate patient's official chart;

(2) Has a written treatment plan consistent with the evaluation, diagnosis, prognosis, and goals of treatment;

(3) Receives treatment consistent with the treatment plan;

(4) Receives periodic reevaluations of the treatment plan by the professional staff at intervals

not to exceed thirty days;

- (5) Is provided with adequate medical treatment for physical disease or injury;
- (6) Receives humane care and treatment, including, without being limited to, the following:
 - (a) Access to the facilities and personnel required by the treatment plan;
 - (b) A humane psychological and physical environment;
 - (c) The right to obtain current information concerning the treatment program, the expected outcomes of treatment, and the expectations for the inmate patient's participation in the treatment program in terms that the inmate patient reasonably can understand;
 - (d) Opportunity for participation in programs designed to help the inmate patient acquire the skills needed to work toward discharge from the psychiatric hospital;
 - (e) The right to be free from unnecessary or excessive medication and from unnecessary restraints or isolation;
 - (f) All other rights afforded inmates in the custody of the department consistent with rules, policy, and procedure of the department.

(F) The department shall hold a hearing for the continued hospitalization of an inmate patient who is transported or transferred to a psychiatric hospital pursuant to division (B)(4) or (C)(1) of this section prior to the expiration of the initial thirty-day period of hospitalization. The department shall hold any subsequent hearings, if necessary, not later than ninety days after the first thirty-day hearing and then not later than each one hundred and eighty days after the immediately prior hearing. An independent decision-maker shall conduct the hearings at the psychiatric hospital in which the inmate patient is confined. The inmate patient shall be afforded all of the rights set forth in this section for the hearing prior to transfer to the psychiatric hospital. The department may not waive a hearing for continued commitment. A hearing for continued commitment is mandatory for an inmate patient transported or transferred to a psychiatric hospital pursuant to division (B)(4) or (C)(1) of this section unless the inmate patient has the capacity to make a reasoned choice to execute a waiver and waives the hearing in writing. An inmate patient who is transferred to a psychiatric hospital pursuant to an uncontested transfer under division (C)(2) of this section and who has scheduled hearings after withdrawal of consent for hospitalization may waive any of the scheduled hearings if the inmate has the capacity to make a reasoned choice and executes a written waiver of the hearing.

If upon completion of the hearing the independent decision-maker does not find by clear and convincing evidence that the inmate patient is a person with a mental illness subject to hospitalization, the independent decision-maker shall order the inmate patient's discharge from the psychiatric hospital. If the independent decision-maker finds by clear and convincing evidence that the inmate patient is a person with a mental illness subject to hospitalization, the independent decision-maker shall order that the inmate patient remain at the psychiatric hospital for continued hospitalization until the next required hearing.

If at any time prior to the next required hearing for continued hospitalization, the medical

director of the hospital or the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner determines that the treatment needs of the inmate patient could be met equally well in an available and appropriate less restrictive state correctional institution or unit, the medical director ~~or~~, attending physician, or attending nurse may discharge the inmate to that facility.

(G) An inmate patient is entitled to the credits toward the reduction of the inmate patient's stated prison term pursuant to Chapters 2967. and 5120. of the Revised Code under the same terms and conditions as if the inmate patient were in any other institution of the department of rehabilitation and correction.

(H) The adult parole authority may place an inmate patient on parole or under post-release control directly from a psychiatric hospital.

(I) If an inmate patient who is a person with a mental illness subject to hospitalization is to be released from a psychiatric hospital because of the expiration of the inmate patient's stated prison term, the director of rehabilitation and correction or the director's designee, at least fourteen days before the expiration date, may file an affidavit under section 5122.11 or 5123.71 of the Revised Code with the probate court in the county where the psychiatric hospital is located or the probate court in the county where the inmate will reside, alleging that the inmate patient is a person with a mental illness subject to court order, as defined in section 5122.01 of the Revised Code, or a person with an intellectual disability subject to institutionalization by court order, as defined in section 5123.01 of the Revised Code, whichever is applicable. The proceedings in the probate court shall be conducted pursuant to Chapter 5122. or 5123. of the Revised Code except as modified by this division.

Upon the request of the inmate patient, the probate court shall grant the inmate patient an initial hearing under section 5122.141 of the Revised Code or a probable cause hearing under section 5123.75 of the Revised Code before the expiration of the stated prison term. After holding a full hearing, the probate court shall make a disposition authorized by section 5122.15 or 5123.76 of the Revised Code before the date of the expiration of the stated prison term. No inmate patient shall be held in the custody of the department of rehabilitation and correction past the date of the expiration of the inmate patient's stated prison term.

(J) The department of rehabilitation and correction shall set standards for treatment provided to inmate patients.

(K) A certificate, application, record, or report that is made in compliance with this section and that directly or indirectly identifies an inmate or former inmate whose hospitalization has been sought under this section is confidential. No person shall disclose the contents of any certificate, application, record, or report of that nature or any other psychiatric or medical record or report regarding an inmate with a mental illness unless one of the following applies:

(1) The person identified, or the person's legal guardian, if any, consents to disclosure, and the chief clinical officer or designee of mental health services of the department of rehabilitation and correction determines that disclosure is in the best interests of the person.