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Evaluation of Candidates with Previous Licensure

Sec. 19a-14-1. Application for licensure after license has become void

A person previously licensed in Connecticut whose license has become void pursuant to section 19a-88 of the Connecticut General Statutes, may apply for licensure under the terms of these regulations. In determining the qualifications of such a candidate, pursuant to section 19a-14 of the Connecticut General Statutes, the Department of Health Services shall refer the application to the appropriate Board or Commission for review, evaluation, and recommendations. If no Board or Commission exists for the profession in question, the Department of Health Services may make the review and evaluation.

(Effective October 18, 1983)

Sec. 19a-14-2. Review and evaluation of applications

When reviewing and evaluating applications pursuant to section 19a-14-1 of these regulations, the Board, Commission or Department shall consider at least the following: (1) credentials presented for initial licensure; (2) length of practice as a licensed professional; (3) time elapsed since leaving active practice; (4) whether the candidate had been the subject of complaints, investigations or disciplinary actions as a licensed professional; and (5) any continuing education undertaken by the candidate. The Board, Commission or Department must determine whether or not these factors, taken together, meet current licensure requirements.

(Effective October 18, 1983)

Sec. 19a-14-3. Recommendations regarding acceptability

After completion of the review prescribed in section 19a-14-2 of these regulations, the Board or Commission shall make recommendations to the Department regarding the acceptability for licensure of the candidate. At its discretion, the Department may, after considering all licensure requirements and the recommendations of the Board or Commission, grant licensure to the candidate.

(Effective October 18, 1983)

Sec. 19a-14-4. License shall not be issued until or unless complaint resolved

No license shall be issued if there is a complaint awaiting adjudication against the applicant in another state or with the Department of Health Services until such a time as it is resolved in favor of the candidate.

(Effective October 18, 1983)

Sec. 19a-14-5. Suspended or revoked license

An applicant whose license has been suspended or revoked pursuant to section 19a-17 of the Connecticut General Statutes cannot reapply for licensure under the terms of these regulations.

(Effective October 18, 1983)

Approval of Educational Programs for Candidates for Licensure

Secs. 19a-14-6—19a-14-19, inclusive.

Reserved.

Sec. 19a-14-20. Approval of educational programs

Whenever a Board or Commission identified in Section 19a-14 of the Connecticut General Statutes is authorized to approve, with the consent of the Commissioner

of Health Services, educational programs for candidates for licensure, the following procedure shall apply.

The process of approval shall require the Board or Commission to provide the Department of Health Services with a written statement of the approved educational program. The Department shall provide a written response acknowledging receipt of the approved program and noting either consent or refusal of the program. The approved program and an affirmative response from the Department shall be incorporated into the formal minutes of the Board or Commission.

An agreement between the Department and a Board or Commission regarding educational programs shall remain in effect until such time as both parties have a new agreement regarding this matter.

(Effective April 9, 1984)

Prescribing and Administering Examinations for Health Care Professionals

Secs. 19a-14-21—19a-14-29, inclusive.

Reserved.

Sec. 19a-14-30. Prescribing examinations and scores

Pursuant to provisions of the Connecticut General Statutes, the Department of Health Services may prescribe licensing examinations and their passing scores for given professions with the consent of certain Boards and Commissions identified in Section 19a-14 of the General Statutes.

The process of prescribing shall require the Department of Health Services to provide the Board or Commission with a written description of the prescribed examination and passing score. Receipt of this documentation by a board must be noted in the minutes of the next formal Board or Commission meeting. These minutes should also indicate the response of the Board or Commission, i.e., consent or refusal of use of the examination and passing score.

(Effective April 9, 1984)

Sec. 19a-14-31. Agreement of parties

An agreement between the Department and a Board or Commission regarding examinations and passing scores shall remain in effect until such time as both parties have a new agreement regarding these matters.

(Effective April 9, 1984)

Sec. 19a-14-32. Administration of examinations

The Department of Health Services shall administer all examinations under the supervision of the respective Board or Commission. The administration process shall include, but not be limited to, scheduling the examination, finding a suitable site and obtaining and training proctors and/or examiners. The Board or Commission may exercise its authority to supervise by monitoring examination administrations in order to ensure compliance with the agreed upon content and format of the examination and to ensure that all examinations are administered in a fair and secure manner.

(Effective April 9, 1984)

Secs. 19a-14-33—19a-14-39. Reserved

Medical Records

Sec. 19a-14-40. Medical records, definition, purpose

The purpose of a medical record is to provide a vehicle for: documenting actions taken in patient management; documenting patient progress; providing meaningful medical information to other practitioners should the patient transfer to a new provider or should the provider be unavailable for some reason. A medical record shall include, but not be limited to, information sufficient to justify any diagnosis and treatment rendered, dates of treatment, actions taken by non-licensed persons when ordered or authorized by the provider; doctors' orders, nurses notes and charts, birth certificate worksheets, and any other diagnostic data or documents specified in the rules and regulations. All entries must be signed by the person responsible for them.

(Effective August 29, 1984)

Sec. 19a-14-41. Professions involved

Each person licensed or certified pursuant to the following chapters and Acts shall maintain appropriate medical records of the assessment, diagnosis, and course of treatment provided each patient, and such medical records shall be kept for the period prescribed: chapters 334b, 370 thru 373, 375, 376, 378 thru 381, 383 thru 384, 388, 398, 399, and Public Acts 83-352 and 83-441.

(Effective August 29, 1984)

Sec. 19a-14-42. Retention schedule

Unless specified otherwise herein, all parts of a medical record shall be retained for a period of seven (7) years from the last date of treatment, or, upon the death of the patient, for three (3) years.

(a) **Pathology Slides, EEG and ECG Tracings** must each be kept for seven (7) years. If an ECG is taken and the results are unchanged from a previous ECG, then only the most recent results need be retained. Reports on each of these must be kept for the duration of the medical record.

(b) **Lab Reports and PKU Reports** must be kept for at least five (5) years. Only positive (abnormal) lab results need be retained.

(c) **X-Ray Films** must be kept for three (3) years.

(Effective August 29, 1984)

Sec. 19a-14-43. Exceptions

Nothing in these regulations shall prevent a practitioner from retaining records longer than the prescribed minimum. When medical records for a patient are retained by a health care facility or organization, the individual practitioner shall not be required to maintain duplicate records and the retention schedules of the facility or organization shall apply to the records. If a claim of malpractice, unprofessional conduct, or negligence with respect to a particular patient has been made, or if litigation has been commenced, then all records for that patient must be retained until the matter is resolved. A consulting health care provider need not retain records if they are sent to the referring provider, who must retain them. If a patient requests his records to be transferred to another provider who then becomes the primary provider to the patient, then the first provider is no longer required to retain that patient's records.

(Effective August 29, 1984)

Sec. 19a-14-44. Discontinuance of practice

Upon the death or retirement of a practitioner, it shall be the responsibility of the practitioner or surviving responsible relative or executor to inform patients. This must be done by placing a notice in a daily local newspaper published in the community which is the prime locus of the practice. This notice shall be no less than two columns wide and no less than two inches in height. The notice shall appear twice, seven days apart. In addition, an individual letter is to be sent to each patient seen within the three years preceding the date of discontinuance of the practice. Medical records of all patients must be retained for at least sixty days following both the public and private notice to patients.

(Effective August 29, 1984)

Utilization of Controlled Substances by Health Care Professionals

Secs. 19a-14-45—19a-14-49. Reserved

Sec. 19a-14-50. Definitions

For the purposes of these regulations, ''Doctor'' means either a physician licensed pursuant to Chapter 370 of the Connecticut General Statutes or an Optometrist licensed pursuant to Chapter 380 of the Connecticut General Statutes.

(Effective August 29, 1986)

Sec. 19a-14-51. Optician record retention

For each client fitted with prescription eyeglasses or prescribed contact lenses, a licensed optician shall keep a record. When prescription items are dispensed by a registered apprentice optician, the supervising licensed optician must verify the accuracy of all the data included in the client record and indicate this on the record. A client record shall contain the following:

(a) **Prescription Eyewear**

Records shall include:

(1) Doctor's prescription and date, including name of prescribing doctor;

(2) Date of delivering said prescription, to include any duplication of existing lenses;

(3) Facial measurements, to include but not be limited to: interpupillary measures; frame size determinations, including eye size, bridge size, temple length;

(4) Name of frame provided; and

(5) Lens description to include: lens materials; placement of optical centers; lens tint; and, when applicable, multifocal type and placement of multifocal.

(b) **Contact Lenses Prefit**

(1) Prefitting record shall include: date of client visit; doctor's written prescription; doctor's keratometric measures if such measures are provided, and such other measures or observations which are properly within the optician's scope of practice as defined by Connecticut General Statutes Section 20-139;

(2) Any information which would contraindicate the fitting of contact lenses;

(3) The date of the examining doctor's prescription;

(4) A prefitting biomicroscopic record of the external eye made by the doctor, if such is provided; and

(5) Any notice provided to the client regarding the length of time after which the prescription will not be refilled.

(c) **Contact Lens Dispensing**

Records on the dispensing of contact lenses shall include:

(1) All particular lens parameters including manufacturer;
(2) Date of client instruction in handling and hygiene;
(3) Visual acuity recorded with dispensed contact lenses as obtained by use of a standardized snellen-type chart;
(4) If performed, a summary of observations of the physical relationship between dispensed contact lens and cornea, including, but not limited to, biomicroscopic observations;
(5) A recommended wearing schedule; and
(6) A summary of recommended follow-up.
(d) **Contact Lens Follow-up**
Records of visits subsequent to the actual dispensing of contact lenses shall include:
(1) Date of each visit;
(2) Client's current wearing schedule;
(3) Visual acuity recorded with dispensed contact lenses, obtained by use of a standardized snellen-type chart;
(4) Date of next recommended visit; and
(5) A description of any perceived changes in visual acuity or obvious anomalies, and a record of any report made to the client or prescribing doctor.
(Effective August 29, 1986)

Secs. 19a-14-52—19a-14-54. Reserved

Sec. 19a-14-55. Utilization of controlled substances

Those health care practitioners identified in Section 19a-14 of the Connecticut General Statutes and regulated by the Department of Health Services who utilize controlled substances shall be subject to disciplinary action, as set forth in Section 19a-17 of the Connecticut General Statutes, if they utilize or store drugs in a manner which is not consistent with the public interest. In determining the public interest, the following factors shall be considered:
(a) Maintenance of effective controls against diversion of controlled substances into other than duly authorized legitimate medical, scientific, or commercial channels;
(b) Compliance with all applicable state and federal laws and regulations concerning controlled substances;
(c) Any conviction of the practitioner under any state or federal law relating to controlled substances;
(d) Expiration, suspension, revocation, surrender or denial of the practitioner's federal controlled substance registration;
(e) Prescribing, distributing, administering or dispensing of controlled substances in schedules other than those specified in the practitioner's state or federal registration.
(Effective April 9, 1984)