As Introduced

134th General Assembly
Regular Session
2021-2022

S. B. No. 321

Senator Romanchuk
Cosponsor: Senator Lang

A BILL

To amend sections 1.64, 109.921, 124.38, 124.82, 173.501, 173.521, 173.542, 305.03, 313.12, 313.121, 323.153, 339.01, 339.73, 339.76, 339.78, 339.81, 339.82, 503.241, 742.38, 940.09, 955.41, 1337.29, 1347.08, 1561.12, 1571.012, 1731.01, 1751.62, 1751.74, 1753.21, 2105.35, 2108.16, 2108.40, 2111.031, 2111.49, 2133.25, 2135.01, 2151.33, 2151.3515, 2151.421, 2305.235, 2313.14, 2317.47, 2317.54, 2945.38, 2967.05, 3101.05, 3105.091, 3111.12, 3111.90, 3111.93, 3111.94, 3111.96, 3119.05, 3119.54, 3301.0711, 3304.23, 3309.22, 3309.41, 3309.45, 3313.64, 3313.671, 3313.71, 3313.712, 3313.716, 3313.72, 3313.73, 3319.141, 3319.143, 3321.04, 3354.21, 3501.382, 3701.01, 3701.031, 3701.046, 3701.144, 3701.146, 3701.162, 3701.243, 3701.245, 3701.262, 3701.47, 3701.48, 3701.50, 3701.505, 3701.5010, 3701.5010f, 3701.59, 3701.60, 3701.74, 3701.76, 3705.01, 3705.15, 3705.16, 3705.17, 3705.22, 3705.29, 3705.30, 3705.30f, 3705.33, 3705.35, 3707.08, 3707.10, 3707.72, 3709.11, 3709.13, 3709.241, 3710.07, 3715.02, 3715.872, 3721.01, 3721.011, 3721.041, 3721.21,

3727.09, 3727.19, 3742.03, 3742.04, 3742.07, 3742.32, 3901.56, 3916.01, 3916.07, 3916.16, 3923.25, 3923.52, 3923.53, 3923.54, 3923.55, 3923.56, 3923.84, 3929.62, 3929.63, 3929.64, 3929.67, 4113.23, 4123.511, 4123.512, 4123.54, 4123.56, 4123.57, 4123.651, 4123.71, 4123.84, 4123.85, 4303.21, 4503.066, 4506.07, 4507.06, 4507.08, 4507.081, 4507.141, 4507.30, 4511.81, 4723.36, 4725.14, 4729.284, 4729.41, 4729.44, 4729.45, 4729.47, 5119.93, 5119.94, 5120.17, 5120.21, 5122.01, 5122.10, 5122.11, 5122.111, 5122.14, 5145.22, 5164.08, 5502.522, 5739.01, and 5901.28 and to enact sections 1337.111, 2135.15, 4723.436, and 4723.4812 of the Revised Code regarding the authority of advanced practice registered nurses, and to amend the versions of sections 3701.5010, 3705.30, and 3929.67 of the Revised Code that are scheduled to take effect on September 30, 2024, to continue the changes to those sections on and after that date.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1.64, 109.921, 124.38, 124.82, 173.501, 173.521, 173.542, 305.03, 313.12, 313.121, 323.153, 339.01, 339.73, 339.76, 339.78, 339.81, 339.82, 503.241, 742.38, 940.09, 955.41, 1337.29, 1347.08, 1561.12, 1571.012, 1731.01, 1751.62, 1751.74, 1753.21, 2105.35, 2108.16, 2108.40, 2111.031, 2111.49, 2133.25, 2135.01, 2151.33, 2151.3515, 2151.421,

2305.235, 2313.14, 2317.47, 2317.54, 2945.38, 2967.05, 3101.05, 3105.091, 3111.12, 3111.90, 3111.93, 3111.94, 3111.96, 3119.05, 3119.54, 3301.0711, 3304.23, 3309.22, 3309.41, 3309.45, 3313.64, 3313.671, 3313.71, 3313.712, 3313.716, 3313.72, 3313.73, 3319.141, 3319.143, 3321.04, 3354.21, 3501.382, 3701.01, 3701.031, 3701.046, 3701.144, 3701.146, 3701.162, 3701.243, 3701.245, 3701.262, 3701.47, 3701.48, 3701.50, 3701.505, 3701.5010, 3701.59, 3701.60, 3701.74, 3701.76, 3705.01, 3705.15, 3705.16, 3705.17, 3705.22, 3705.29, 3705.30, 3705.33, 3705.35, 3707.08, 3707.10, 3707.72, 3709.11, 3709.13, 3709.241, 3710.07, 3715.02, 3715.872, 3721.01, 3721.011, 3721.041, 3721.21, 3727.09, 3727.19, 3742.03, 3742.04, 3742.07, 3742.32, 3901.56, 3916.01, 3916.07, 3916.16, 3923.25, 3923.52, 3923.53, 3923.54, 3923.55, 3923.56, 3923.84, 3929.62, 3929.63, 3929.64, 3929.67, 4113.23, 4123.511, 4123.512, 4123.54, 4123.56, 4123.57, 4123.651, 4123.71, 4123.84, 4123.85, 4303.21, 4503.066, 4506.07, 4507.06, 4507.08, 4507.081, 4507.141, 4507.30, 4511.81, 4723.36, 4725.14, 4729.284, 4729.41, 4729.44, 4729.45, 4729.47, 5119.93, 5119.94, 5120.17, 5120.21, 5122.01, 5122.10, 5122.11, 5122.111, 5122.14, 5145.22, 5164.08, 5502.522, 5739.01, and 5901.28 be amended and sections 1337.111, 2135.15, 4723.436, and 4723.4812 of the Revised Code be enacted to read as follows:

Sec. 1.64. As used in the Revised Code<u>, when not otherwise defined</u>:

(A) "Certified nurse-midwife" means an advanced practice registered nurse who holds a current, valid license issued under Chapter 4723. of the Revised Code and is designated as a certified nurse-midwife in accordance with section 4723.42 of the Revised Code and rules adopted by the board of nursing.

(B) "Certified nurse practitioner" means an advanced

practice registered nurse who holds a current, valid license issued under Chapter 4723. of the Revised Code and is designated as a certified nurse practitioner in accordance with section 4723.42 of the Revised Code and rules adopted by the board of nursing.

(C) "Clinical nurse specialist" means an advanced practice registered nurse who holds a current, valid license issued under Chapter 4723. of the Revised Code and is designated as a clinical nurse specialist in accordance with section 4723.42 of the Revised Code and rules adopted by the board of nursing.

(D) "Physician assistant" means an individual who is licensed under Chapter 4730. of the Revised Code to provide services as a physician assistant to patients under the supervision, control, and direction of one or more physicians.

Sec. 109.921. (A) As used in this section:

(1) "Rape crisis program" means any of the following:

(a) The nonprofit state sexual assault coalition designated by the center for injury prevention and control of the federal centers for disease control and prevention;

(b) A victim witness assistance program operated by a prosecuting attorney;

(c) A program operated by a government-based or nonprofit entity that provides a full continuum of services to victims of sexual assault, including hotlines, victim advocacy, and support services from the onset of the need for services through the completion of healing, that does not provide medical services, and that may refer victims to physicians<u>, clinical nurse specialists, or certified nurse practitioners</u> for medical care but does not engage in or refer for services for which the use

of genetic services funds is prohibited by section 3701.511 of the Revised Code.

(2) "Sexual assault" means any of the following:

(a) A violation of section 2907.02, 2907.03, 2907.04, 2907.05, or former section 2907.12 of the Revised Code;

(b) A violation of an existing or former municipal ordinance or law of this or any other state or the United States that is or was substantially equivalent to any section listed in division (A)(2)(a) of this section.

(B) There is hereby created in the state treasury the rape crisis program trust fund, consisting of money paid into the fund pursuant to sections 307.515 and 311.172 of the Revised Code and any money appropriated to the fund by the general assembly or donated to the fund. The attorney general shall administer the fund. The attorney general may use not more than five per cent of the money deposited or appropriated into the fund to pay costs associated with administering this section and shall use at least ninety-five per cent of the money deposited or appropriated into the fund for the purpose of providing funding to rape crisis programs under this section.

(C)(1) The attorney general shall adopt rules under Chapter 119. of the Revised Code that establish procedures for rape crisis programs to apply to the attorney general for funding out of the rape crisis program trust fund and procedures for the attorney general to distribute money out of the fund to rape crisis programs.

(2) The attorney general may decide upon an application for funding out of the rape crisis program trust fund without a hearing. A decision of the attorney general to grant or deny

funding is final and not appealable under Chapter 119. or any other provision of the Revised Code.

(D) A rape crisis program that receives funding out of the rape crisis program trust fund shall use the money received only for the following purposes:

(1) If the program is the nonprofit state sexual assault coalition, to provide training and technical assistance to service providers;

(2) If the program is a victim witness assistance program, to provide victims of sexual assault with hotlines, victim advocacy, or support services;

(3) If the program is a government-based or nonprofit entity that provides a full continuum of services to victims of sexual assault, to provide those services and education to prevent sexual assault.

Sec. 124.38. Each of the following shall be entitled for each completed eighty hours of service to sick leave of four and six-tenths hours with pay:

(A) Employees in the various offices of the county, municipal, and civil service township service, other than superintendents and management employees, as defined in section 5126.20 of the Revised Code, of county boards of developmental disabilities;

(B) Employees of any state college or university;

(C) Any employee of any board of education for whom sick leave is not provided by section 3319.141 of the Revised Code, provided that the employee is not a substitute, adult education instructor who is scheduled to work the full-time equivalent of

less than one hundred twenty days per school year, or a person who is employed on an as-needed, seasonal, or intermittent basis.

Employees may use sick leave, upon approval of the responsible administrative officer of the employing unit, for absence due to personal illness, pregnancy, injury, exposure to contagious disease that could be communicated to other employees, and illness, injury, or death in the employee's immediate family. Unused sick leave shall be cumulative without limit. When sick leave is used, it shall be deducted from the employee's credit on the basis of one hour for every one hour of absence from previously scheduled work.

The previously accumulated sick leave of an employee who has been separated from the public service shall be placed to the employee's credit upon the employee's re-employment in the public service, provided that the re-employment takes place within ten years of the date on which the employee was last terminated from public service. This ten-year period shall be tolled for any period during which the employee holds elective public office, whether by election or by appointment.

An employee who transfers from one public agency to another shall be credited with the unused balance of the employee's accumulated sick leave up to the maximum of the sick leave accumulation permitted in the public agency to which the employee transfers.

The appointing authorities of the various offices of the county service may permit all or any part of a person's accrued but unused sick leave acquired during service with any regional council of government established in accordance with Chapter 167. of the Revised Code to be credited to the employee upon a

transfer as if the employee were transferring from one public agency to another under this section.

The appointing authority of each employing unit shall require an employee to furnish a satisfactory written, signed statement to justify the use of sick leave. If medical attention is required, a certificate stating the nature of the illness from a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner shall be required to justify the use of sick leave. Falsification of either ~~a written, signed~~ the statement or ~~a physician's~~ certificate shall be grounds for disciplinary action, including dismissal.

This section does not interfere with existing unused sick leave credit in any agency of government where attendance records are maintained and credit has been given employees for unused sick leave.

Notwithstanding this section or any other section of the Revised Code, any appointing authority of a county office, department, commission, board, or body may, upon notification to the board of county commissioners, establish alternative schedules of sick leave for employees of the appointing authority for whom the state employment relations board has not established an appropriate bargaining unit pursuant to section 4117.06 of the Revised Code, as long as the alternative schedules are not inconsistent with the provisions of at least one collective bargaining agreement covering other employees of that appointing authority, if such a collective bargaining agreement exists. If no such collective bargaining agreement exists, an appointing authority may, upon notification to the board of county commissioners, establish an alternative schedule

of sick leave for its employees that does not diminish the sick leave benefits granted by this section.

Sec. 124.82. (A) Except as provided in division (D) of this section, the department of administrative services, in consultation with the superintendent of insurance, shall, in accordance with competitive selection procedures of Chapter 125. of the Revised Code, contract with an insurance company or a health plan in combination with an insurance company, authorized to do business in this state, for the issuance of a policy or contract of health, medical, hospital, dental, vision, or surgical benefits, or any combination of those benefits, covering state employees who are paid directly by warrant of the director of budget and management, including elected state officials. The department may fulfill its obligation under this division by exercising its authority under division (A)(2) of section 124.81 of the Revised Code.

(B) Except as provided in division (D) of this section, the department may, in addition, in consultation with the superintendent of insurance, negotiate and contract with health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code, in their approved service areas only, for issuance of a contract or contracts of health care services, covering state employees who are paid directly by warrant of the director of budget and management, including elected state officials. The department may enter into contracts with one or more insurance carriers or health plans to provide the same plan of benefits, provided that:

(1) The employee be permitted to exercise the option as to which plan the employee will select under division (A) or (B) of this section, at a time that shall be determined by the

department;

(2) The health insuring corporations do not refuse to accept the employee, or the employee and the employee's family, if the employee exercises the option to select care provided by the corporations;

(3) The employee may choose participation in only one of the plans sponsored by the department;

(4) The director of health examines and certifies to the department that the quality and adequacy of care rendered by the health insuring corporations meet at least the standards of care provided by hospitals ~~and~~, physicians, and advanced practice registered nurses in that employee's community, who would be providing such care as would be covered by a contract awarded under division (A) of this section.

(C) All or any portion of the cost, premium, or charge for the coverage in divisions (A) and (B) of this section may be paid in such manner or combination of manners as the department determines and may include the proration of health care costs, premiums, or charges for part-time employees.

(D) Notwithstanding divisions (A) and (B) of this section, the department may provide benefits equivalent to those that may be paid under a policy or contract issued by an insurance company or a health plan pursuant to division (A) or (B) of this section.

(E) This section does not prohibit the state office of collective bargaining from entering into an agreement with an employee representative for the purposes of providing fringe benefits, including, but not limited to, hospitalization, surgical care, major medical care, disability, dental care,

vision care, medical care, hearing aids, prescription drugs, group life insurance, sickness and accident insurance, group legal services or other benefits, or any combination of those benefits, to employees paid directly by warrant of the director of budget and management through a jointly administered trust fund. The employer's contribution for the cost of the benefit care shall be mutually agreed to in the collectively bargained agreement. The amount, type, and structure of fringe benefits provided under this division is subject to the determination of the board of trustees of the jointly administered trust fund. Notwithstanding any other provision of the Revised Code, competitive bidding does not apply to the purchase of fringe benefits for employees under this division when those benefits are provided through a jointly administered trust fund.

(F) Members of state boards or commissions may be covered by any policy, contract, or plan of benefits or services described in division (A) or (B) of this section. Board or commission members who are appointed for a fixed term and who are compensated on a per meeting basis, or paid only for expenses, or receive a combination of per diem payments and expenses shall pay the entire amount of the premiums, costs, or charges for that coverage.

Sec. 173.501. (A) As used in this section:

"Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

"PACE provider" has the same meaning as in the "Social Security Act," section 1934(a)(3), 42 U.S.C. 1396u-4(a)(3).

(B) The department of aging shall establish a home first component of the PACE program under which eligible individuals

may be enrolled in the PACE program in accordance with this section. An individual is eligible for the PACE program's home first component if both of the following apply:

(1) The individual has been determined to be eligible for the PACE program.

(2) At least one of the following applies:

(a) The individual has been admitted to a nursing facility.

(b) A physician, clinical nurse specialist, or certified nurse practitioner has determined and documented in writing that the individual has a medical condition that, unless the individual is enrolled in home and community-based services such as the PACE program, will require the individual to be admitted to a nursing facility within thirty days of the physician's or nurse's determination.

(c) The individual has been hospitalized and a physician, clinical nurse specialist, or certified nurse practitioner has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the PACE program, the individual is to be transported directly from the hospital to a nursing facility and admitted.

(d) Both of the following apply:

(i) The individual is the subject of a report made under section 5101.63 of the Revised Code regarding abuse, neglect, or exploitation or such a report referred to a county department of job and family services under section 5126.31 of the Revised Code or has made a request to a county department for protective services as defined in section 5101.60 of the Revised Code.

(ii) A county department of job and family services and an area agency on aging have jointly documented in writing that, unless the individual is enrolled in home and community-based services such as the PACE program, the individual should be admitted to a nursing facility.

(C) Each month, the department of aging shall identify individuals who are eligible for the home first component of the PACE program. When the department identifies such an individual, the department shall notify the PACE provider serving the area in which the individual resides. The PACE provider shall determine whether the PACE program is appropriate for the individual and whether the individual would rather participate in the PACE program than continue or begin to reside in a nursing facility. If the PACE provider determines that the PACE program is appropriate for the individual and the individual would rather participate in the PACE program than continue or begin to reside in a nursing facility, the PACE provider shall so notify the department of aging. On receipt of the notice from the PACE provider, the department of aging shall approve the individual's enrollment in the PACE program in accordance with priorities established in rules adopted under section 173.50 of the Revised Code.

Sec. 173.521. (A) Unless the medicaid-funded component of the PASSPORT program is terminated pursuant to division (C) of section 173.52 of the Revised Code, the department shall establish a home first component of the PASSPORT program under which eligible individuals may be enrolled in the medicaid-funded component of the PASSPORT program in accordance with this section. An individual is eligible for the PASSPORT program's home first component if both of the following apply:

(1) The individual has been determined to be eligible for the medicaid-funded component of the PASSPORT program.

(2) At least one of the following applies:

(a) The individual has been admitted to a nursing facility.

(b) A physician, clinical nurse specialist, or certified nurse practitioner has determined and documented in writing that the individual has a medical condition that, unless the individual is enrolled in home and community-based services such as the PASSPORT program, will require the individual to be admitted to a nursing facility within thirty days of the physician's or nurse's determination.

(c) The individual has been hospitalized and a physician, clinical nurse specialist, or certified nurse practitioner has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the PASSPORT program, the individual is to be transported directly from the hospital to a nursing facility and admitted.

(d) Both of the following apply:

(i) The individual is the subject of a report made under section 5101.63 of the Revised Code regarding abuse, neglect, or exploitation or such a report referred to a county department of job and family services under section 5126.31 of the Revised Code or has made a request to a county department for protective services as defined in section 5101.60 of the Revised Code.

(ii) A county department of job and family services and an area agency on aging have jointly documented in writing that, unless the individual is enrolled in home and community-based services such as the PASSPORT program, the individual should be

admitted to a nursing facility.

(B) Each month, each area agency on aging shall identify individuals residing in the area that the agency serves who are eligible for the home first component of the PASSPORT program. When an area agency on aging identifies such an individual, the agency shall notify the long-term care consultation program administrator serving the area in which the individual resides. The administrator shall determine whether the PASSPORT program is appropriate for the individual and whether the individual would rather participate in the PASSPORT program than continue or begin to reside in a nursing facility. If the administrator determines that the PASSPORT program is appropriate for the individual and the individual would rather participate in the PASSPORT program than continue or begin to reside in a nursing facility, the administrator shall so notify the department of aging. On receipt of the notice from the administrator, the department shall approve the individual's enrollment in the medicaid-funded component of the PASSPORT program regardless of the unified waiting list established under section 173.55 of the Revised Code, unless the enrollment would cause the component to exceed any limit on the number of individuals who may be enrolled in the component as set by the United States secretary of health and human services in the PASSPORT waiver.

Sec. 173.542. (A) Unless the medicaid-funded component of the assisted living program is terminated pursuant to division (C) of section 173.54 of the Revised Code, the department of aging shall establish a home first component of the assisted living program under which eligible individuals may be enrolled in the medicaid-funded component of the assisted living program in accordance with this section. An individual is eligible for the assisted living program's home first component if both of

the following apply:

(1) The individual has been determined to be eligible for the medicaid-funded component of the assisted living program.

(2) At least one of the following applies:

(a) The individual has been admitted to a nursing facility.

(b) A physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined and documented in writing that the individual has a medical condition that, unless the individual is enrolled in home and community-based services such as the assisted living program, will require the individual to be admitted to a nursing facility within thirty days of the physician's or nurse's determination.

(c) The individual has been hospitalized and a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined and documented in writing that, unless the individual is enrolled in home and community-based services such as the assisted living program, the individual is to be transported directly from the hospital to a nursing facility and admitted.

(d) Both of the following apply:

(i) The individual is the subject of a report made under section 5101.63 of the Revised Code regarding abuse, neglect, or exploitation or such a report referred to a county department of job and family services under section 5126.31 of the Revised Code or has made a request to a county department for protective services as defined in section 5101.60 of the Revised Code.

(ii) A county department of job and family services and an

area agency on aging have jointly documented in writing that, unless the individual is enrolled in home and community-based services such as the assisted living program, the individual should be admitted to a nursing facility.

(B) Each month, each area agency on aging shall identify individuals residing in the area that the area agency on aging serves who are eligible for the home first component of the assisted living program. When an area agency on aging identifies such an individual and determines that there is a vacancy in a residential care facility participating in the medicaid-funded component of the assisted living program that is acceptable to the individual, the agency shall notify the long-term care consultation program administrator serving the area in which the individual resides. The administrator shall determine whether the assisted living program is appropriate for the individual and whether the individual would rather participate in the assisted living program than continue or begin to reside in a nursing facility. If the administrator determines that the assisted living program is appropriate for the individual and the individual would rather participate in the assisted living program than continue or begin to reside in a nursing facility, the administrator shall so notify the department of aging. On receipt of the notice from the administrator, the department shall approve the individual's enrollment in the medicaid-funded component of the assisted living program regardless of the unified waiting list established under section 173.55 of the Revised Code, unless the enrollment would cause the component to exceed any limit on the number of individuals who may participate in the component as set by the United States secretary of health and human services in the assisted living waiver.

Sec. 305.03. (A)(1) Whenever any county officer, except the county auditor or county treasurer, fails to perform the duties of office for ninety consecutive days, except in case of sickness or injury as provided in divisions (B) and (C) of this section, the office shall be deemed vacant.

(2) Whenever any county auditor or county treasurer fails to perform the duties of office for thirty consecutive days, except in case of sickness or injury as provided in divisions (B) and (C) of this section, the office shall be deemed vacant.

(B) Whenever any county officer is absent because of sickness or injury, the officer shall cause to be filed with the board of county commissioners a ~~physician's~~ certificate from a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner of the officer's sickness or injury. If the certificate is not filed with the board within ten days after the expiration of thirty consecutive days, in the case of a county auditor or county treasurer, or within ten days after the expiration of ninety consecutive days of absence, in the case of all other county officers, the office shall be deemed vacant.

(C) Whenever a county officer files a ~~physician's~~ certificate under division (B) of this section, but continues to be absent for an additional thirty days commencing immediately after the last day on which this certificate may be filed under division (B) of this section, the office shall be deemed vacant.

(D) If at any time two county commissioners in a county are absent and have filed a ~~physician's~~ certificate under division (B) of this section, the county coroner, in addition to performing the duties of coroner, shall serve as county commissioner until at least one of the absent commissioners

returns to office or until the office of at least one of the absent commissioners is deemed vacant under this section and the vacancy is filled. If the coroner so requests, the coroner shall be paid a per diem rate for the coroner's service as a commissioner. That per diem rate shall be the annual salary specified by law for a county commissioner of that county whose term of office began in the same year as the coroner's term of office began, divided by the number of days in the year.

While the coroner is serving as a county commissioner, the coroner shall be considered an acting county commissioner and shall perform the duties of the office of county commissioner until at least one of the absent commissioners returns to office or until the office of at least one of the absent commissioners is deemed vacant. Before assuming the office of acting county commissioner, the coroner shall take an oath of office as provided in sections 3.22 and 3.23 of the Revised Code. The coroner's service as an acting county commissioner does not constitute the holding of an incompatible public office or employment in violation of any statutory or common law prohibition against the simultaneous holding of more than one public office or employment.

The coroner shall give a new bond in the same amount and signed and approved as provided in section 305.04 of the Revised Code. The bond shall be conditioned for the faithful discharge of the coroner's duties as acting county commissioner and for the payment of any loss or damage that the county may sustain by reason of the coroner's failure in those duties. The bond, along with the oath of office and approval of the probate judge indorsed on it, shall be deposited and paid for as provided for the bonds in section 305.04 of the Revised Code.

(E) Any vacancy declared under this section shall be filled in the manner provided by section 305.02 of the Revised Code.

(F) This section shall not apply to a county officer while in the active military service of the United States.

Sec. 313.12. (A) When any person dies as a result of criminal or other violent means, by casualty, by suicide, or in any suspicious or unusual manner, when any person, including a child under two years of age, dies suddenly when in apparent good health, or when any person with a developmental disability dies regardless of the circumstances, the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner called in attendance, or any member of an ambulance service, emergency squad, or law enforcement agency who obtains knowledge thereof arising from the person's duties, shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and circumstances of the death, and any other information that is required pursuant to sections 313.01 to 313.22 of the Revised Code. In such cases, if a request is made for cremation, the funeral director called in attendance shall immediately notify the coroner.

(B) As used in this section, "developmental disability" has the same meaning as in section 5123.01 of the Revised Code.

Sec. 313.121. (A) As used in this section, "parent" means either parent, except that if one parent has been designated the residential parent and legal custodian of the child, "parent" means the designated residential parent and legal custodian, and if a person other than a parent is the child's legal guardian, "parent" means the legal guardian.

(B) If a child under two years of age dies suddenly when in apparent good health, the death shall be reported immediately to the coroner of the county in which the death occurred, as required by section 313.12 of the Revised Code. Except as provided in division (C) of this section, the coroner or deputy coroner shall perform an autopsy on the child. The autopsy shall be performed in accordance with rules adopted by the director of health under section 313.122 of the Revised Code. The coroner or deputy coroner may perform research procedures and tests when performing the autopsy.

If the child was one year of age or younger at the time of death and the death occurred suddenly and unexpectedly, the cause of which is not immediately obvious prior to investigation, the coroner, deputy coroner, or other individual who has been designated to investigate the child's death shall complete a sudden unexplained infant death investigation reporting form (SUIDI reporting form) developed by the United States centers for disease control and prevention or an alternative reporting form. The director of health may develop an alternative reporting form in consultation with the Ohio state coroners association. The individual who completes the reporting form shall retain the form and send a copy of it to the appropriate child fatality review board or regional child fatality review board established under section 307.621 of the Revised Code. If a coroner or deputy coroner completes the reporting form, a copy of the coroner's report described in section 313.09 of the Revised Code shall also be sent to the board.

A completed reporting form and copies of completed reporting forms are not public records under section 149.43 of the Revised Code.

(C) A coroner or deputy coroner is not required to perform an autopsy if the coroner of the county in which the death occurred or a court with jurisdiction over the deceased body determines under section 313.131 of the Revised Code that an autopsy is contrary to the religious beliefs of the child. If the coroner or the court makes such a determination, the coroner shall notify the health district or department of health with jurisdiction in the area in which the child's parent resides. For purposes of this division, the religious beliefs of the parents of a child shall be considered to be the religious beliefs of the child.

(D) If the child's parent makes a written or verbal request for the preliminary results of the autopsy after the results are available, the coroner, or a person designated by the coroner, shall give the parent an oral statement of the preliminary results.

The coroner, within a reasonable time after the final results of the autopsy are reported, shall send written notice of the results to the state department of health, the health district or department with jurisdiction in the area in which the child's parent resides, and, upon the request of a parent of the child, to the child's attending physician<u>, clinical nurse specialist, or certified nurse practitioner</u>. Upon the written request of a parent of the child and the payment of the transcript fee required by section 313.10 of the Revised Code, the coroner shall send written notice of the final results to that parent. The notice sent to the state department of health shall include all of the information specified in rules adopted under section 313.122 of the Revised Code.

(E) On the occurrence of any of the following, the health

district or department with jurisdiction in the area in which the child's parent resides shall offer the parent any counseling or other supportive services it has available:

(1) When it learns through any source that an autopsy is being performed on a child under two years of age who died suddenly when in apparent good health;

(2) When it receives notice that the final result of an autopsy performed pursuant to this section concluded that the child died of sudden infant death syndrome;

(3) When it is notified by the coroner that, pursuant to division (C) of this section, an autopsy was not performed.

(F) When a health district or department receives notice that the final result of an autopsy performed pursuant to this section concluded that the child died of sudden infant death syndrome or that, pursuant to division (C) of this section, an autopsy was not performed but sudden infant death syndrome may have been the cause of death, it shall offer the child's parent information about sudden infant death syndrome. The state department of health shall ensure that current information on sudden infant death syndrome is available for distribution by health districts and departments.

Sec. 323.153. (A) To obtain a reduction in real property taxes under division (A) or (B) of section 323.152 of the Revised Code or in manufactured home taxes under division (B) of section 323.152 of the Revised Code, the owner shall file an application with the county auditor of the county in which the owner's homestead is located.

To obtain a reduction in real property taxes under division (A) of section 323.152 of the Revised Code, the

occupant of a homestead in a housing cooperative shall file an application with the nonprofit corporation that owns and operates the housing cooperative, in accordance with this paragraph. Not later than the first day of March each year, the corporation shall obtain applications from the county auditor's office and provide one to each new occupant. Not later than the first day of May, any occupant who may be eligible for a reduction in taxes under division (A) of section 323.152 of the Revised Code shall submit the completed application to the corporation. Not later than the fifteenth day of May, the corporation shall file all completed applications, and the information required by division (B) of section 323.159 of the Revised Code, with the county auditor of the county in which the occupants' homesteads are located. Continuing applications shall be furnished to an occupant in the manner provided in division (C)(4) of this section.

(1) An application for reduction based upon a physical or mental disability shall be accompanied by a certificate attesting to the fact that the applicant is permanently and totally disabled, signed by a person licensed to practice in this state and in accordance with the following: a certificate pertaining to a physical disability shall be signed by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner and ~~an application for reduction based upon~~ a certificate pertaining to a mental disability shall be ~~accompanied by a certificate~~ signed by a physician ~~or~~, psychologist ~~licensed to practice in this state~~, ~~attesting to the fact that the applicant is permanently and totally disabled~~or clinical nurse specialist or certified nurse practitioner certified as a psychiatric-mental health CNS or psychiatric-mental health NP by the American nurses

credentialing center. The certificate shall be in a form that the tax commissioner requires and shall include the definition of permanently and totally disabled as set forth in section 323.151 of the Revised Code. An application for reduction based upon a disability certified as permanent and total by a state or federal agency having the function of so classifying persons shall be accompanied by a certificate from that agency.

An application by a disabled veteran for the reduction under division (A)(2) of section 323.152 of the Revised Code shall be accompanied by a letter or other written confirmation from the United States department of veterans affairs, or its predecessor or successor agency, showing that the veteran qualifies as a disabled veteran.

An application by the surviving spouse of a public service officer killed in the line of duty for the reduction under division (A)(3) of section 323.152 of the Revised Code shall be accompanied by a letter or other written confirmation from an employee or officer of the board of trustees of a retirement or pension fund in this state or another state or from the chief or other chief executive of the department, agency, or other employer for which the public service officer served when killed in the line of duty affirming that the public service officer was killed in the line of duty.

An application for a reduction under division (A) of section 323.152 of the Revised Code constitutes a continuing application for a reduction in taxes for each year in which the dwelling is the applicant's homestead.

(2) An application for a reduction in taxes under division (B) of section 323.152 of the Revised Code shall be filed only if the homestead or manufactured or mobile home was transferred

in the preceding year or did not qualify for and receive the reduction in taxes under that division for the preceding tax year. The application for homesteads transferred in the preceding year shall be incorporated into any form used by the county auditor to administer the tax law in respect to the conveyance of real property pursuant to section 319.20 of the Revised Code or of used manufactured homes or used mobile homes as defined in section 5739.0210 of the Revised Code. The owner of a manufactured or mobile home who has elected under division (D)(4) of section 4503.06 of the Revised Code to be taxed under division (D)(2) of that section for the ensuing year may file the application at the time of making that election. The application shall contain a statement that failure by the applicant to affirm on the application that the dwelling on the property conveyed is the applicant's homestead prohibits the owner from receiving the reduction in taxes until a proper application is filed within the period prescribed by division (A)(3) of this section. Such an application constitutes a continuing application for a reduction in taxes for each year in which the dwelling is the applicant's homestead.

(3) Failure to receive a new application filed under division (A)(1) or (2) or notification under division (C) of this section after an application for reduction has been approved is prima-facie evidence that the original applicant is entitled to the reduction in taxes calculated on the basis of the information contained in the original application. The original application and any subsequent application, including any late application, shall be in the form of a signed statement and shall be filed on or before the thirty-first day of December of the year for which the reduction is sought. The original application and any subsequent application for a reduction in

manufactured home taxes shall be filed in the year preceding the year for which the reduction is sought. The statement shall be on a form, devised and supplied by the tax commissioner, which shall require no more information than is necessary to establish the applicant's eligibility for the reduction in taxes and the amount of the reduction, and, except for homesteads that are units in a housing cooperative, shall include an affirmation by the applicant that ownership of the homestead was not acquired from a person, other than the applicant's spouse, related to the owner by consanguinity or affinity for the purpose of qualifying for the real property or manufactured home tax reduction provided for in division (A) or (B) of section 323.152 of the Revised Code. The form shall contain a statement that conviction of willfully falsifying information to obtain a reduction in taxes or failing to comply with division (C) of this section results in the revocation of the right to the reduction for a period of three years. In the case of an application for a reduction in taxes for persons described in division (A)(1)(b)(iii) of section 323.152 of the Revised Code, the form shall contain a statement that signing the application constitutes a delegation of authority by the applicant to the tax commissioner or the county auditor, individually or in consultation with each other, to examine any tax or financial records relating to the income of the applicant as stated on the application for the purpose of determining eligibility for the exemption or a possible violation of division (D) or (E) of this section.

(B) A late application for a tax reduction for the year preceding the year in which an original application is filed, or for a reduction in manufactured home taxes for the year in which an original application is filed, may be filed with the original application. If the county auditor determines the information

contained in the late application is correct, the auditor shall determine the amount of the reduction in taxes to which the applicant would have been entitled for the preceding tax year had the applicant's application been timely filed and approved in that year.

The amount of such reduction shall be treated by the auditor as an overpayment of taxes by the applicant and shall be refunded in the manner prescribed in section 5715.22 of the Revised Code for making refunds of overpayments. The county auditor shall certify the total amount of the reductions in taxes made in the current year under this division to the tax commissioner, who shall treat the full amount thereof as a reduction in taxes for the preceding tax year and shall make reimbursement to the county therefor in the manner prescribed by section 323.156 of the Revised Code, from money appropriated for that purpose.

(C)(1) If, in any year after an application has been filed under division (A)(1) or (2) of this section, the owner does not qualify for a reduction in taxes on the homestead or on the manufactured or mobile home set forth on such application, the owner shall notify the county auditor that the owner is not qualified for a reduction in taxes.

(2) If, in any year after an application has been filed under division (A)(1) of this section, the occupant of a homestead in a housing cooperative does not qualify for a reduction in taxes on the homestead, the occupant shall notify the county auditor that the occupant is not qualified for a reduction in taxes or file a new application under division (A)(1) of this section.

(3) If the county auditor or county treasurer discovers

that an owner of property or occupant of a homestead in a housing cooperative not entitled to the reduction in taxes under division (A) or (B) of section 323.152 of the Revised Code failed to notify the county auditor as required by division (C)(1) or (2) of this section, a charge shall be imposed against the property in the amount by which taxes were reduced under that division for each tax year the county auditor ascertains that the property was not entitled to the reduction and was owned by the current owner or, in the case of a homestead in a housing cooperative, occupied by the current occupant. Interest shall accrue in the manner prescribed by division (B) of section 323.121 or division (G)(2) of section 4503.06 of the Revised Code on the amount by which taxes were reduced for each such tax year as if the reduction became delinquent taxes at the close of the last day the second installment of taxes for that tax year could be paid without penalty. The county auditor shall notify the owner or occupant, by ordinary mail, of the charge, of the owner's or occupant's right to appeal the charge, and of the manner in which the owner or occupant may appeal. The owner or occupant may appeal the imposition of the charge and interest by filing an appeal with the county board of revision not later than the last day prescribed for payment of real and public utility property taxes under section 323.12 of the Revised Code following receipt of the notice and occurring at least ninety days after receipt of the notice. The appeal shall be treated in the same manner as a complaint relating to the valuation or assessment of real property under Chapter 5715. of the Revised Code. The charge and any interest shall be collected as other delinquent taxes.

(4) Each year during January, the county auditor shall furnish by ordinary mail a continuing application to each person

receiving a reduction under division (A) of section 323.152 of the Revised Code. The continuing application shall be used to report changes in total income, ownership, occupancy, disability, and other information earlier furnished the auditor relative to the reduction in taxes on the property. The continuing application shall be returned to the auditor not later than the thirty-first day of December; provided, that if such changes do not affect the status of the homestead exemption or the amount of the reduction to which the owner is entitled under division (A) of section 323.152 of the Revised Code or to which the occupant is entitled under section 323.159 of the Revised Code, the application does not need to be returned.

(5) Each year during February, the county auditor, except as otherwise provided in this paragraph, shall furnish by ordinary mail an original application to the owner, as of the first day of January of that year, of a homestead or a manufactured or mobile home that transferred during the preceding calendar year and that qualified for and received a reduction in taxes under division (B) of section 323.152 of the Revised Code for the preceding tax year. In order to receive the reduction under that division, the owner shall file the application with the county auditor not later than the thirty-first day of December. If the application is not timely filed, the auditor shall not grant a reduction in taxes for the homestead for the current year, and shall notify the owner that the reduction in taxes has not been granted, in the same manner prescribed under section 323.154 of the Revised Code for notification of denial of an application. Failure of an owner to receive an application does not excuse the failure of the owner to file an original application. The county auditor is not required to furnish an application under this paragraph for any

homestead for which application has previously been made on a form incorporated into any form used by the county auditor to administer the tax law in respect to the conveyance of real property or of used manufactured homes or used mobile homes, and an owner who previously has applied on such a form is not required to return an application furnished under this paragraph.

(D) No person shall knowingly make a false statement for the purpose of obtaining a reduction in the person's real property or manufactured home taxes under section 323.152 of the Revised Code.

(E) No person shall knowingly fail to notify the county auditor of changes required by division (C) of this section that have the effect of maintaining or securing a reduction in taxes under section 323.152 of the Revised Code.

(F) No person shall knowingly make a false statement or certification attesting to any person's physical or mental condition for purposes of qualifying such person for tax relief pursuant to sections 323.151 to 323.159 of the Revised Code.

Sec. 339.01. (A) As used in sections 339.01 to 339.17 of the Revised Code:

(1) "Hospital facilities" has the meaning given in section 140.01 of the Revised Code.

(2) "County hospital" includes all of the county hospital's branches and hospital facilities, wherever located.

(3) "Outpatient health facility" means a facility where medical care and preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services are provided to outpatients by or under the direction of a physician, certified

nurse-midwife, clinical nurse specialist, certified nurse practitioner, or dentist.

(B) A board of county commissioners may purchase, acquire, lease, appropriate, and construct a county hospital or hospital facilities thereof. After a county hospital or hospital facilities have been fully completed and sufficiently equipped for occupancy, any subsequent improvements, enlargements, or rebuilding of any such facility shall be made by the board of county hospital trustees or a hospital commission appointed pursuant to section 339.14 of the Revised Code.

(C)(1) A board of county commissioners, board of county hospital trustees, or hospital commission may purchase, acquire, lease, appropriate, or construct an outpatient health facility in another county to serve as a branch of the county hospital. The outpatient health facility may include office space for physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners. The facility shall be operated pursuant to the law that regulates the operation of the county hospital.

(2) When a proposal to establish an outpatient health facility in another county is made by a board of hospital trustees or a hospital commission, all of the following apply:

(a) The board of county hospital trustees or hospital commission shall give written notice to its board of county commissioners and to the board of county commissioners of the county where the facility is to be located. The board of county commissioners where the facility is to be located, by resolution adopted within forty days after receipt of the notice, may object to the proposed facility. The resolution shall include an explanation of the objection and may make any recommendations

the board considers necessary. The board shall send a copy of the resolution to the board of county hospital trustees or the hospital commission and to the board of county commissioners of the county that proposes to locate the facility in the other county.

(b) Except as provided in division (C)(2)(c) of this section, the board of county hospital trustees or the hospital commission may establish and operate the facility, unless the board of county commissioners of the county proposing to locate the facility in the other county, not later than twenty days after receiving a resolution of objection from the other county's board of county commissioners pursuant to division (C)(2)(a) of this section, adopts a resolution denying the trustees or commission the right to establish the facility.

(c) If a board of county commissioners provides a subsidy for uncompensated care to a board of county hospital trustees or hospital commission, the board of county hospital trustees or hospital commission may establish and operate the outpatient health facility only if that board of county commissioners approves the establishment of the facility.

(D) Notwithstanding division (C) of this section, a board of county hospital trustees of a charter county hospital, as defined in section 339.061 of the Revised Code, may purchase, acquire, lease, construct, own, operate, or manage hospital facilities in a county contiguous to a charter county. Such hospital facilities shall be operated pursuant to the law that regulates the operation of a charter county hospital.

(E) A county hospital may be designated as a monument to commemorate the services of the soldiers, sailors, marines, and pioneers of the county.

Sec. 339.73. Each county or district tuberculosis control unit shall ensure that tuberculosis treatment is made available to all individuals with tuberculosis who reside in the area served by the unit. In making treatment available, the tuberculosis control unit may provide the treatment or make referrals for receipt of treatment from other entities. The unit may make referrals for receipt of temporary housing.

The tuberculosis treatment provided under this section is limited to cases of active tuberculosis and infected contacts and includes provision of antituberculosis medication, conduct of an investigation under section 339.80 of the Revised Code, provision of appropriate follow-up services for confirmed and suspected cases of active tuberculosis, and provision of services by a physician, clinical nurse specialist, or certified nurse practitioner through a course of therapy that meets the standards for tuberculosis treatment established by the United States centers for disease control and prevention or the American thoracic society.

The tuberculosis control unit shall serve all residents within its jurisdiction, regardless of the length of time that the individual has resided in the area or the individual's income and resources. An individual who receives tuberculosis treatment shall disclose to the tuberculosis control unit the identity of any third party against whom the individual has or may have a right of recovery for the treatment provided. The board of county commissioners is the payor of last resort for tuberculosis treatment and shall pay for treatment only to the extent that payment is not made through third-party benefits.

Sec. 339.76. The board of county commissioners of any county may establish and maintain one or more tuberculosis

clinics in the county and may employ physicians, clinical nurse specialists, certified nurse practitioners, public health nurses, and other persons for the operation of such clinics or other means as are provided for the prevention, cure, and treatment of tuberculosis. The board may provide by tax levies, or otherwise, the necessary funds for such clinics to be established, maintained, and operated. Clinics so established shall be under the control of the board of county commissioners, and shall be supervised by a board of three trustees, similar in all respects to and with all the powers enjoyed by a board of trustees of a county hospital, or by a city or general district board of health within the county, as the board of county commissioners designates.

The boards of county commissioners of two or more counties may join together to establish a joint county tuberculosis clinic. Clinics so established shall be under the control of the joint boards of county commissioners of the member counties and shall be supervised by a board of trustees, such board to consist of an equal number of trustees from each of the member counties, with all of the powers enjoyed by a board of trustees of a county hospital, or by a city or general health district board of health within the county where the clinic is located, as the member boards of county commissioners shall designate. The cost of the establishment and the maintenance of such clinics shall be distributed among the member counties as agreed upon by such members, and such costs shall be paid from the respective county general funds, or from tax levies, or both.

Sec. 339.78. (A) When a physician, clinical nurse specialist, or certified nurse practitioner completes diagnostic studies confirming that an individual has tuberculosis, the physician or nurse shall report the confirmed case of

tuberculosis to the county or district tuberculosis control unit. A physician or nurse shall make a report to the tuberculosis control unit prior to completion of diagnostic studies if the signs and symptoms demonstrated by an individual are sufficient for the physician or nurse to suspect that the individual has tuberculosis. At any time it is determined that an individual's tuberculosis is resistant to one or more drugs, the physician or nurse shall make a report to the unit.

The physician, clinical nurse specialist, or certified nurse practitioner attending an individual with tuberculosis shall document the individual's adherence to the treatment regimen that the physician or nurse prescribes and make a report to the tuberculosis control unit if the individual does not adhere to the regimen.

In each report made under this division, the physician, clinical nurse specialist, or certified nurse practitioner shall provide all information that the tuberculosis control unit requests. The information shall be provided at intervals specified by the tuberculosis control unit.

(B) In addition to accepting reports made by physicians, clinical nurse specialists, or certified nurse practitioners under division (A) of this section, a county or district tuberculosis control unit shall accept reports made as follows:

(1) The administrator of a hospital, clinic, or other facility that is providing services to an individual who is confirmed to have or is suspected of having tuberculosis shall report the case to the tuberculosis control unit;

(2) The administrator of a laboratory that performs tests for tuberculosis on human specimens shall report to the

tuberculosis control unit each positive tuberculosis test result obtained;

(3) Any person who suspects that an individual has tuberculosis may report that suspicion to the tuberculosis control unit.

Sec. 339.81. Any information, data, and reports with respect to a case of tuberculosis that are furnished to, or procured by, a county or district tuberculosis control unit or the department of health shall be confidential and used only for statistical, scientific, and medical research for the purpose of controlling tuberculosis in this state. No physician, clinical nurse specialist, certified nurse practitioner, hospital, or other entity furnishing information, data, or reports pursuant to this chapter shall by reason of such furnishing be deemed to have violated any confidential relationship, be held to answer for willful betrayal of a professional confidence, or be held liable in damages to any person.

Sec. 339.82. Except as provided in section 339.89 of the Revised Code, all of the following apply to individuals with tuberculosis:

(A)(1) An individual who has been diagnosed as having active tuberculosis shall complete the entire tuberculosis treatment regimen prescribed for the individual by a physician, clinical nurse specialist, or certified nurse practitioner. The regimen prescribed shall include a course of antituberculosis medication, recommendations for management of tuberculosis, and instructions for following contagion precautions to prevent the spread of tuberculosis.

(2) If an individual fails to take prescribed

antituberculosis medication in accordance with division (A)(1) of this section, the county or district tuberculosis control unit shall establish a procedure under which the individual is required to be witnessed ingesting the antituberculosis medication by individuals designated by the unit. The individual shall take the medication in accordance with the procedure.

(B) An individual with communicable tuberculosis who is not hospitalized or otherwise confined shall not attend any public gathering or be in any public place that the county or district tuberculosis control unit determines cannot be maintained in a manner adequate to protect others from the spread of the disease. An individual with communicable tuberculosis who cannot be maintained outside of a hospital in a manner adequate to protect others from the spread of the disease shall submit to hospitalization and remain hospitalized.

(C) An individual with active tuberculosis who intends to travel or relocate shall notify the county or district tuberculosis control unit. The unit shall notify the Ohio department of health when an individual with active tuberculosis relocates. The department shall notify the tuberculosis control unit of the tuberculosis control district to which the individual intends to travel or relocate or the appropriate public health authority of the state to which the individual intends to travel or relocate.

Sec. 503.241. Whenever any township officer ceases to reside in the township, or is absent from the township for ninety consecutive days, except in case of sickness or injury as provided in this section, ~~his~~ the officer's office shall be deemed vacant and the board of township trustees shall declare a vacancy to exist in such office.

Such vacancy shall be filled in the manner provided by section 503.24 of the Revised Code. Whenever any township officer is absent from the township because of sickness or injury, ~~he~~ the officer shall cause to be filed with the board of township trustees a ~~physician's~~ certificate from a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner of ~~his~~ the officer's sickness or injury. If such certificate is not filed with the board within ten days after the expiration of the ninety consecutive days of absence from the township, ~~his~~ the officer's office shall be deemed vacant and the board of township trustees shall declare a vacancy to exist in such office.

This section shall not apply to a township officer while in the active military service of the United States.

Sec. 742.38. (A)(1) The board of trustees of the Ohio police and fire pension fund shall adopt rules establishing minimum medical testing and diagnostic standards or procedures to be incorporated into physical examinations administered by physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners to prospective members of the fund. The standards or procedures shall include diagnosis and evaluation of the existence of any heart disease, cardiovascular disease, or respiratory disease. The rules shall specify the form of the physician's or nurse's report and the information to be included in it.

The board shall notify all employers of the establishment of the minimum standards or procedures and shall include with the notice a copy of the standards or procedures. The board shall notify all employers of any changes made to the standards or procedures. Once the standards or procedures take effect,

employers shall cause each prospective member of the fund to submit to a physical examination that incorporates the standards or procedures.

(2) Division (A)(2) of this section applies to an employee who becomes a member of the fund on or after the date the minimum standards or procedures described in division (A)(1) of this section take effect. For each employee described in division (A)(2) of this section, the employer shall forward to the board a copy of the physician's or nurse's report of a physical examination that incorporates the standards or procedures described in division (A)(1) of this section. If an employer fails to forward the report in the form required by the board on or before the date that is sixty days after the employee becomes a member of the fund, the board shall assess against the employer a penalty determined under section 742.353 of the Revised Code.

(B) Application for a disability benefit may be made by a member of the fund or, if the member is incapacitated as defined in rules adopted by the board, by a person acting on the member's behalf. Not later than fourteen days after receiving an application for a disability benefit from a member or a person acting on behalf of a member, the board shall notify the member's employer that an application has been filed. The notice shall state the member's position or rank. Not later than twenty-eight days after receiving the notice or filing an application on behalf of a member, the employer shall forward to the board a statement certifying the member's job description and any other information required by the board to process the application.

If the member applying for a disability benefit becomes a

member of the fund prior to the date the minimum standards or procedures described in division (A)(1) of this section take effect, the board may request from the member's employer a copy of the physician's or nurse's report of the member's physical examination taken on entry into the police or fire department or, if the employer does not have a copy of the report, a written statement certifying that the employer does not have a copy of the report. If an employer fails to forward the report or statement in the form required by the board on or before the date that is twenty-eight days after the date of the request, the board shall assess against the employer a penalty determined under section 742.353 of the Revised Code. The board shall maintain the information submitted under this division and division (A)(2) of this section in the member's file.

(C) For purposes of determining under division (D) of this section whether a member of the fund is disabled, the board shall adopt rules establishing objective criteria under which the board shall make the determination. The rules shall include standards that provide for all of the following:

(1) Evaluating a member's illness or injury on which an application for disability benefits is based;

(2) Defining the occupational duties of a police officer or firefighter;

(3) Providing for the board to assign competent and disinterested physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, and vocational evaluators to conduct examinations of a member;

(4) Requiring a written report for each disability application that includes a summary of findings, medical

opinions, including an opinion on whether the illness or injury upon which the member's application for disability benefits is based was caused or induced by the actual performance of the member's official duties, and any recommendations or comments based on the medical opinions;

(5) Providing for the board to consider the member's potential for retraining or reemployment.

(D) This division does not apply to members of the fund who have elected to receive benefits and pensions in accordance with division (A) or (B) of section 742.37 of the Revised Code or from a police relief and pension fund or a firemen's relief and pension fund in accordance with the rules of that fund in force on April 1, 1947.

As used in this division:

"Totally disabled" means a member of the fund is unable to perform the duties of any gainful occupation for which the member is reasonably fitted by training, experience, and accomplishments. Absolute helplessness is not a prerequisite of being totally disabled.

"Permanently disabled" means a condition of disability from which there is no present indication of recovery.

"Hazardous duty" has the same meaning as in 5 C.F.R. 550.902, as amended.

(1) A member of the fund who is permanently and totally disabled as the result of the performance of the member's official duties as a member of a police or fire department shall be paid annual disability benefits in accordance with division (A) of section 742.39 of the Revised Code. In determining whether a member of the fund is permanently and totally

disabled, the board shall consider standards adopted under division (C) of this section applicable to the determination.

(2) A member of the fund who is permanently and partially disabled as the result of the performance of the member's official duties as a member of a police or fire department shall, if the disability prevents the member from performing those duties and impairs the member's earning capacity, receive annual disability benefits in accordance with division (B) of section 742.39 of the Revised Code. In determining whether a member of the fund is permanently and partially disabled, the board shall consider standards adopted under division (C) of this section applicable to the determination.

(3)(a) A member of the fund who is permanently disabled as a result of heart disease or any cardiovascular or respiratory disease of a chronic nature, which disease or any evidence of which disease was not revealed by the physical examination passed by the member on entry into the department or another examination specified in rules the board adopts under section 742.10 of the Revised Code, is presumed to have incurred the disease while performing the member's official duties, unless the contrary is shown by competent evidence. The board may waive the requirement that the absence of disease be evidenced by a physical examination if competent medical evidence of a type specified in rules adopted under section 742.10 of the Revised Code is submitted documenting that the disease was not evident prior to or at the time of entry into the department.

(b) A member of the fund who is a member of a fire department, has been assigned to at least six years of hazardous duty as a member of a fire department, and is disabled as a result of cancer, is presumed to have incurred the cancer while

performing the member's official duties if the member was exposed to an agent classified by the international agency for research on cancer or its successor agency as a group 1 or 2A carcinogen.

(c) The presumption described in division (D)(3)(b) of this section is rebuttable in any of the following situations:

(i) There is evidence that the member incurred the type of cancer being alleged before becoming a member of the department.

(ii) There is evidence that the member's exposure, outside the scope of the member's official duties, to cigarettes, tobacco products, or other conditions presenting an extremely high risk for the development of the cancer alleged, was probably a significant factor in the cause or progression of the cancer.

(iii) There is evidence that shows, by a preponderance of competent scientific evidence, that exposure to the type of carcinogen alleged did not or could not have caused the cancer being alleged.

(iv) There is evidence that the member was not exposed to an agent classified by the international agency for research on cancer or its successor agency as a group 1 or 2A carcinogen.

(v) The member is seventy years of age or older.

(d) The presumption described in division (D)(3)(b) of this section does not apply if it has been more than fifteen years since the member was last assigned to hazardous duty as a member of a fire department.

(4) A member of the fund who has five or more years of service credit and has incurred a permanent disability not

caused or induced by the actual performance of the member's official duties as a member of the department, or by the member's own negligence, shall if the disability prevents the member from performing those duties and impairs the member's earning capacity, receive annual disability benefits in accordance with division (C) of section 742.39 of the Revised Code. In determining whether a member of the fund is permanently disabled, the board shall consider standards adopted under division (C) of this section applicable to the determination.

(5) The board shall notify a member of its final action awarding a disability benefit to the member within thirty days of the final action. The notice shall be sent by certified mail, return receipt requested. Not later than ninety days after receipt of notice from the board, the member shall elect, on a form provided by the board, either to accept or waive the disability benefit award. If the member elects to waive the disability benefit award or fails to make an election within the time period, the award is rescinded. A member who later seeks a disability benefit award shall be required to make a new application, which shall be dealt with in accordance with the procedures used for original disability benefit applications.

A person is not eligible to apply for or receive disability benefits under this division, section 742.39 of the Revised Code, or division (C)(2), (3), (4), or (5) of former section 742.37 of the Revised Code unless the person is a member of the fund on the date on which the application for disability benefits is submitted to the fund.

With the exception of persons who may make application for increased benefits as provided in division (D)(2) or (4) of this section or division (C)(3) or (5) of former section 742.37 of

the Revised Code on or after July 24, 1986, or persons who may make application for benefits as provided in section 742.26 of the Revised Code, no person receiving a pension or benefit under this section or division (C) of former section 742.37 of the Revised Code may apply for any new, changed, or different benefit.

(E) Notwithstanding the requirement of section 742.41 of the Revised Code that all medical reports and recommendations required are privileged, the board shall submit to the administrator of workers' compensation any data necessary for the report required under section 4123.86 of the Revised Code.

Sec. 940.09. ~~(A)As~~ (A) As used in this section:

(1) "Receiving employee" means an employee of a soil and water conservation district who receives donated sick leave as authorized by this section.

(2) "Donating employee" means an employee of a soil and water conservation district who donates sick leave as authorized by this section.

(3) "Paid leave" has the same meaning as in section 124.391 of the Revised Code.

(4) "Full-time employee" means an employee of a soil and water conservation district whose regular hours of service for the district total forty hours per week or who renders any other standard of service accepted as full-time by the district.

(5) "Full-time limited hours employee" means an employee of a soil and water conservation district whose regular hours of service for the district total twenty-five to thirty-nine hours per week or who renders any other standard of service accepted as full-time limited hours by the district.

(B)(1) An employee of a soil and water conservation district is eligible to become a receiving employee if the employee is a full-time employee, or a full-time limited hours employee, who has completed the prescribed probationary period, has used up all accrued paid leave, and has been placed on an approved, unpaid, medical-related leave of absence for a period of at least thirty consecutive working days because of the employee's own serious illness or because of a serious illness of a member of the employee's immediate family.

(2) An employee who desires to become a receiving employee shall submit to the board of supervisors of the employing soil and water conservation district, along with a satisfactory physician's, certified nurse-midwife's, clinical nurse specialist's, or certified nurse practitioner's certification, a written request for donated sick leave. The board of supervisors shall determine whether the employee is eligible to become a receiving employee and shall approve the request if it determines the employee is eligible.

(C)(1) A board of supervisors that approves a request for an employee to become a receiving employee shall forward the approved application to a committee that the Ohio association of soil and water conservation district employees shall appoint to act as a clearinghouse for the donation of sick leave under this section. The committee shall post notice for not less than ten days informing all employees of soil and water conservation districts throughout the state that it has received an approved application to become a receiving employee.

(2) A soil and water conservation district employee desiring to become a donating employee shall complete and submit a sick leave donation form to the employee's immediate

supervisor within twenty days after the date of the initial posting of the notice described in division (C)(1) of this section. If the board of supervisors of the employing district of an employee desiring to become a donating employee approves the sick leave donation, the board shall forward to the committee, together with a check equal to the total value of the sick leave donation, a copy of the sick leave donation form, and the board shall notify the receiving employee regarding the donation.

(D) If the committee described in division (C)(1) of this section receives a sick leave donation form and a check from a board of supervisors, the committee shall deposit the check into an account that it shall establish to be used to dispense funds to the employing district of a receiving employee. The committee shall notify the board of supervisors of the employing district of a receiving employee of the amount of sick leave donated. The board of supervisors shall bill the committee during each pay period for the receiving employee's gross hourly wages in an amount that does not exceed the amount donated to the receiving employee. The board of supervisors, with the approval of the county auditor, shall provide for the deposit into its appropriate payroll account of any payments it receives for the benefit of a receiving employee.

(E) The donation and receipt of sick leave under this section is subject to all of the following:

(1) All donations of sick leave shall be voluntary.

(2) A donating employee is eligible to donate not less than eight hours and not more than eighty hours of sick leave during the same calendar year.

(3) The value of an hour of sick leave donated is the value of the donating employee's gross hourly wage. The number of hours received by a receiving employee from a donating employee shall be a number that, when multiplied by the receiving employee's gross hourly wage, equals the amount resulting when the donating employee's gross hourly wage is multiplied by the number of hours of sick leave donated.

(4) No paid leave shall accrue to a receiving employee for any compensation received through donated sick leave, and the receipt of donated sick leave does not affect the date on which a receiving employee first qualifies for continuation of health insurance coverage.

(5) If a receiving employee does not use all donated sick leave during the period of the employee's leave of absence, the unused balance shall remain in the account that the committee described in division (C)(1) of this section established under division (D) of this section and shall be used to dispense funds in the future to the employing district of a receiving employee.

Sec. 955.41. The board of county commissioners, not later than the third regular meeting after it is presented with the account provided for by section 955.42 of the Revised Code, shall examine the account and, if it is found in whole or part correct and just, may order a payment in whole or in part to either the patient, the representative of the patient referred to in that section, or the physician or advanced practice registered nurse who rendered the patient's medical or surgical treatment, in accordance with their respective claims, provided that a payment is made only for an account with respect to which the board determines the patient, the patient's estate, or the patient's parent or guardian, as applicable, is unable, without

deprivation of basic needs, to further provide for the payment of the expenses incurred for the medical or surgical treatment. A person shall not receive for one bite or injury a sum exceeding one thousand five hundred dollars.

Sec. 1337.111. A person who holds a current, valid license issued under Chapter 4723. of the Revised Code to practice as an advanced practice registered nurse may take any action that may be taken by an attending physician under sections 1337.11 to 1337.17 of the Revised Code and has the immunity provided by section 1337.15 of the Revised Code if the action is taken pursuant to a standard care arrangement with a collaborating physician.

Sec. 1337.29. (A) A power of attorney is effective when executed unless the principal provides in the power of attorney that it becomes effective at a future date or upon the occurrence of a future event or contingency.

(B) If a power of attorney becomes effective upon the occurrence of a future event or contingency, the principal, in the power of attorney, may authorize one or more persons to determine in a writing or other record that the event or contingency has occurred.

(C) If a power of attorney becomes effective upon the principal's incapacity and the principal has not authorized a person to determine whether the principal is incapacitated, or the person authorized is unable or unwilling to make the determination, the power of attorney becomes effective upon one of the following determinations made in a writing or other record:

(1) A determination by ~~a physician who has examined the~~

~~principal or a licensed psychologist who has evaluated the principal~~ any of the following that the principal is incapacitated within the meaning of division (E)(1) of section 1337.22 of the Revised Code~~.~~:

(a) A physician who has examined the principal;

(b) A clinical nurse specialist who is certified as a psychiatric-mental health CNS by the American nurses credentialing center and has examined the principal;

(c) A certified nurse practitioner who is certified as a psychiatric-mental health NP by the American nurses credentialing center and has examined the principal;

(d) A licensed psychologist who has evaluated the principal.

(2) A determination by an attorney at law, a judge, or an appropriate governmental official that the principal is incapacitated within the meaning of division (E)(2) of section 1337.22 of the Revised Code.

(D) A person authorized by the principal in the power of attorney to determine that the principal is incapacitated may act as the principal's personal representative pursuant to 42 U.S.C. 1320d to 1320d-8, and applicable regulations, to obtain access to the principal's health-care information and communicate with the principal's health-care provider.

Sec. 1347.08. (A) Every state or local agency that maintains a personal information system, upon the request and the proper identification of any person who is the subject of personal information in the system, shall:

(1) Inform the person of the existence of any personal

information in the system of which the person is the subject;

(2) Except as provided in divisions (C) and (E)(2) of this section, permit the person, the person's legal guardian, or an attorney who presents a signed written authorization made by the person, to inspect all personal information in the system of which the person is the subject;

(3) Inform the person about the types of uses made of the personal information, including the identity of any users usually granted access to the system.

(B) Any person who wishes to exercise a right provided by this section may be accompanied by another individual of the person's choice.

(C)(1) A state or local agency, upon request, shall disclose medical, psychiatric, or psychological information to a person who is the subject of the information or to the person's legal guardian, unless ~~a physician, psychiatrist, or psychologist~~ one of the following determines for the agency that the disclosure of the information is likely to have an adverse effect on the person~~, in which case~~: a physician, including such a person who specializes as a psychiatrist; an advanced practice registered nurse, including such a person who specializes as a psychiatric-mental health nurse practitioner or psychiatric clinical nurse specialist; or a psychologist. If such a determination is made, the information shall be released to ~~a physician, psychiatrist, or psychologist~~ one of the following who is designated by the person or by the person's legal guardian: a physician, including such a person who specializes as a psychiatrist; an advanced practice registered nurse, including such a person who specializes as a psychiatric-mental health nurse practitioner or psychiatric clinical nurse

specialist; or a psychologist.

(2) Upon the signed written request of ~~either~~ a licensed attorney at law ~~or~~, a licensed physician, or an advanced practice registered nurse designated by the inmate, together with the signed written request of an inmate of a correctional institution under the administration of the department of rehabilitation and correction, the department shall disclose medical information to the designated attorney ~~or~~, physician, or advanced practice registered nurse as provided in division (C) of section 5120.21 of the Revised Code.

(D) If an individual who is authorized to inspect personal information that is maintained in a personal information system requests the state or local agency that maintains the system to provide a copy of any personal information that the individual is authorized to inspect, the agency shall provide a copy of the personal information to the individual. Each state and local agency may establish reasonable fees for the service of copying, upon request, personal information that is maintained by the agency.

(E)(1) This section regulates access to personal information that is maintained in a personal information system by persons who are the subject of the information, but does not limit the authority of any person, including a person who is the subject of personal information maintained in a personal information system, to inspect or have copied, pursuant to section 149.43 of the Revised Code, a public record as defined in that section.

(2) This section does not provide a person who is the subject of personal information maintained in a personal information system, the person's legal guardian, or an attorney

authorized by the person, with a right to inspect or have copied, or require an agency that maintains a personal information system to permit the inspection of or to copy, a confidential law enforcement investigatory record or trial preparation record, as defined in divisions (A)(2) and (4) of section 149.43 of the Revised Code.

(F) This section does not apply to any of the following:

(1) The contents of an adoption file maintained by the department of health under sections 3705.12 to 3705.124 of the Revised Code;

(2) Information contained in the putative father registry established by section 3107.062 of the Revised Code, regardless of whether the information is held by the department of job and family services or, pursuant to section 3111.69 of the Revised Code, the office of child support in the department or a child support enforcement agency;

(3) Papers, records, and books that pertain to an adoption and that are subject to inspection in accordance with section 3107.17 of the Revised Code;

(4) Records specified in division (A) of section 3107.52 of the Revised Code;

(5) Records that identify an individual described in division (A)(1) of section 3721.031 of the Revised Code, or that would tend to identify such an individual;

(6) Files and records that have been expunged under division (D)(1) or (2) of section 3721.23 of the Revised Code;

(7) Records that identify an individual described in division (A)(1) of section 3721.25 of the Revised Code, or that

would tend to identify such an individual;

(8) Records that identify an individual described in division (A)(1) of section 5165.88 of the Revised Code, or that would tend to identify such an individual;

(9) Test materials, examinations, or evaluation tools used in an examination for licensure as a nursing home administrator that the board of executives of long-term services and supports administers under section 4751.15 of the Revised Code or contracts under that section with a private or government entity to administer;

(10) Information contained in a database established and maintained pursuant to section 5101.13 of the Revised Code;

(11) Information contained in a database established and maintained pursuant to section 5101.631 of the Revised Code.

Sec. 1561.12. An applicant for any examination or certificate under this section shall, before being examined, register the applicant's name with the chief of the division of mineral resources management and file with the chief an affidavit as to all matters of fact establishing the applicant's right to receive the examination and a certificate from a reputable and disinterested physician, clinical nurse specialist, or certified nurse practitioner as to the physical condition of the applicant showing that the applicant is physically capable of performing the duties of the office or position.

Each applicant for examination for any of the following positions shall present evidence satisfactory to the chief that the applicant has been a resident and citizen of this state for two years next preceding the date of application:

(A) An applicant for the position of deputy mine inspector of underground mines shall have had actual practical experience of not less than six years in underground mines. In lieu of two of the six years of actual practical experience required in underground mines, the chief may accept as the equivalent thereof a certificate evidencing graduation from an accredited school of mines or mining, after a four-year course of study.

The applicant shall pass an examination as to the applicant's practical and technological knowledge of mine surveying, mining machinery, and appliances; the proper development and operation of mines; the best methods of working and ventilating mines; the nature, properties, and powers of noxious, poisonous, and explosive gases, particularly methane; the best means and methods of detecting, preventing, and removing the accumulation of such gases; the use and operation of gas detecting devices and appliances; first aid to the injured; and the uses and dangers of electricity as applied and used in, at, and around mines. The applicant shall also hold a certificate for foreperson of gaseous mines issued by the chief.

(B) An applicant for the position of deputy mine inspector of surface mines shall have had actual practical mining experience of not less than six years in surface mines. In lieu of two of the six years of actual practical experience required, the chief may accept as the equivalent thereof a certificate evidencing graduation from an accredited school of mines or mining, after a four-year course of study. The applicant shall pass an examination as to the applicant's practical and technological knowledge of surface mine surveying, machinery, and appliances; the proper development and operations of surface mines; first aid to the injured; and the use and dangers of explosives and electricity as applied and used in, at, and

around surface mines. The applicant shall also hold a surface mine foreperson certificate issued by the chief.

(C) An applicant for the position of electrical inspector shall have had at least five years' practical experience in the installation and maintenance of electrical circuits and equipment in mines, and the applicant shall be thoroughly familiar with the principles underlying the safety features of permissible and approved equipment as authorized and used in mines.

The applicant shall be required to pass the examination required for deputy mine inspectors and an examination testing and determining the applicant's qualification and ability to competently inspect and administer the mining law that relates to electricity used in and around mines and mining in this state.

(D) An applicant for the position of superintendent or assistant superintendent of rescue stations shall possess the same qualifications as those required for a deputy mine inspector. In addition, the applicant shall present evidence satisfactory to the chief that the applicant is sufficiently qualified and trained to organize, supervise, and conduct group training classes in first aid, safety, and rescue work.

The applicant shall pass the examination required for deputy mine inspectors and shall be tested as to the applicant's practical and technological experience and training in first aid, safety, and mine rescue work.

(E) An applicant for the position of mine chemist shall have such educational training as is represented by the degree MS in chemistry from a university of recognized standing, and at

least five years of actual practical experience in research work in chemistry or as an assistant chemist. The chief may provide that an equivalent combination of education and experience together with a wide knowledge of the methods of and skill in chemical analysis and research may be accepted in lieu of the above qualifications. It is preferred that the chemist shall have had actual experience in mineralogy and metallurgy.

Sec. 1571.012. An applicant for the position of gas storage well inspector shall register the applicant's name with the chief of the division of oil and gas resources management and file with the chief an affidavit as to all matters of fact establishing the applicant's right to take the examination for that position and a certificate from a reputable and disinterested physician, clinical nurse specialist, or certified nurse practitioner as to the physical condition of the applicant showing that the applicant is physically capable of performing the duties of the position. The applicant also shall present evidence satisfactory to the chief that the applicant has been a resident and citizen of this state for at least two years next preceding the date of application.

An applicant shall possess the same qualifications as an applicant for the position of deputy mine inspector established in section 1561.12 of the Revised Code. In addition, the applicant shall have practical knowledge and experience of and in the operation, location, drilling, maintenance, and abandonment of oil and gas wells, especially in coal or mineral bearing townships, and shall have a thorough knowledge of the latest and best method of plugging and sealing abandoned oil and gas wells.

An applicant for gas storage well inspector shall pass an

examination conducted by the chief to determine the applicant's fitness to act as gas storage well inspector before being eligible for appointment.

Sec. 1731.01. As used in this chapter:

(A) "Alliance" or "small employer health care alliance" means an existing or newly created organization that has been granted a certificate of authority by the superintendent of insurance under section 1731.021 of the Revised Code and that is either of the following:

(1) A chamber of commerce, trade association, professional organization, or any other organization that has all of the following characteristics:

(a) Is a nonprofit corporation or association;

(b) Has members that include or are exclusively small employers;

(c) Sponsors or is part of a program to assist such small employer members to obtain coverage for their employees under one or more health benefit plans;

(d) Except as provided in division (A)(1)(e) of this section, is not directly or indirectly controlled, through voting membership, representation on its governing board, or otherwise, by any insurance company, person, firm, or corporation that sells insurance, any provider, or by persons who are officers, trustees, or directors of such enterprises, or by any combination of such enterprises or persons.

(e) Division (A)(1)(d) of this section does not apply to an organization that is comprised of members who are either insurance agents or providers, that is controlled by the

organization's members or by the organization itself, and that elects to offer health insurance exclusively to any or all of the following:

(i) Employees and retirees of the organization;

(ii) Insurance agents and providers that are members of the organization;

(iii) Employees and retirees of the agents or providers specified in division (A)(1)(e)(ii) of this section;

(iv) Families and dependents of the employees, providers, agents, and retirees specified in divisions (A)(1)(e)(i), (A)(1)(e)(ii), and (A)(1)(e)(iii) of this section.

(2) A nonprofit corporation controlled by one or more organizations described in division (A)(1) of this section.

(B) "Alliance program" or "alliance health care program" means a program sponsored by a small employer health care alliance that assists small employer members of such small employer health care alliance or any other small employer health care alliance to obtain coverage for their employees under one or more health benefit plans, and that includes at least one agreement between a small employer health care alliance and an insurer that contains the insurer's agreement to offer and sell one or more health benefit plans to such small employers and contains all of the other features required under section 1731.04 of the Revised Code.

(C) "Eligible employees, retirees, their dependents, and members of their families," as used together or separately, means the active employees of a small employer, or retired former employees of a small employer or predecessor firm or organization, their dependents or members of their families, who

are eligible for coverage under the terms of the applicable alliance program.

(D) "Enrolled small employer" or "enrolled employer" means a small employer that has obtained coverage for its eligible employees from an insurer under an alliance program.

(E) "Health benefit plan" means any hospital or medical expense policy of insurance or a health care plan provided by an insurer, including a health insuring corporation plan, provided by or through an insurer, or any combination thereof. "Health benefit plan" does not include any of the following:

(1) A policy covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care, except where any of the foregoing is offered as an addition, indorsement, or rider to a health benefit plan;

(2) Coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(3) Coverage issued by a health insuring corporation authorized to offer supplemental health care services only.

(F) "Insurer" means an insurance company authorized to do the business of sickness and accident insurance in this state or, for the purposes of this chapter, a health insuring corporation authorized to issue health care plans in this state.

(G) "Participants" or "beneficiaries" means those eligible employees, retirees, their dependents, and members of their

families who are covered by health benefit plans provided by an insurer to enrolled small employers under an alliance program.

(H) "Provider" means a hospital, urgent care facility, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, ~~certified registered nurse anesthetist~~advanced practice registered nurse, dietitian, or other health care provider licensed by this state, or group of such health care providers.

(I) "Qualified alliance program" means an alliance program under which health care benefits are provided to one thousand or more participants.

(J) "Small employer," regardless of its definition in any other chapter of the Revised Code, in this chapter means an employer that employs no more than five hundred full-time employees, at least a majority of whom are employed at locations within this state.

(1) For this purpose:

(a) Each entity that is controlled by, controls, or is under common control with, one or more other entities shall, together with such other entities, be considered to be a single employer.

(b) "Full-time employee" means a person who normally works at least twenty-five hours per week and at least forty weeks per year for the employer.

(c) An employer will be treated as having five hundred or fewer full-time employees on any day if, during the prior calendar year or any twelve consecutive months during the twenty-four full months immediately preceding that day, the mean number of full-time employees employed by the employer does not

exceed five hundred.

(2) An employer that qualifies as a small employer for purposes of becoming an enrolled small employer continues to be treated as a small employer for purposes of this chapter until such time as it fails to meet the conditions described in division (J)(1) of this section for any period of thirty-six consecutive months after first becoming an enrolled small employer, unless earlier disqualified under the terms of the alliance program.

Sec. 1751.62. (A) As used in this section:

(1) "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(2) "Medicare reimbursement rate" means the reimbursement rate paid in Ohio under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(B) Every individual or group health insuring corporation policy, contract, or agreement providing basic health care

services that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D)(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by

medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive remuneration in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a health care facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in

section 3727.01 of the Revised Code.

Sec. 1751.74. (A) To implement a quality assurance program required by section 1751.73 of the Revised Code, a health insuring corporation shall do both of the following:

(1) Develop and maintain the appropriate infrastructure and disclosure systems necessary to measure and report, on a regular basis, the quality of health care services provided to enrollees, based on a systematic collection, analysis, and reporting of relevant data. The health insuring corporation shall ~~assure~~ ensure that a committee that includes participating physicians~~ have~~, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners has the opportunity to participate in developing, implementing, and evaluating the quality assurance program and all other programs implemented by the health insuring corporation that relate to the utilization of health care services. A committee that includes participating physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners shall also have the opportunity to participate in the derivation of data assessments, statistical analyses, and outcome interpretations from programs monitoring the utilization of health care services.

(2) Develop and maintain an organizational program for designing, measuring, assessing, and improving the processes and outcomes of health care.

(B) A quality assurance program shall:

(1) Establish an internal system capable of identifying opportunities to improve health care, which system is structured to identify practices that result in improved health care

outcomes, to identify problematic utilization patterns, and to identify those providers that may be responsible for either exemplary or problematic patterns. The quality assurance program shall use the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the quality of health care services provided to enrollees.

(2) Develop a written statement of its objectives, lines of authority and accountability, evaluation tools, and performance improvement activities;

(3) Require an annual effectiveness review of the program;

(4) Provide a description of how the health insuring corporation intends to do all of the following:

(a) Analyze both processes and outcomes of health care, including focused review of individual cases as appropriate, to discern the causes of variation;

(b) Identify the targeted diagnoses and treatments to be reviewed by the quality assurance program each year, based on consideration of practices and diagnoses that affect a substantial number of the health insuring corporation's enrollees or that could place enrollees at serious risk;

(c) Use a range of appropriate methods to analyze quality of health care, including collection and analysis of information on over-utilization and under-utilization of health care services; evaluation of courses of treatment and outcomes based on current medical research, knowledge, standards, and practice guidelines; and collection and analysis of information specific to enrollees or providers;

(d) Compare quality assurance program findings with past

performance, internal goals, and external standards;

(e) Measure the performance of participating providers and conduct peer review activities;

(f) Utilize treatment protocols and practice parameters developed with appropriate clinical input;

(g) Implement improvement strategies related to quality assurance program findings;

(h) Evaluate periodically, but not less than annually, the effectiveness of the improvement strategies.

Sec. 1753.21. (A) If a policy, contract, or agreement of a health insuring corporation uses a restricted formulary of prescription drugs, the health insuring corporation shall do both of the following:

(1) Develop such a formulary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of the members of which are physicians or advanced practice registered nurses affiliated with the health insuring corporation who may prescribe prescription drugs and pharmacists affiliated with the health insuring corporation; or in consultation with and with the approval of a pharmacy and therapeutics committee that is independent of the health insuring corporation consisting of physicians or advanced practice registered nurses who may prescribe prescription drugs in their state of licensure and pharmacists who are authorized to practice in their state of licensure;

(2) Establish a procedure by which an enrollee may obtain, without penalty or additional cost sharing beyond that provided for formulary drugs under the enrollee's contract with the health insuring corporation, coverage of a specific nonformulary

drug when the prescriber documents in the enrollee's medical record and certifies that the formulary alternative has been ineffective in the treatment of the enrollee's disease or condition, or that the formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the enrollee.

(B) Nothing in this section shall be construed to require a health insuring corporation to place any particular pharmaceutical product or therapeutic class of product on any formulary, or to prohibit a health insuring corporation from restricting payments for any specific pharmaceutical product or therapeutic class of product, including, but not limited to, a requirement that the product be prescribed only by a defined specialist or subspecialist.

Sec. 2105.35. In addition to any provisions of the Rules of Evidence, the following provisions relating to the determination of death and status apply:

(A)(1) An individual is dead if the individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards. If the respiratory and circulatory functions of an individual are being artificially sustained, under accepted medical standards a determination that death has occurred is made by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner by observing and conducting a test to determine that the irreversible cessation of all functions of the brain has occurred.

(2) A physician, certified nurse-midwife, clinical nurse

specialist, or certified nurse practitioner who makes a determination of death in accordance with division (A) of this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the physician's or nurse's acts or the acts of others based on that determination.

(3) Any person who acts in good faith and relies on a determination of death made by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner in accordance with division (A) of this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the person's actions.

(B) A certified or authenticated copy of a death certificate purporting to be issued by an official or agency of the place where the death of an individual purportedly occurred is prima-facie evidence of the fact, place, date, and time of the individual's death and the identity of the decedent.

(C) A certified or authenticated copy of any record or report of a domestic or foreign governmental agency that an individual is missing, detained, dead, or alive is prima-facie evidence of the status and of the dates, circumstances, and places disclosed by the record or report.

(D) In the absence of prima-facie evidence of death under division (B) or (C) of this section, the fact of death may be established by clear and convincing evidence, including circumstantial evidence.

(E) Except as provided in division (F) of this section, a presumption of the death of an individual arises when either of

the following applies:

(1) The individual has disappeared and has been continuously absent from the individual's place of last domicile for a five-year period without being heard from during the period;

(2) The individual has disappeared and has been continuously absent from the individual's place of last domicile without being heard from and was at the beginning of the individual's absence exposed to a specific peril of death, even though the absence has continued for less than a five-year period.

(F) When an individual who is on active duty in the armed services of the United States has been officially determined to be absent in a status of "missing" or "missing in action," a presumption of death arises when the head of the federal department concerned has made a finding of death pursuant to the "Federal Missing Persons Act," 80 Stat. 625 (1966), 37 U.S.C.A. 551, as amended.

(G) In the absence of evidence disputing the time of death stipulated on a document described in division (B) or (C) of this section, a document described in either of those divisions that stipulates a time of death of an individual one hundred twenty hours or more after the time of death of another individual, however the time of death of the other individual is determined, establishes by clear and convincing evidence that the individual survived the other individual by one hundred twenty hours.

Sec. 2108.16. (A) Except as provided in division (B) of this section, a physician or technician may remove a donated

part from the body of a donor that the physician or technician is qualified to remove.

(B) Neither the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who attends the decedent at death nor the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who determines the time of the decedent's death shall participate in the procedures for removing or transplanting a part from the decedent.

Sec. 2108.40. An individual is dead if the individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards. If the respiratory and circulatory functions of a person are being artificially sustained, under accepted medical standards a determination that death has occurred is made by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner by observing and conducting a test to determine that the irreversible cessation of all functions of the brain has occurred.

A physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who makes a determination of death in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the physician's or nurse's acts or the acts of others based on that determination.

Any person who acts in good faith in reliance on a determination of death made by a physician, certified nurse-

midwife, clinical nurse specialist, or certified nurse practitioner in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the person's actions.

Sec. 2111.031. In connection with an application for the appointment of a guardian for an alleged incompetent, the court may appoint physicians, advanced practice registered nurses certified as psychiatric-mental health clinical nurse specialists or psychiatric-mental health nurse practitioners, and other qualified persons to examine, investigate, or represent the alleged incompetent, to assist the court in deciding whether a guardianship is necessary. If the person is determined to be an incompetent and a guardian is appointed for the person, the costs, fees, or expenses incurred to so assist the court shall be charged either against the estate of the person or against the applicant, unless the court determines, for good cause shown, that the costs, fees, or expenses are to be recovered from the county, in which case they shall be charged against the county. If the person is not determined to be an incompetent or a guardian is not appointed for the person, the costs, fees, or expenses incurred to so assist the court shall be charged against the applicant, unless the court determines, for good cause shown, that the costs, fees, or expenses are to be recovered from the county, in which case they shall be charged against the county.

A court may require the applicant to make an advance deposit of an amount that the court determines is necessary to defray the anticipated costs of examinations of an alleged incompetent and to cover fees or expenses to be incurred to assist it in deciding whether a guardianship is necessary.

This section does not affect or apply to the duties of a probate court investigator under sections 2111.04 and 2111.041 of the Revised Code.

Sec. 2111.49. (A)(1) Subject to division (A)(3) of this section, the guardian of an incompetent person shall file a guardian's report with the court two years after the date of the issuance of the guardian's letters of appointment and biennially after that time, or at any other time upon the motion or a rule of the probate court. The report shall be in a form prescribed by the court and shall include all of the following.

(a) The present address of the place of residence of the ward;

(b) The present address of the guardian;

(c) If the place of residence of the ward is not the ward's personal home, the name of the facility at which the ward resides and the name of the person responsible for the ward's care;

(d) The approximate number of times during the period covered by the report that the guardian has had contact with the ward, the nature of those contacts, and the date that the ward was last seen by the guardian;

(e) Any major changes in the physical or mental condition of the ward observed by the guardian;

(f) The opinion of the guardian as to the necessity for the continuation of the guardianship;

(g) The opinion of the guardian as to the adequacy of the present care of the ward;

(h) The date that the ward was last examined or otherwise

seen by a physician, clinical nurse specialist, or certified nurse practitioner and the purpose of that visit;

(i) A statement by a licensed physician, licensed clinical nurse specialist, licensed certified nurse practitioner, licensed clinical psychologist, licensed independent social worker, licensed professional clinical counselor, or developmental disability team that has evaluated or examined the ward within three months prior to the date of the report as to the need for continuing the guardianship.

(2) The court shall review a report filed pursuant to division (A)(1) of this section to determine if a continued necessity for the guardianship exists. The court may direct a probate court investigator to verify aspects of the report.

(3) Division (A)(1) of this section applies to guardians appointed prior to, as well as on or after, the effective date of this section. A guardian appointed prior to that date shall file the first report in accordance with any applicable court rule or motion, or, in the absence of such a rule or motion, upon the next occurring date on which a report would have been due if division (A)(1) of this section had been in effect on the date of appointment as guardian, and shall file all subsequently due reports biennially after that time.

(B) If, upon review of any report required by division (A)(1) of this section, the court finds that it is necessary to intervene in a guardianship, the court shall take any action that it determines is necessary, including, but not limited to, terminating or modifying the guardianship.

(C) Except as provided in this division, for any guardianship, upon written request by the ward, the ward's

attorney, or any other interested party made at any time after the expiration of one hundred twenty days from the date of the original appointment of the guardian, a hearing shall be held in accordance with section 2111.02 of the Revised Code to evaluate the continued necessity of the guardianship. Upon written request, the court shall conduct a minimum of one hearing under this division in the calendar year in which the guardian was appointed, and upon written request, shall conduct a minimum of one hearing in each of the following calendar years. Upon its own motion or upon written request, the court may, in its discretion, conduct a hearing within the first one hundred twenty days after appointment of the guardian or conduct more than one hearing in a calendar year. If the ward alleges competence, the burden of proving incompetence shall be upon the applicant for guardianship or the guardian, by clear and convincing evidence.

Sec. 2133.25. (A) The department of health, by rule adopted pursuant to Chapter 119. of the Revised Code, shall adopt a standardized method of procedure for the withholding of CPR by physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, emergency medical services personnel, and health care facilities in accordance with sections 2133.21 to 2133.26 of the Revised Code. The standardized method shall specify criteria for determining when a do-not-resuscitate order ~~issued by a physician~~ is current. The standardized method so adopted shall be the "do-not-resuscitate protocol" for purposes of sections 2133.21 to 2133.26 of the Revised Code. The department also shall approve one or more standard forms of DNR identification to be used throughout this state.

(B) The department of health shall adopt rules in

accordance with Chapter 119. of the Revised Code for the administration of sections 2133.21 to 2133.26 of the Revised Code.

(C) The department of health shall appoint an advisory committee to advise the department in the development of rules under this section. The advisory committee shall include, but shall not be limited to, representatives of each of the following organizations:

(1) The association for hospitals and health systems (OHA);

(2) The Ohio state medical association;

(3) The Ohio chapter of the American college of emergency physicians;

(4) The Ohio hospice organization;

(5) The Ohio council for home care;

(6) The Ohio health care association;

(7) The Ohio ambulance association;

(8) The Ohio medical directors association;

(9) The Ohio association of emergency medical services;

(10) The bioethics network of Ohio;

(11) The Ohio nurses association;

(12) The Ohio academy of nursing homes;

(13) The Ohio association of professional firefighters;

(14) The department of developmental disabilities;

(15) The Ohio osteopathic association;

(16) The association of Ohio philanthropic homes~~,~~ and housing ~~and~~ services for the aging;

(17) The catholic conference of Ohio;

(18) The department of aging;

(19) The department of mental health and addiction services;

(20) The Ohio private residential association;

(21) The northern Ohio fire fighters association;

(22) The Ohio association of advanced practice nurses.

Sec. 2135.01. As used in sections 2135.01 to ~~2135.14~~ 2135.15 of the Revised Code:

(A) "Adult" means a person who is eighteen years of age or older.

(B) "Capacity to consent to mental health treatment decisions" means the functional ability to understand information about the risks of, benefits of, and alternatives to the proposed mental health treatment, to rationally use that information, to appreciate how that information applies to the declarant, and to express a choice about the proposed treatment.

(C) "Declarant" means an adult who has executed a declaration for mental health treatment in accordance with this chapter.

(D) "Declaration for mental health treatment" or "declaration" means a written document declaring preferences or instructions regarding mental health treatment executed in accordance with this chapter.

(E) "Designated physician" means the physician the

declarant has named in a declaration for mental health treatment and has assigned the primary responsibility for the declarant's mental health treatment or, if the declarant has not so named a physician, the physician who has accepted that responsibility.

(F) "Guardian" means a person appointed by a probate court pursuant to Chapter 2111. of the Revised Code to have the care and management of the person of an incompetent.

(G) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health.

(H) "Health care facility" has the same meaning as in section 1337.11 of the Revised Code.

(I) "Incompetent" has the same meaning as in section 2111.01 of the Revised Code.

(J) "Informed consent" means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the nature, purpose, and goal of the treatment or procedures, including the substantial risks and hazards inherent in the proposed treatment or procedures and any alternative treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

(K) "Medical record" means any document or combination of documents that pertains to a declarant's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained in the process of the declarant's health care.

(L) "Mental health treatment" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's mental condition or mental health, including, but

not limited to, electroconvulsive or other convulsive treatment, treatment of mental illness with medication, and admission to and retention in a health care facility.

(M) "Mental health treatment decision" means informed consent, refusal to give informed consent, or withdrawal of informed consent to mental health treatment.

(N) "Mental health treatment provider" means physicians, physician assistants, psychologists, licensed independent social workers, licensed professional clinical counselors, and psychiatric nurses.

(O) "Physician" means a person who is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(P) "Professional disciplinary action" means action taken by the board or other entity that regulates the professional conduct of health care personnel, including, but not limited to, the state medical board, the state board of psychology, and the state board of nursing.

(Q) "Proxy" means an adult designated to make mental health treatment decisions for a declarant under a valid declaration for mental health treatment.

(R) "Psychiatric nurse" means a registered nurse who holds a master's degree or doctorate in nursing with a specialization in psychiatric nursing.

(S) "Psychiatrist" has the same meaning as in section 5122.01 of the Revised Code.

(T) "Psychologist" has the same meaning as in section 4732.01 of the Revised Code.

(U) "Registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

(V) "Tort action" means a civil action for damages for injury, death, or loss to person or property, other than a civil action for damages for a breach of contract or another agreement between persons.

Sec. 2135.15. A person who holds a current, valid license issued under Chapter 4723. of the Revised Code to practice as an advanced practice registered nurse and is also a psychiatric nurse may take any action that may be taken by a designated physician or physician under sections 2135.01 to 2135.14 of the Revised Code.

Sec. 2151.33. (A) Pending hearing of a complaint filed under section 2151.27 of the Revised Code or a motion filed or made under division (B) of this section and the service of citations, the juvenile court may make any temporary disposition of any child that it considers necessary to protect the best interest of the child and that can be made pursuant to division (B) of this section. Upon the certificate of one or more reputable practicing physicians, certified nurse practitioners, or clinical nurse specialists, the court may summarily provide for emergency medical and surgical treatment that appears to be immediately necessary to preserve the health and well-being of any child concerning whom a complaint or an application for care has been filed, pending the service of a citation upon the child's parents, guardian, or custodian. The court may order the parents, guardian, or custodian, if the court finds the parents, guardian, or custodian able to do so, to reimburse the court for the expense involved in providing the emergency medical or surgical treatment. Any person who disobeys the order for

reimbursement may be adjudged in contempt of court and punished accordingly.

If the emergency medical or surgical treatment is furnished to a child who is found at the hearing to be a nonresident of the county in which the court is located and if the expense of the medical or surgical treatment cannot be recovered from the parents, legal guardian, or custodian of the child, the board of county commissioners of the county in which the child has a legal settlement shall reimburse the court for the reasonable cost of the emergency medical or surgical treatment out of its general fund.

(B)(1) After a complaint, petition, writ, or other document initiating a case dealing with an alleged or adjudicated abused, neglected, or dependent child is filed and upon the filing or making of a motion pursuant to division (C) of this section, the court, prior to the final disposition of the case, may issue any of the following temporary orders to protect the best interest of the child:

(a) An order granting temporary custody of the child to a particular party;

(b) An order for the taking of the child into custody pursuant to section 2151.31 of the Revised Code pending the outcome of the adjudicatory and dispositional hearings;

(c) An order granting, limiting, or eliminating parenting time or visitation rights with respect to the child;

(d) An order requiring a party to vacate a residence that will be lawfully occupied by the child;

(e) An order requiring a party to attend an appropriate counseling program that is reasonably available to that party;

(f) Any other order that restrains or otherwise controls the conduct of any party which conduct would not be in the best interest of the child.

(2) Prior to the final disposition of a case subject to division (B)(1) of this section, the court shall do both of the following:

(a) Issue an order pursuant to Chapters 3119. to 3125. of the Revised Code requiring the parents, guardian, or person charged with the child's support to pay support for the child.

(b) Issue an order requiring the parents, guardian, or person charged with the child's support to continue to maintain any health insurance coverage for the child that existed at the time of the filing of the complaint, petition, writ, or other document, or to obtain health insurance coverage in accordance with sections 3119.29 to 3119.56 of the Revised Code.

(C)(1) A court may issue an order pursuant to division (B) of this section upon its own motion or if a party files a written motion or makes an oral motion requesting the issuance of the order and stating the reasons for it. Any notice sent by the court as a result of a motion pursuant to this division shall contain a notice that any party to a juvenile proceeding has the right to be represented by counsel and to have appointed counsel if the person is indigent.

(2) If a child is taken into custody pursuant to section 2151.31 of the Revised Code and placed in shelter care, the public children services agency or private child placing agency with which the child is placed in shelter care shall file or make a motion as described in division (C)(1) of this section before the end of the next day immediately after the date on

which the child was taken into custody and, at a minimum, shall request an order for temporary custody under division (B)(1)(a) of this section.

(3) A court that issues an order pursuant to division (B)(1)(b) of this section shall comply with section 2151.419 of the Revised Code.

(D) The court may grant an ex parte order upon its own motion or a motion filed or made pursuant to division (C) of this section requesting such an order if it appears to the court that the best interest and the welfare of the child require that the court issue the order immediately. The court, if acting on its own motion, or the person requesting the granting of an ex parte order, to the extent possible, shall give notice of its intent or of the request to the parents, guardian, or custodian of the child who is the subject of the request. If the court issues an ex parte order, the court shall hold a hearing to review the order within seventy-two hours after it is issued or before the end of the next day after the day on which it is issued, whichever occurs first. The court shall give written notice of the hearing to all parties to the action and shall appoint a guardian ad litem for the child prior to the hearing.

The written notice shall be given by all means that are reasonably likely to result in the party receiving actual notice and shall include all of the following:

(1) The date, time, and location of the hearing;

(2) The issues to be addressed at the hearing;

(3) A statement that every party to the hearing has a right to counsel and to court-appointed counsel, if the party is indigent;

(4) The name, telephone number, and address of the person requesting the order;

(5) A copy of the order, except when it is not possible to obtain it because of the exigent circumstances in the case.

If the court does not grant an ex parte order pursuant to a motion filed or made pursuant to division (C) of this section or its own motion, the court shall hold a shelter care hearing on the motion within ten days after the motion is filed. The court shall give notice of the hearing to all affected parties in the same manner as set forth in the Juvenile Rules.

(E) The court, pending the outcome of the adjudicatory and dispositional hearings, shall not issue an order granting temporary custody of a child to a public children services agency or private child placing agency pursuant to this section, unless the court determines and specifically states in the order that the continued residence of the child in the child's current home will be contrary to the child's best interest and welfare and the court complies with section 2151.419 of the Revised Code.

(F) Each public children services agency and private child placing agency that receives temporary custody of a child pursuant to this section shall exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives of the child, including any adult relatives suggested by the parents, within thirty days of the child's removal from the custody of the child's parents, in accordance with 42 U.S.C. 671(a)(29). The agency shall also maintain in the child's case record written documentation that it has placed the child, to the extent that it is consistent with the best interest, welfare, and special needs of the child, in the most

family-like setting available and in close proximity to the home of the parents, custodian, or guardian of the child.

(G) For good cause shown, any court order that is issued pursuant to this section may be reviewed by the court at any time upon motion of any party to the action or upon the motion of the court.

(H)(1) Pending the hearing of a complaint filed under section 2151.27 of the Revised Code or a motion filed or made under division (B) of this section and the service of citations, a public children services agency may request that the superintendent of the bureau of criminal identification and investigation conduct a criminal records check with respect to each parent, guardian, custodian, prospective custodian, or prospective placement whose actions resulted in a temporary disposition under division (A) of this section. The public children services agency may request that the superintendent obtain information from the federal bureau of investigation as part of the criminal records check of each parent, guardian, custodian, prospective custodian, or prospective placement.

(2) Each public children services agency authorized by division (H) of this section to request a criminal records check shall do both of the following:

(a) Provide to each parent, guardian, custodian, prospective custodian, or prospective placement for whom a criminal records check is requested a copy of the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section and obtain the completed form and impression sheet from the parent, guardian, custodian, prospective custodian, or prospective

placement;

(b) Forward the completed form and impression sheet to the superintendent of the bureau of criminal identification and investigation.

(3) A parent, guardian, custodian, prospective custodian, or prospective placement who is given a form and fingerprint impression sheet under division (H)(2)(a) of this section and who fails to complete the form or provide fingerprint impressions may be held in contempt of court.

Sec. 2151.3515. As used in sections 2151.3515 to 2151.3535 of the Revised Code:

(A) "Emergency medical service organization," "emergency medical technician-basic," "emergency medical technician-intermediate," "first responder," and "paramedic" have the same meanings as in section 4765.01 of the Revised Code.

(B) "Emergency medical service worker" means a first responder, emergency medical technician-basic, emergency medical technician-intermediate, or paramedic.

(C) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(D) "Hospital employee" means any of the following persons:

(1) A physician or advanced practice registered nurse who has been granted privileges to practice at the hospital;

(2) A nurse, physician assistant, or nursing assistant employed by the hospital;

(3) An authorized person employed by the hospital who is

acting under the direction of a physician or nurse described in division ~~(E)(1)~~ (D)(1) of this section.

(E) "Law enforcement agency" means an organization or entity made up of peace officers.

(F) "Nurse" means a person who is licensed under Chapter 4723. of the Revised Code to practice as a registered nurse or licensed practical nurse.

(G) "Nursing assistant" means a person designated by a hospital as a nurse aide or nursing assistant whose job is to aid nurses, physicians, and physician assistants in the performance of their duties.

(H) "Peace officer" means a sheriff, deputy sheriff, constable, police officer of a township or joint police district, marshal, deputy marshal, municipal police officer, or a state highway patrol trooper.

(I) "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.

(J) "Physician assistant" means an individual who holds a current, valid license to practice as a physician assistant issued under Chapter 4730. of the Revised Code.

(K) "Advanced practice registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

Sec. 2151.421. (A)(1)(a) No person described in division (A)(1)(b) of this section who is acting in an official or professional capacity and knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in a

similar position to suspect, that a child under eighteen years of age, or a person under twenty-one years of age with a developmental disability or physical impairment, has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child shall fail to immediately report that knowledge or reasonable cause to suspect to the entity or persons specified in this division. Except as otherwise provided in this division or section 5120.173 of the Revised Code, the person making the report shall make it to the public children services agency or a peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred. If the person making the report is a peace officer, the officer shall make it to the public children services agency in the county in which the child resides or in which the abuse or neglect is occurring or has occurred. In the circumstances described in section 5120.173 of the Revised Code, the person making the report shall make it to the entity specified in that section.

(b) Division (A)(1)(a) of this section applies to any person who is an attorney; health care professional; practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code; licensed school psychologist; independent marriage and family therapist or marriage and family therapist; coroner; administrator or employee of a child day-care center; administrator or employee of a residential camp, child day camp, or private, nonprofit therapeutic wilderness camp; administrator or employee of a certified child care agency or other public or private children services agency; school teacher; school employee; school authority; peace officer; humane society agent; dog warden,

deputy dog warden, or other person appointed to act as an animal control officer for a municipal corporation or township in accordance with state law, an ordinance, or a resolution; person, other than a cleric, rendering spiritual treatment through prayer in accordance with the tenets of a well-recognized religion; employee of a county department of job and family services who is a professional and who works with children and families; superintendent or regional administrator employed by the department of youth services; superintendent, board member, or employee of a county board of developmental disabilities; investigative agent contracted with by a county board of developmental disabilities; employee of the department of developmental disabilities; employee of a facility or home that provides respite care in accordance with section 5123.171 of the Revised Code; employee of an entity that provides homemaker services; employee of a qualified organization as defined in section 2151.90 of the Revised Code; a host family as defined in section 2151.90 of the Revised Code; foster caregiver; a person performing the duties of an assessor pursuant to Chapter 3107. or 5103. of the Revised Code; third party employed by a public children services agency to assist in providing child or family related services; court appointed special advocate; or guardian ad litem.

(c) If two or more health care professionals, after providing health care services to a child, determine or suspect that the child has been or is being abused or neglected, the health care professionals may designate one of the health care professionals to report the abuse or neglect. A single report made under this division shall meet the reporting requirements of division (A)(1) of this section.

(2) Except as provided in division (A)(3) of this section,

an attorney ~~or a~~, physician, or advanced practice registered nurse is not required to make a report pursuant to division (A)(1) of this section concerning any communication the attorney ~~or~~, physician, or advanced practice registered nurse receives from a client or patient in an attorney-client ~~or~~, physician-patient, or advanced practice registered nurse-patient relationship, if, in accordance with division (A) or (B) of section 2317.02 of the Revised Code, the attorney ~~or~~, physician, or advanced practice registered nurse could not testify with respect to that communication in a civil or criminal proceeding.

(3) The client or patient in an attorney-client ~~or~~, physician-patient, or advanced practice registered nurse-patient relationship described in division (A)(2) of this section is deemed to have waived any testimonial privilege under division (A) or (B) of section 2317.02 of the Revised Code with respect to any communication the attorney ~~or~~, physician, or advanced practice registered nurse receives from the client or patient in that attorney-client ~~or~~, physician-patient, or advanced practice registered nurse-patient relationship, and the attorney ~~or~~, physician, or advanced practice registered nurse shall make a report pursuant to division (A)(1) of this section with respect to that communication, if all of the following apply:

(a) The client or patient, at the time of the communication, is a child under eighteen years of age or is a person under twenty-one years of age with a developmental disability or physical impairment.

(b) The attorney ~~or~~, physician, or advanced practice registered nurse knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar position to suspect that the client or patient has suffered or

faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the client or patient.

(c) The abuse or neglect does not arise out of the client's or patient's attempt to have an abortion without the notification of her parents, guardian, or custodian in accordance with section 2151.85 of the Revised Code.

(4)(a) No cleric and no person, other than a volunteer, designated by any church, religious society, or faith acting as a leader, official, or delegate on behalf of the church, religious society, or faith who is acting in an official or professional capacity, who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that a child under eighteen years of age, or a person under twenty-one years of age with a developmental disability or physical impairment, has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, and who knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, that another cleric or another person, other than a volunteer, designated by a church, religious society, or faith acting as a leader, official, or delegate on behalf of the church, religious society, or faith caused, or poses the threat of causing, the wound, injury, disability, or condition that reasonably indicates abuse or neglect shall fail to immediately report that knowledge or reasonable cause to believe to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, the person making the report shall make it to the public children services agency or a

peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred. In the circumstances described in section 5120.173 of the Revised Code, the person making the report shall make it to the entity specified in that section.

(b) Except as provided in division (A)(4)(c) of this section, a cleric is not required to make a report pursuant to division (A)(4)(a) of this section concerning any communication the cleric receives from a penitent in a cleric-penitent relationship, if, in accordance with division (C) of section 2317.02 of the Revised Code, the cleric could not testify with respect to that communication in a civil or criminal proceeding.

(c) The penitent in a cleric-penitent relationship described in division (A)(4)(b) of this section is deemed to have waived any testimonial privilege under division (C) of section 2317.02 of the Revised Code with respect to any communication the cleric receives from the penitent in that cleric-penitent relationship, and the cleric shall make a report pursuant to division (A)(4)(a) of this section with respect to that communication, if all of the following apply:

(i) The penitent, at the time of the communication, is a child under eighteen years of age or is a person under twenty-one years of age with a developmental disability or physical impairment.

(ii) The cleric knows, or has reasonable cause to believe based on facts that would cause a reasonable person in a similar position to believe, as a result of the communication or any observations made during that communication, the penitent has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that

reasonably indicates abuse or neglect of the penitent.

(iii) The abuse or neglect does not arise out of the penitent's attempt to have an abortion performed upon a child under eighteen years of age or upon a person under twenty-one years of age with a developmental disability or physical impairment without the notification of her parents, guardian, or custodian in accordance with section 2151.85 of the Revised Code.

(d) Divisions (A)(4)(a) and (c) of this section do not apply in a cleric-penitent relationship when the disclosure of any communication the cleric receives from the penitent is in violation of the sacred trust.

(e) As used in divisions (A)(1) and (4) of this section, "cleric" and "sacred trust" have the same meanings as in section 2317.02 of the Revised Code.

(B) Anyone who knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar circumstances to suspect, that a child under eighteen years of age, or a person under twenty-one years of age with a developmental disability or physical impairment, has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or other condition of a nature that reasonably indicates abuse or neglect of the child may report or cause reports to be made of that knowledge or reasonable cause to suspect to the entity or persons specified in this division. Except as provided in section 5120.173 of the Revised Code, a person making a report or causing a report to be made under this division shall make it or cause it to be made to the public children services agency or to a peace officer. In the circumstances described in section 5120.173 of the Revised Code,

a person making a report or causing a report to be made under this division shall make it or cause it to be made to the entity specified in that section.

(C) Any report made pursuant to division (A) or (B) of this section shall be made forthwith either by telephone or in person and shall be followed by a written report, if requested by the receiving agency or officer. The written report shall contain:

(1) The names and addresses of the child and the child's parents or the person or persons having custody of the child, if known;

(2) The child's age and the nature and extent of the child's injuries, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to have occurred or of the threat of injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to exist, including any evidence of previous injuries, abuse, or neglect;

(3) Any other information, including, but not limited to, results and reports of any medical examinations, tests, or procedures performed under division (D) of this section, that might be helpful in establishing the cause of the injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to have occurred or of the threat of injury, abuse, or neglect that is known or reasonably suspected or believed, as applicable, to exist.

(D)(1) Any person, who is required by division (A) of this section to report child abuse or child neglect that is known or reasonably suspected or believed to have occurred, may take or cause to be taken color photographs of areas of trauma visible

on a child and, if medically necessary for the purpose of diagnosing or treating injuries that are suspected to have occurred as a result of child abuse or child neglect, perform or cause to be performed radiological examinations and any other medical examinations of, and tests or procedures on, the child.

(2) The results and any available reports of examinations, tests, or procedures made under division (D)(1) of this section shall be included in a report made pursuant to division (A) of this section. Any additional reports of examinations, tests, or procedures that become available shall be provided to the public children services agency, upon request.

(3) If a health care professional provides health care services in a hospital, children's advocacy center, or emergency medical facility to a child about whom a report has been made under division (A) of this section, the health care professional may take any steps that are reasonably necessary for the release or discharge of the child to an appropriate environment. Before the child's release or discharge, the health care professional may obtain information, or consider information obtained, from other entities or individuals that have knowledge about the child. Nothing in division (D)(3) of this section shall be construed to alter the responsibilities of any person under sections 2151.27 and 2151.31 of the Revised Code.

(4) A health care professional may conduct medical examinations, tests, or procedures on the siblings of a child about whom a report has been made under division (A) of this section and on other children who reside in the same home as the child, if the professional determines that the examinations, tests, or procedures are medically necessary to diagnose or treat the siblings or other children in order to determine

whether reports under division (A) of this section are warranted with respect to such siblings or other children. The results of the examinations, tests, or procedures on the siblings and other children may be included in a report made pursuant to division (A) of this section.

(5) Medical examinations, tests, or procedures conducted under divisions (D)(1) and (4) of this section and decisions regarding the release or discharge of a child under division (D)(3) of this section do not constitute a law enforcement investigation or activity.

(E)(1) When a peace officer receives a report made pursuant to division (A) or (B) of this section, upon receipt of the report, the peace officer who receives the report shall refer the report to the appropriate public children services agency, unless an arrest is made at the time of the report that results in the appropriate public children services agency being contacted concerning the possible abuse or neglect of a child or the possible threat of abuse or neglect of a child.

(2) When a public children services agency receives a report pursuant to this division or division (A) or (B) of this section, upon receipt of the report, the public children services agency shall do both of the following:

(a) Comply with section 2151.422 of the Revised Code;

(b) If the county served by the agency is also served by a children's advocacy center and the report alleges sexual abuse of a child or another type of abuse of a child that is specified in the memorandum of understanding that creates the center as being within the center's jurisdiction, comply regarding the report with the protocol and procedures for referrals and

investigations, with the coordinating activities, and with the authority or responsibility for performing or providing functions, activities, and services stipulated in the interagency agreement entered into under section 2151.428 of the Revised Code relative to that center.

(F) No peace officer shall remove a child about whom a report is made pursuant to this section from the child's parents, stepparents, or guardian or any other persons having custody of the child without consultation with the public children services agency, unless, in the judgment of the officer, and, if the report was made by a physician or advanced practice registered nurse, the physician or nurse, immediate removal is considered essential to protect the child from further abuse or neglect. The agency that must be consulted shall be the agency conducting the investigation of the report as determined pursuant to section 2151.422 of the Revised Code.

(G)(1) Except as provided in section 2151.422 of the Revised Code or in an interagency agreement entered into under section 2151.428 of the Revised Code that applies to the particular report, the public children services agency shall investigate, within twenty-four hours, each report of child abuse or child neglect that is known or reasonably suspected or believed to have occurred and of a threat of child abuse or child neglect that is known or reasonably suspected or believed to exist that is referred to it under this section to determine the circumstances surrounding the injuries, abuse, or neglect or the threat of injury, abuse, or neglect, the cause of the injuries, abuse, neglect, or threat, and the person or persons responsible. The investigation shall be made in cooperation with the law enforcement agency and in accordance with the memorandum of understanding prepared under division (K) of this section. A

representative of the public children services agency shall, at the time of initial contact with the person subject to the investigation, inform the person of the specific complaints or allegations made against the person. The information shall be given in a manner that is consistent with division (I)(1) of this section and protects the rights of the person making the report under this section.

A failure to make the investigation in accordance with the memorandum is not grounds for, and shall not result in, the dismissal of any charges or complaint arising from the report or the suppression of any evidence obtained as a result of the report and does not give, and shall not be construed as giving, any rights or any grounds for appeal or post-conviction relief to any person. The public children services agency shall report each case to the uniform statewide automated child welfare information system that the department of job and family services shall maintain in accordance with section 5101.13 of the Revised Code. The public children services agency shall submit a report of its investigation, in writing, to the law enforcement agency.

(2) The public children services agency shall make any recommendations to the county prosecuting attorney or city director of law that it considers necessary to protect any children that are brought to its attention.

(H)(1)(a) Except as provided in divisions (H)(1)(b) and (I)(3) of this section, any person, health care professional, hospital, institution, school, health department, or agency shall be immune from any civil or criminal liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of any of the following:

(i) Participating in the making of reports pursuant to division (A) of this section or in the making of reports in good faith, pursuant to division (B) of this section;

(ii) Participating in medical examinations, tests, or procedures under division (D) of this section;

(iii) Providing information used in a report made pursuant to division (A) of this section or providing information in good faith used in a report made pursuant to division (B) of this section;

(iv) Participating in a judicial proceeding resulting from a report made pursuant to division (A) of this section or participating in good faith in a proceeding resulting from a report made pursuant to division (B) of this section.

(b) Immunity under division (H)(1)(a)(ii) of this section shall not apply when a health care provider has deviated from the standard of care applicable to the provider's profession.

(c) Notwithstanding section 4731.22 of the Revised Code, the physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report submitted pursuant to this section.

(2) In any civil or criminal action or proceeding in which it is alleged and proved that participation in the making of a report under this section was not in good faith or participation in a judicial proceeding resulting from a report made under this section was not in good faith, the court shall award the prevailing party reasonable attorney's fees and costs and, if a civil action or proceeding is voluntarily dismissed, may award

reasonable attorney's fees and costs to the party against whom the civil action or proceeding is brought.

(I)(1) Except as provided in divisions (I)(4) and (O) of this section and sections 2151.423 and 2151.4210 of the Revised Code, a report made under this section is confidential. The information provided in a report made pursuant to this section and the name of the person who made the report shall not be released for use, and shall not be used, as evidence in any civil action or proceeding brought against the person who made the report. Nothing in this division shall preclude the use of reports of other incidents of known or suspected abuse or neglect in a civil action or proceeding brought pursuant to division (N) of this section against a person who is alleged to have violated division (A)(1) of this section, provided that any information in a report that would identify the child who is the subject of the report or the maker of the report, if the maker of the report is not the defendant or an agent or employee of the defendant, has been redacted. In a criminal proceeding, the report is admissible in evidence in accordance with the Rules of Evidence and is subject to discovery in accordance with the Rules of Criminal Procedure.

(2)(a) Except as provided in division (I)(2)(b) of this section, no person shall permit or encourage the unauthorized dissemination of the contents of any report made under this section.

(b) A health care professional that obtains the same information contained in a report made under this section from a source other than the report may disseminate the information, if its dissemination is otherwise permitted by law.

(3) A person who knowingly makes or causes another person

to make a false report under division (B) of this section that alleges that any person has committed an act or omission that resulted in a child being an abused child or a neglected child is guilty of a violation of section 2921.14 of the Revised Code.

(4) If a report is made pursuant to division (A) or (B) of this section and the child who is the subject of the report dies for any reason at any time after the report is made, but before the child attains eighteen years of age, the public children services agency or peace officer to which the report was made or referred, on the request of the child fatality review board, the suicide fatality review committee, or the director of health pursuant to guidelines established under section 3701.70 of the Revised Code, shall submit a summary sheet of information providing a summary of the report to the review board or review committee of the county in which the deceased child resided at the time of death or to the director. On the request of the review board, review committee, or director, the agency or peace officer may, at its discretion, make the report available to the review board, review committee, or director. If the county served by the public children services agency is also served by a children's advocacy center and the report of alleged sexual abuse of a child or another type of abuse of a child is specified in the memorandum of understanding that creates the center as being within the center's jurisdiction, the agency or center shall perform the duties and functions specified in this division in accordance with the interagency agreement entered into under section 2151.428 of the Revised Code relative to that advocacy center.

(5) A public children services agency shall advise a person alleged to have inflicted abuse or neglect on a child who is the subject of a report made pursuant to this section,

including a report alleging sexual abuse of a child or another type of abuse of a child referred to a children's advocacy center pursuant to an interagency agreement entered into under section 2151.428 of the Revised Code, in writing of the disposition of the investigation. The agency shall not provide to the person any information that identifies the person who made the report, statements of witnesses, or police or other investigative reports.

(J) Any report that is required by this section, other than a report that is made to the state highway patrol as described in section 5120.173 of the Revised Code, shall result in protective services and emergency supportive services being made available by the public children services agency on behalf of the children about whom the report is made, in an effort to prevent further neglect or abuse, to enhance their welfare, and, whenever possible, to preserve the family unit intact. The agency required to provide the services shall be the agency conducting the investigation of the report pursuant to section 2151.422 of the Revised Code.

(K)(1) Each public children services agency shall prepare a memorandum of understanding that is signed by all of the following:

(a) If there is only one juvenile judge in the county, the juvenile judge of the county or the juvenile judge's representative;

(b) If there is more than one juvenile judge in the county, a juvenile judge or the juvenile judges' representative selected by the juvenile judges or, if they are unable to do so for any reason, the juvenile judge who is senior in point of service or the senior juvenile judge's representative;

(c) The county peace officer;

(d) All chief municipal peace officers within the county;

(e) Other law enforcement officers handling child abuse and neglect cases in the county;

(f) The prosecuting attorney of the county;

(g) If the public children services agency is not the county department of job and family services, the county department of job and family services;

(h) The county humane society;

(i) If the public children services agency participated in the execution of a memorandum of understanding under section 2151.426 of the Revised Code establishing a children's advocacy center, each participating member of the children's advocacy center established by the memorandum.

(2) A memorandum of understanding shall set forth the normal operating procedure to be employed by all concerned officials in the execution of their respective responsibilities under this section and division (C) of section 2919.21, division (B)(1) of section 2919.22, division (B) of section 2919.23, and section 2919.24 of the Revised Code and shall have as two of its primary goals the elimination of all unnecessary interviews of children who are the subject of reports made pursuant to division (A) or (B) of this section and, when feasible, providing for only one interview of a child who is the subject of any report made pursuant to division (A) or (B) of this section. A failure to follow the procedure set forth in the memorandum by the concerned officials is not grounds for, and shall not result in, the dismissal of any charges or complaint arising from any reported case of abuse or neglect or the

suppression of any evidence obtained as a result of any reported child abuse or child neglect and does not give, and shall not be construed as giving, any rights or any grounds for appeal or post-conviction relief to any person.

(3) A memorandum of understanding shall include all of the following:

(a) The roles and responsibilities for handling emergency and nonemergency cases of abuse and neglect;

(b) Standards and procedures to be used in handling and coordinating investigations of reported cases of child abuse and reported cases of child neglect, methods to be used in interviewing the child who is the subject of the report and who allegedly was abused or neglected, and standards and procedures addressing the categories of persons who may interview the child who is the subject of the report and who allegedly was abused or neglected.

(4) If a public children services agency participated in the execution of a memorandum of understanding under section 2151.426 of the Revised Code establishing a children's advocacy center, the agency shall incorporate the contents of that memorandum in the memorandum prepared pursuant to this section.

(5) The clerk of the court of common pleas in the county may sign the memorandum of understanding prepared under division (K)(1) of this section. If the clerk signs the memorandum of understanding, the clerk shall execute all relevant responsibilities as required of officials specified in the memorandum.

(L)(1) Except as provided in division (L)(4) or (5) of this section, a person who is required to make a report pursuant

to division (A) of this section may make a reasonable number of requests of the public children services agency that receives or is referred the report, or of the children's advocacy center that is referred the report if the report is referred to a children's advocacy center pursuant to an interagency agreement entered into under section 2151.428 of the Revised Code, to be provided with the following information:

(a) Whether the agency or center has initiated an investigation of the report;

(b) Whether the agency or center is continuing to investigate the report;

(c) Whether the agency or center is otherwise involved with the child who is the subject of the report;

(d) The general status of the health and safety of the child who is the subject of the report;

(e) Whether the report has resulted in the filing of a complaint in juvenile court or of criminal charges in another court.

(2) A person may request the information specified in division (L)(1) of this section only if, at the time the report is made, the person's name, address, and telephone number are provided to the person who receives the report.

When a peace officer or employee of a public children services agency receives a report pursuant to division (A) or (B) of this section the recipient of the report shall inform the person of the right to request the information described in division (L)(1) of this section. The recipient of the report shall include in the initial child abuse or child neglect report that the person making the report was so informed and, if

provided at the time of the making of the report, shall include the person's name, address, and telephone number in the report.

Each request is subject to verification of the identity of the person making the report. If that person's identity is verified, the agency shall provide the person with the information described in division (L)(1) of this section a reasonable number of times, except that the agency shall not disclose any confidential information regarding the child who is the subject of the report other than the information described in those divisions.

(3) A request made pursuant to division (L)(1) of this section is not a substitute for any report required to be made pursuant to division (A) of this section.

(4) If an agency other than the agency that received or was referred the report is conducting the investigation of the report pursuant to section 2151.422 of the Revised Code, the agency conducting the investigation shall comply with the requirements of division (L) of this section.

(5) A health care professional who made a report under division (A) of this section, or on whose behalf such a report was made as provided in division (A)(1)(c) of this section, may authorize a person to obtain the information described in division (L)(1) of this section if the person requesting the information is associated with or acting on behalf of the health care professional who provided health care services to the child about whom the report was made.

(M) The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The department of job and family

services may enter into a plan of cooperation with any other governmental entity to aid in ensuring that children are protected from abuse and neglect. The department shall make recommendations to the attorney general that the department determines are necessary to protect children from child abuse and child neglect.

(N) Whoever violates division (A) of this section is liable for compensatory and exemplary damages to the child who would have been the subject of the report that was not made. A person who brings a civil action or proceeding pursuant to this division against a person who is alleged to have violated division (A)(1) of this section may use in the action or proceeding reports of other incidents of known or suspected abuse or neglect, provided that any information in a report that would identify the child who is the subject of the report or the maker of the report, if the maker is not the defendant or an agent or employee of the defendant, has been redacted.

(O)(1) As used in this division:

(a) "Out-of-home care" includes a nonchartered nonpublic school if the alleged child abuse or child neglect, or alleged threat of child abuse or child neglect, described in a report received by a public children services agency allegedly occurred in or involved the nonchartered nonpublic school and the alleged perpetrator named in the report holds a certificate, permit, or license issued by the state board of education under section 3301.071 or Chapter 3319. of the Revised Code.

(b) "Administrator, director, or other chief administrative officer" means the superintendent of the school district if the out-of-home care entity subject to a report made pursuant to this section is a school operated by the district.

(2) No later than the end of the day following the day on which a public children services agency receives a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved an out-of-home care entity, the agency shall provide written notice of the allegations contained in and the person named as the alleged perpetrator in the report to the administrator, director, or other chief administrative officer of the out-of-home care entity that is the subject of the report unless the administrator, director, or other chief administrative officer is named as an alleged perpetrator in the report. If the administrator, director, or other chief administrative officer of an out-of-home care entity is named as an alleged perpetrator in a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved the out-of-home care entity, the agency shall provide the written notice to the owner or governing board of the out-of-home care entity that is the subject of the report. The agency shall not provide witness statements or police or other investigative reports.

(3) No later than three days after the day on which a public children services agency that conducted the investigation as determined pursuant to section 2151.422 of the Revised Code makes a disposition of an investigation involving a report of alleged child abuse or child neglect, or a report of an alleged threat of child abuse or child neglect, that allegedly occurred in or involved an out-of-home care entity, the agency shall send written notice of the disposition of the investigation to the administrator, director, or other chief administrative officer and the owner or governing board of the out-of-home care entity.

The agency shall not provide witness statements or police or other investigative reports.

(P) As used in this section:

(1) "Children's advocacy center" and "sexual abuse of a child" have the same meanings as in section 2151.425 of the Revised Code.

(2) "Health care professional" means an individual who provides health-related services ~~including~~. "Health care professional" includes all of the following: a physician, including a hospital intern or resident~~,~~; a dentist~~,~~; a podiatrist~~,~~; a registered nurse, including such a nurse who is an advanced practice registered nurse; a licensed practical nurse~~,~~; a registered nurse or licensed practical nurse who is a visiting nurse~~,~~; a licensed psychologist~~,~~; a speech-language pathologist~~,~~; an audiologist~~,~~; a person engaged in social work or the practice of professional counseling~~,~~; and an employee of a home health agency. "Health care professional" does not include a practitioner of a limited branch of medicine as specified in section 4731.15 of the Revised Code, licensed school psychologist, independent marriage and family therapist or marriage and family therapist, or coroner.

(3) "Investigation" means the public children services agency's response to an accepted report of child abuse or neglect through either an alternative response or a traditional response.

(4) "Peace officer" means a sheriff, deputy sheriff, constable, police officer of a township or joint police district, marshal, deputy marshal, municipal police officer, or ~~a~~ state highway patrol trooper.

Sec. 2305.235. (A) As used in this section:

(1) "Automated external defibrillation" means the process of applying a specialized defibrillator to a person in cardiac arrest, allowing the defibrillator to interpret the cardiac rhythm, and, if appropriate, delivering an electrical shock to the heart to allow it to resume effective electrical activity.

(2) "Physician" has the same meaning as in section 4765.01 of the Revised Code.

(B) Except in the case of willful or wanton misconduct, no physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner shall be held liable in civil damages for injury, death, or loss to person or property for providing a prescription for an automated external defibrillator approved for use as a medical device by the United States food and drug administration or consulting with a person regarding the use and maintenance of a defibrillator.

(C) Except in the case of willful or wanton misconduct, no person shall be held liable in civil damages for injury, death, or loss to person or property for doing any of the following:

(1) Providing training in automated external defibrillation and cardiopulmonary resuscitation;

(2) Authorizing, directing, or supervising the installation or placement of an automated external defibrillator;

(3) Designing, managing, or operating a cardiopulmonary resuscitation or automated external defibrillation program;

(4) Acquiring an automated external defibrillator;

(5) Owning, managing, or having responsibility for a

premises or location where an automated external defibrillator has been placed.

(D) Except in the case of willful or wanton misconduct or when there is no good faith attempt to activate an emergency medical services system in accordance with section 3701.85 of the Revised Code, no person shall be held liable in civil damages for injury, death, or loss to person or property, or held criminally liable, for performing automated external defibrillation in good faith, regardless of whether the person has obtained appropriate training on how to perform automated external defibrillation or successfully completed a course in cardiopulmonary resuscitation.

Sec. 2313.14. (A) Except as provided by section 2313.15 of the Revised Code, the court of common pleas or the commissioners of jurors shall not excuse a person who is liable to serve as a juror and who is drawn and notified, unless it is shown to the satisfaction of the judge or commissioners by either the juror or another person acquainted with the facts that one or more of the following applies:

(1) The interests of the public will be materially injured by the juror's attendance.

(2) The juror's spouse or a near relative of the juror or the juror's spouse has recently died or is dangerously ill.

(3) The juror is a cloistered member of a religious organization.

(4) The prospective juror has a mental or physical condition that causes the prospective juror to be incapable of performing jury service. The court or commissioners may require the prospective juror to provide the court with documentation

from a physician licensed to practice medicine or a clinical nurse specialist or certified nurse practitioner verifying that a mental or physical condition renders the prospective juror unfit for jury service for the remainder of the jury year.

(5) Jury service would otherwise cause undue or extreme physical or financial hardship to the prospective juror or a person under the care or supervision of the prospective juror. A judge of the court for which the prospective juror was called to jury service shall make undue or extreme physical or financial hardship determinations. The judge may delegate the authority to make these determinations to an appropriate court employee appointed by the court.

(6) The juror is over seventy-five years of age, and the juror requests to be excused.

(7) The prospective juror is an active member of a recognized Amish sect and requests to be excused because of the prospective juror's sincere belief that as a result of that membership the prospective juror cannot pass judgment in a judicial matter.

(8) The prospective juror is on active duty pursuant to an executive order of the president of the United States, an act of the congress of the United States, or section 5919.29 or 5923.21 of the Revised Code.

(B)(1) A prospective juror who requests to be excused from jury service under this section shall take all actions necessary to obtain a ruling on that request by not later than the date on which the prospective juror is scheduled to appear for jury duty.

(2) A prospective juror who requests to be excused as

provided in division (A)(6) of this section shall inform the appropriate court employee appointed by the court of the prospective juror's request to be so excused by not later than the date on which the prospective juror is scheduled to appear for jury duty. The prospective juror shall inform that court employee of the request to be so excused by appearing in person before the employee or contacting the employee by telephone, in writing, or by electronic mail.

(C)(1) For purposes of this section, undue or extreme physical or financial hardship is limited to circumstances in which any of the following apply:

(a) The prospective juror would be required to abandon a person under the prospective juror's personal care or supervision due to the impossibility of obtaining an appropriate substitute caregiver during the period of participation in the jury pool or on the jury.

(b) The prospective juror would incur costs that would have a substantial adverse impact on the payment of the prospective juror's necessary daily living expenses or on those for whom the prospective juror provides the principal means of support.

(c) The prospective juror would suffer physical hardship that would result in illness or disease.

(2) Undue or extreme physical or financial hardship does not exist solely based on the fact that a prospective juror will be required to be absent from the prospective juror's place of employment.

(D) A prospective juror who asks a judge to grant an excuse based on undue or extreme physical or financial hardship

shall provide the judge with documentation that the judge finds to clearly support the request to be excused. If a prospective juror fails to provide satisfactory documentation, the court may deny the request to be excused.

(E) An excuse, whether permanent or not, approved pursuant to this section shall not extend beyond that jury year. Every approved excuse shall be recorded and filed with the commissioners of jurors. A person is excused from jury service permanently only when the deciding judge determines that the underlying grounds for being excused are of a permanent nature.

(F) No person shall be exempted or excused from jury service or be granted a postponement of jury service by reason of any financial contribution to any public or private organization.

(G) The commissioners shall keep a record of all proceedings before them or in their office, of all persons who are granted an excuse or postponement, and of the time of and reasons for each excuse.

Sec. 2317.47. Whenever it is relevant in a civil or criminal action or proceeding to determine the paternity or identity of any person, the trial court on motion shall order any party to the action and any person involved in the controversy or proceeding to submit to one or more blood-grouping tests, to be made by qualified physicians, clinical nurse specialists, or certified nurse practitioners or other qualified persons, not to exceed three, to be selected by the court and under such restrictions or directions as the court or judge deems proper. In cases where exclusion is established, the results of the tests together with the findings of the experts of the fact of nonpaternity are receivable in evidence. Such

experts shall be subject to cross-examination by both parties after the court has caused them to disclose their findings to the court or to the court and jury. Whenever the court orders such blood-grouping tests to be taken and one of the parties refuses to submit to such test, such fact shall be disclosed upon the trial unless good cause is shown to the contrary. The court shall determine how and by whom the costs of such examination shall be paid.

Sec. 2317.54. No hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program or pediatric respite care program shall be held liable for a physician's or advanced practice registered nurse's failure to obtain an informed consent from the physician's or nurse's patient prior to a surgical or medical procedure or course of procedures, unless the physician or nurse is an employee of the hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program or pediatric respite care program.

Written consent to a surgical or medical procedure or course of procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, minority, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances, including either of the following:

(1) The parent, whether the parent is an adult or a minor, of the parent's minor child;

(2) An adult whom the parent of the minor child has given written authorization to consent to a surgical or medical procedure or course of procedures for the parent's minor child.

Any use of a consent form that fulfills the requirements stated in divisions (A), (B), and (C) of this section has no effect on the common law rights and liabilities, including the right of a physician to obtain the oral or implied consent of a patient to a medical procedure, that may exist as between physicians and patients on July 28, 1975.

As used in this section the term "hospital" has the same meaning as in section 2305.113 of the Revised Code; "ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code; "hospice care program" and "pediatric respite care program" have the same meanings as in section 3712.01 of the Revised Code~~, and~~; "home health agency" has the same meaning as in section 3740.01 of the Revised Code; and "advanced practice registered nurse" has the same meaning as in section 4723.01 of the Revised Code. The provisions of this division apply to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine.

Sec. 2945.38. (A) If the issue of a defendant's competence to stand trial is raised and if the court, upon conducting the hearing provided for in section 2945.37 of the Revised Code, finds that the defendant is competent to stand trial, the defendant shall be proceeded against as provided by law. If the court finds the defendant competent to stand trial and the defendant is receiving psychotropic drugs or other medication, the court may authorize the continued administration of the drugs or medication or other appropriate treatment in order to maintain the defendant's competence to stand trial, unless the defendant's attending physician, clinical nurse specialist, or certified nurse practitioner advises the court against continuation of the drugs, other medication, or treatment.

(B)(1)(a)(i) If the defendant has been charged with a felony offense or a misdemeanor offense of violence for which the prosecutor has not recommended the procedures under division (B)(1)(a)(vi) of this section and if, after taking into consideration all relevant reports, information, and other evidence, the court finds that the defendant is incompetent to stand trial and that there is a substantial probability that the

defendant will become competent to stand trial within one year if the defendant is provided with a course of treatment, the court shall order the defendant to undergo treatment.

(ii) If the defendant has been charged with a felony offense and if, after taking into consideration all relevant reports, information, and other evidence, the court finds that the defendant is incompetent to stand trial, but the court is unable at that time to determine whether there is a substantial probability that the defendant will become competent to stand trial within one year if the defendant is provided with a course of treatment, the court shall order continuing evaluation and treatment of the defendant for a period not to exceed four months to determine whether there is a substantial probability that the defendant will become competent to stand trial within one year if the defendant is provided with a course of treatment.

(iii) If the defendant has not been charged with a felony offense but has been charged with a misdemeanor offense of violence and if, after taking into consideration all relevant reports, information, and other evidence, the court finds that the defendant is incompetent to stand trial, but the court is unable at that time to determine whether there is a substantial probability that the defendant will become competent to stand trial within the time frame permitted under division (C)(1) of this section, the court may order continuing evaluation and treatment of the defendant for a period not to exceed the maximum period permitted under that division.

(iv) If the defendant has not been charged with a felony offense or a misdemeanor offense of violence, but has been charged with a misdemeanor offense that is not a misdemeanor

offense of violence and if, after taking into consideration all relevant reports, information, and other evidence, the court finds that the defendant is incompetent to stand trial, but the court is unable at that time to determine whether there is a substantial probability that the defendant will become competent to stand trial within the time frame permitted under division (C)(1) of this section, the court shall dismiss the charges and follow the process outlined in division (B)(1)(a)(v)(I) of this section.

(v) If the defendant has not been charged with a felony offense or a misdemeanor offense of violence, or if the defendant has been charged with a misdemeanor offense of violence and the prosecutor has recommended the procedures under division (B)(1)(a)(vi) of this section, and if, after taking into consideration all relevant reports, information, and other evidence, the trial court finds that the defendant is incompetent to stand trial, the trial court shall do one of the following:

(I) Dismiss the charges pending against the defendant. A dismissal under this division is not a bar to further prosecution based on the same conduct. Upon dismissal of the charges, the trial court shall discharge the defendant unless the court or prosecutor, after consideration of the requirements of section 5122.11 of the Revised Code, files an affidavit in probate court alleging that the defendant is a mentally ill person subject to court order or a person with an intellectual disability subject to institutionalization by court order. If an affidavit is filed in probate court, the trial court may detain the defendant for ten days pending a hearing in the probate court and shall send to the probate court copies of all written reports of the defendant's mental condition that were prepared

pursuant to section 2945.371 of the Revised Code. The trial court or prosecutor shall specify in the appropriate space on the affidavit that the defendant is a person described in this subdivision.

(II) Order the defendant to undergo outpatient competency restoration treatment at a facility operated or certified by the department of mental health and addiction services as being qualified to treat mental illness, at a public or community mental health facility, or in the care of a psychiatrist or other mental health professional. If a defendant who has been released on bail or recognizance refuses to comply with court-ordered outpatient treatment under this division, the court may dismiss the charges pending against the defendant and proceed under division (B)(1)(a)(v)(I) of this section or may amend the conditions of bail or recognizance and order the sheriff to take the defendant into custody and deliver the defendant to a center, program, or facility operated or certified by the department of mental health and addiction services for treatment.

(vi) If the defendant has not been charged with a felony offense but has been charged with a misdemeanor offense of violence and after taking into consideration all relevant reports, information, and other evidence, the court finds that the defendant is incompetent to stand trial, the prosecutor in the case may recommend that the court follow the procedures prescribed in division (B)(1)(a)(v) of this section. If the prosecutor does not make such a recommendation, the court shall follow the procedures in division (B)(1)(a)(i) of this section.

(b) The court order for the defendant to undergo treatment or continuing evaluation and treatment under division (B)(1)(a)

of this section shall specify that the defendant, if determined to require mental health treatment or continuing evaluation and treatment, either shall be committed to the department of mental health and addiction services for treatment or continuing evaluation and treatment at a hospital, facility, or agency, as determined to be clinically appropriate by the department of mental health and addiction services or shall be committed to a facility certified by the department of mental health and addiction services as being qualified to treat mental illness, to a public or community mental health facility, or to a psychiatrist or another mental health professional for treatment or continuing evaluation and treatment. Prior to placing the defendant, the department of mental health and addiction services shall obtain court approval for that placement following a hearing. The court order for the defendant to undergo treatment or continuing evaluation and treatment under division (B)(1)(a) of this section shall specify that the defendant, if determined to require treatment or continuing evaluation and treatment for an intellectual disability, shall receive treatment or continuing evaluation and treatment at an institution or facility operated by the department of developmental disabilities, at a facility certified by the department of developmental disabilities as being qualified to treat intellectual disabilities, at a public or private intellectual disabilities facility, or by a psychiatrist or another intellectual disabilities professional. In any case, the order may restrict the defendant's freedom of movement as the court considers necessary. The prosecutor in the defendant's case shall send to the chief clinical officer of the hospital, facility, or agency where the defendant is placed by the department of mental health and addiction services, or to the managing officer of the institution, the director of the program

or facility, or the person to which the defendant is committed, copies of relevant police reports and other background information that pertains to the defendant and is available to the prosecutor unless the prosecutor determines that the release of any of the information in the police reports or any of the other background information to unauthorized persons would interfere with the effective prosecution of any person or would create a substantial risk of harm to any person.

In determining the place of commitment, the court shall consider the extent to which the person is a danger to the person and to others, the need for security, the availability of housing and supportive services, including outpatient mental health services in the community, and the type of crime involved and shall order the least restrictive alternative available that is consistent with public safety and treatment goals. In weighing these factors, the court shall give preference to protecting public safety and the availability of housing and supportive services.

(c) If the defendant is found incompetent to stand trial, if the chief clinical officer of the hospital, facility, or agency where the defendant is placed, or the managing officer of the institution, the director of the program or facility, or the person to which the defendant is committed for treatment or continuing evaluation and treatment under division (B)(1)(b) of this section determines that medication is necessary to restore the defendant's competency to stand trial, and if the defendant lacks the capacity to give informed consent or refuses medication, the chief clinical officer of the hospital, facility, or agency where the defendant is placed, or the managing officer of the institution, the director of the program or facility, or the person to which the defendant is committed

for treatment or continuing evaluation and treatment may petition the court for authorization for the involuntary administration of medication. The court shall hold a hearing on the petition within five days of the filing of the petition if the petition was filed in a municipal court or a county court regarding an incompetent defendant charged with a misdemeanor or within ten days of the filing of the petition if the petition was filed in a court of common pleas regarding an incompetent defendant charged with a felony offense. Following the hearing, the court may authorize the involuntary administration of medication or may dismiss the petition.

(2) If the court finds that the defendant is incompetent to stand trial and that, even if the defendant is provided with a course of treatment, there is not a substantial probability that the defendant will become competent to stand trial within one year, the court shall order the discharge of the defendant, unless upon motion of the prosecutor or on its own motion, the court either seeks to retain jurisdiction over the defendant pursuant to section 2945.39 of the Revised Code or files an affidavit in the probate court for the civil commitment of the defendant pursuant to Chapter 5122. or 5123. of the Revised Code alleging that the defendant is a mentally ill person subject to court order or a person with an intellectual disability subject to institutionalization by court order. If an affidavit is filed in the probate court, the trial court shall send to the probate court copies of all written reports of the defendant's mental condition that were prepared pursuant to section 2945.371 of the Revised Code.

The trial court may issue the temporary order of detention that a probate court may issue under section 5122.11 or 5123.71 of the Revised Code, to remain in effect until the probable

cause or initial hearing in the probate court. Further proceedings in the probate court are civil proceedings governed by Chapter 5122. or 5123. of the Revised Code.

(C) No defendant shall be required to undergo treatment, including any continuing evaluation and treatment, under division (B)(1) of this section for longer than whichever of the following periods is applicable:

(1) One year, if the most serious offense with which the defendant is charged is one of the following offenses:

(a) Aggravated murder, murder, or an offense of violence for which a sentence of death or life imprisonment may be imposed;

(b) An offense of violence that is a felony of the first or second degree;

(c) A conspiracy to commit, an attempt to commit, or complicity in the commission of an offense described in division (C)(1)(a) or (b) of this section if the conspiracy, attempt, or complicity is a felony of the first or second degree.

(2) Six months, if the most serious offense with which the defendant is charged is a felony other than a felony described in division (C)(1) of this section;

(3) Sixty days, if the most serious offense with which the defendant is charged is a misdemeanor of the first or second degree;

(4) Thirty days, if the most serious offense with which the defendant is charged is a misdemeanor of the third or fourth degree, a minor misdemeanor, or an unclassified misdemeanor.

(D) Any defendant who is committed pursuant to this

section shall not voluntarily admit the defendant or be voluntarily admitted to a hospital or institution pursuant to section 5122.02, 5122.15, 5123.69, or 5123.76 of the Revised Code.

(E) Except as otherwise provided in this division, a defendant who is charged with an offense and is committed by the court under this section to the department of mental health and addiction services or is committed to an institution or facility for the treatment of intellectual disabilities shall not be granted unsupervised on-grounds movement, supervised off-grounds movement, or nonsecured status except in accordance with the court order. The court may grant a defendant supervised off-grounds movement to obtain medical treatment or specialized habilitation treatment services if the person who supervises the treatment or the continuing evaluation and treatment of the defendant ordered under division (B)(1)(a) of this section informs the court that the treatment or continuing evaluation and treatment cannot be provided at the hospital or facility where the defendant is placed by the department of mental health and addiction services or the institution or facility to which the defendant is committed. The chief clinical officer of the hospital or facility where the defendant is placed by the department of mental health and addiction services or the managing officer of the institution or director of the facility to which the defendant is committed, or a designee of any of those persons, may grant a defendant movement to a medical facility for an emergency medical situation with appropriate supervision to ensure the safety of the defendant, staff, and community during that emergency medical situation. The chief clinical officer of the hospital or facility where the defendant is placed by the department of mental health and addiction

services or the managing officer of the institution or director of the facility to which the defendant is committed shall notify the court within twenty-four hours of the defendant's movement to the medical facility for an emergency medical situation under this division.

(F) The person who supervises the treatment or continuing evaluation and treatment of a defendant ordered to undergo treatment or continuing evaluation and treatment under division (B)(1)(a) of this section shall file a written report with the court at the following times:

(1) Whenever the person believes the defendant is capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense;

(2) For a felony offense, fourteen days before expiration of the maximum time for treatment as specified in division (C) of this section and fourteen days before the expiration of the maximum time for continuing evaluation and treatment as specified in division (B)(1)(a) of this section, and, for a misdemeanor offense, ten days before the expiration of the maximum time for treatment, as specified in division (C) of this section;

(3) At a minimum, after each six months of treatment;

(4) Whenever the person who supervises the treatment or continuing evaluation and treatment of a defendant ordered under division (B)(1)(a) of this section believes that there is not a substantial probability that the defendant will become capable of understanding the nature and objective of the proceedings against the defendant or of assisting in the defendant's defense

even if the defendant is provided with a course of treatment.

(G) A report under division (F) of this section shall contain the examiner's findings, the facts in reasonable detail on which the findings are based, and the examiner's opinion as to the defendant's capability of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense. If, in the examiner's opinion, the defendant remains incapable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense and there is a substantial probability that the defendant will become capable of understanding the nature and objective of the proceedings against the defendant and of assisting in the defendant's defense if the defendant is provided with a course of treatment, if in the examiner's opinion the defendant remains mentally ill or continues to have an intellectual disability, and if the maximum time for treatment as specified in division (C) of this section has not expired, the report also shall contain the examiner's recommendation as to the least restrictive placement or commitment alternative that is consistent with the defendant's treatment needs for restoration to competency and with the safety of the community. The court shall provide copies of the report to the prosecutor and defense counsel.

(H) If a defendant is committed pursuant to division (B)(1) of this section, within ten days after the treating physician<u>, clinical nurse specialist, or certified nurse practitioner</u> of the defendant or the examiner of the defendant who is employed or retained by the treating facility advises that there is not a substantial probability that the defendant will become capable of understanding the nature and objective of the proceedings against the defendant or of assisting in the

defendant's defense even if the defendant is provided with a course of treatment, within ten days after the expiration of the maximum time for treatment as specified in division (C) of this section, within ten days after the expiration of the maximum time for continuing evaluation and treatment as specified in division (B)(1)(a) of this section, within thirty days after a defendant's request for a hearing that is made after six months of treatment, or within thirty days after being advised by the treating physician, clinical nurse specialist, or certified nurse practitioner or examiner that the defendant is competent to stand trial, whichever is the earliest, the court shall conduct another hearing to determine if the defendant is competent to stand trial and shall do whichever of the following is applicable:

(1) If the court finds that the defendant is competent to stand trial, the defendant shall be proceeded against as provided by law.

(2) If the court finds that the defendant is incompetent to stand trial, but that there is a substantial probability that the defendant will become competent to stand trial if the defendant is provided with a course of treatment, and the maximum time for treatment as specified in division (C) of this section has not expired, the court, after consideration of the examiner's recommendation, shall order that treatment be continued, may change the facility or program at which the treatment is to be continued, and shall specify whether the treatment is to be continued at the same or a different facility or program.

(3) If the court finds that the defendant is incompetent to stand trial, if the defendant is charged with an offense

listed in division (C)(1) of this section, and if the court finds that there is not a substantial probability that the defendant will become competent to stand trial even if the defendant is provided with a course of treatment, or if the maximum time for treatment relative to that offense as specified in division (C) of this section has expired, further proceedings shall be as provided in sections 2945.39, 2945.401, and 2945.402 of the Revised Code.

(4) If the court finds that the defendant is incompetent to stand trial, if the most serious offense with which the defendant is charged is a misdemeanor or a felony other than a felony listed in division (C)(1) of this section, and if the court finds that there is not a substantial probability that the defendant will become competent to stand trial even if the defendant is provided with a course of treatment, or if the maximum time for treatment relative to that offense as specified in division (C) of this section has expired, the court shall dismiss the indictment, information, or complaint against the defendant. A dismissal under this division is not a bar to further prosecution based on the same conduct. The court shall discharge the defendant unless the court or prosecutor files an affidavit in probate court for civil commitment pursuant to Chapter 5122. or 5123. of the Revised Code. If an affidavit for civil commitment is filed, the court may detain the defendant for ten days pending civil commitment and shall send to the probate court copies of all written reports of the defendant's mental condition prepared pursuant to section 2945.371 of the Revised Code.

All of the following provisions apply to persons charged with a misdemeanor or a felony other than a felony listed in division (C)(1) of this section who are committed by the probate

court subsequent to the court's or prosecutor's filing of an affidavit for civil commitment under authority of this division:

(a) The chief clinical officer of the entity, hospital, or facility, the managing officer of the institution, the director of the program, or the person to which the defendant is committed or admitted shall do all of the following:

(i) Notify the prosecutor, in writing, of the discharge of the defendant, send the notice at least ten days prior to the discharge unless the discharge is by the probate court, and state in the notice the date on which the defendant will be discharged;

(ii) Notify the prosecutor, in writing, when the defendant is absent without leave or is granted unsupervised, off-grounds movement, and send this notice promptly after the discovery of the absence without leave or prior to the granting of the unsupervised, off-grounds movement, whichever is applicable;

(iii) Notify the prosecutor, in writing, of the change of the defendant's commitment or admission to voluntary status, send the notice promptly upon learning of the change to voluntary status, and state in the notice the date on which the defendant was committed or admitted on a voluntary status.

(b) Upon receiving notice that the defendant will be granted unsupervised, off-grounds movement, the prosecutor either shall re-indict the defendant or promptly notify the court that the prosecutor does not intend to prosecute the charges against the defendant.

(I) If a defendant is convicted of a crime and sentenced to a jail or workhouse, the defendant's sentence shall be reduced by the total number of days the defendant is confined

for evaluation to determine the defendant's competence to stand trial or treatment under this section and sections 2945.37 and 2945.371 of the Revised Code or by the total number of days the defendant is confined for evaluation to determine the defendant's mental condition at the time of the offense charged.

Sec. 2967.05. (A) As used in this section:

(1) "Imminent danger of death" means that the inmate has a medically diagnosable condition that will cause death to occur within a short period of time.

As used in division (A)(1) of this section, "within a short period of time" means generally within six months.

(2)(a) "Medically incapacitated" means any diagnosable medical condition, including mental dementia and severe, permanent medical or cognitive disability, that prevents the inmate from completing activities of daily living without significant assistance, that incapacitates the inmate to the extent that institutional confinement does not offer additional restrictions, that is likely to continue throughout the entire period of parole, and that is unlikely to improve noticeably.

(b) "Medically incapacitated" does not include conditions related solely to mental illness unless the mental illness is accompanied by injury, disease, or organic defect.

(3)(a) "Terminal illness" means a condition that satisfies all of the following criteria:

(i) The condition is irreversible and incurable and is caused by disease, illness, or injury from which the inmate is unlikely to recover.

(ii) In accordance with reasonable medical standards and a

reasonable degree of medical certainty, the condition is likely to cause death to the inmate within twelve months.

(iii) Institutional confinement of the inmate does not offer additional protections for public safety or against the inmate's risk to reoffend.

(b) The department of rehabilitation and correction shall adopt rules pursuant to Chapter 119. of the Revised Code to implement the definition of "terminal illness" in division (A)(3)(a) of this section.

(B) Upon the recommendation of the director of rehabilitation and correction, accompanied by a certificate of the attending physician, clinical nurse specialist, or certified nurse practitioner that an inmate is terminally ill, medically incapacitated, or in imminent danger of death, the governor may order the inmate's release as if on parole, reserving the right to return the inmate to the institution pursuant to this section. If, subsequent to the inmate's release, the inmate's health improves so that the inmate is no longer terminally ill, medically incapacitated, or in imminent danger of death, the inmate shall be returned, by order of the governor, to the institution from which the inmate was released. If the inmate violates any rules or conditions applicable to the inmate, the inmate may be returned to an institution under the control of the department of rehabilitation and correction. The governor may direct the adult parole authority to investigate or cause to be investigated the inmate and make a recommendation. An inmate released under this section shall be subject to supervision by the adult parole authority in accordance with any recommendation of the adult parole authority that is approved by the governor. The adult parole authority shall adopt rules pursuant to section

119.03 of the Revised Code to establish the procedure for medical release of an inmate when an inmate is terminally ill, medically incapacitated, or in imminent danger of death.

(C) No inmate is eligible for release under this section if the inmate is serving a death sentence, a sentence of life without parole, a sentence under Chapter 2971. of the Revised Code for a felony of the first or second degree, a sentence for aggravated murder or murder, or a mandatory prison term for an offense of violence or any specification described in Chapter 2941. of the Revised Code.

Sec. 3101.05. (A) The parties to a marriage shall make an application for a marriage license. Each of the persons seeking a marriage license shall personally appear in the probate court within the county where either resides, or, if neither is a resident of this state, where the marriage is expected to be solemnized. If neither party is a resident of this state, the marriage may be solemnized only in the county where the license is obtained. Each party shall make application and shall state upon oath, the party's name, age, residence, place of birth, occupation, father's name, and mother's maiden name, if known, and the name of the person who is expected to solemnize the marriage. If either party has been previously married, the application shall include the names of the parties to any previous marriage and of any minor children, and if divorced the jurisdiction, date, and case number of the decree. If either applicant is the age of seventeen years, the judge shall require the applicants to state that they received marriage counseling satisfactory to the court. Except as otherwise provided in this division, the application also shall include each party's social security number. In lieu of requiring each party's social security number on the application, the court may obtain each

party's social security number, retain the social security numbers in a separate record, and allow a number other than the social security number to be used on the application for reference purposes. If a court allows the use of a number other than the social security number to be used on the application for reference purposes, the record containing the social security number is not a public record, except that, in any of the circumstances set forth in divisions (C)(1) to (5) of section 3101.051 of the Revised Code, the record containing the social security number shall be made available for inspection under section 149.43 of the Revised Code.

Immediately upon receipt of an application for a marriage license, the court shall place the parties' record in a book kept for that purpose. If the probate judge is satisfied that there is no legal impediment and if one or both of the parties are present, the probate judge shall grant the marriage license.

If the judge is satisfied from the affidavit of a reputable physician, clinical nurse specialist, or certified nurse practitioner in active practice and residing in the county where the probate court is located, that one of the parties is unable to appear in court, by reason of illness or other physical disability, a marriage license may be granted upon application and oath of the other party to the contemplated marriage; but in that case the person who is unable to appear in court, at the time of making application for a marriage license, shall make and file in that court, an affidavit setting forth the information required of applicants for a marriage license.

A probate judge may grant a marriage license under this section at any time after the application is made.

A marriage license issued shall not display the social

security number of either party to the marriage.

Each person seeking a marriage license shall present documentary proof of age in the form of any one of the following:

(1) A copy of a birth record;

(2) A birth certificate issued by the department of health, a local registrar of vital statistics, or other public office charged with similar duties by the laws of another state, territory, or country;

(3) A baptismal record showing the person's date of birth;

(4) A passport;

(5) A license or permit to operate a motor vehicle as defined under section 4501.01 of the Revised Code;

(6) Any government- or school-issued identification card showing the person's date of birth;

(7) An immigration record showing the person's date of birth;

(8) A naturalization record showing the person's date of birth;

(9) A court record or any other document or record issued by a governmental entity showing the person's date of birth.

(B) An applicant for a marriage license who knowingly makes a false statement in an application or affidavit prescribed by this section is guilty of falsification under section 2921.13 of the Revised Code.

(C) No licensing officer shall issue a marriage license if the officer has not received the application, affidavit, or

other statements prescribed by this section or if the officer has reason to believe that any of the statements in a marriage license application or in an affidavit prescribed by this section are false.

(D) Any fine collected for violation of this section shall be paid to the use of the county together with the costs of prosecution.

Sec. 3105.091. (A) At any time after thirty days from the service of summons or first publication of notice in an action for divorce, annulment, or legal separation, or at any time after the filing of a petition for dissolution of marriage, the court of common pleas, upon its own motion or the motion of one of the parties, may order the parties to undergo conciliation for the period of time not exceeding ninety days as the court specifies, and, if children are involved in the proceeding, the court may order the parties to take part in family counseling during the course of the proceeding or for any reasonable period of time as directed by the court. An order requiring conciliation shall set forth the conciliation procedure and name the conciliator. The conciliation procedures may include without limitation referrals to the conciliation judge as provided in Chapter 3117. of the Revised Code, public or private marriage counselors, family service agencies, community health services, physicians, clinical nurse specialists, certified nurse practitioners, licensed psychologists, or ~~clergymen~~ members of the clergy. The court, in its order requiring the parties to undergo family counseling, may name the counselor and shall set forth the required type of counseling, the length of time for the counseling, and any other specific conditions required by it. The court shall direct and order the manner in which the costs of any conciliation procedures and of any family

counseling are to be paid.

(B) No action for divorce, annulment, or legal separation, in which conciliation or family counseling has been ordered, shall be heard or decided until the conciliation or family counseling has concluded and been reported to the court.

Sec. 3111.12. (A) In an action under sections 3111.01 to 3111.18 of the Revised Code, the mother of the child and the alleged father are competent to testify and may be compelled to testify by subpoena. If a witness refuses to testify upon the ground that the testimony or evidence of the witness might tend to incriminate the witness and the court compels the witness to testify, the court may grant the witness immunity from having the testimony of the witness used against the witness in subsequent criminal proceedings.

(B) Testimony of a physician or certified nurse-midwife concerning the medical circumstances of the mother's pregnancy and the condition and characteristics of the child upon birth is not privileged.

(C) Testimony relating to sexual access to the mother by a man at a time other than the probable time of conception of the child is inadmissible in evidence, unless offered by the mother.

(D) If, pursuant to section 3111.09 of the Revised Code, a court orders genetic tests to be conducted, orders disclosure of information regarding a DNA record stored in the DNA database pursuant to section 109.573 of the Revised Code, or intends to use a report of genetic test results obtained from tests conducted pursuant to former section 3111.21 or 3111.22 or sections 3111.38 to 3111.54 of the Revised Code, a party may object to the admission into evidence of any of the genetic test

results or of the DNA record information by filing a written objection with the court that ordered the tests or disclosure or intends to use a report of genetic test results. The party shall file the written objection with the court no later than fourteen days after the report of the test results or the DNA record information is mailed to the attorney of record of a party or to a party. The party making the objection shall send a copy of the objection to all parties.

If a party files a written objection, the report of the test results or the DNA record information shall be admissible into evidence as provided by the Rules of Evidence. If a written objection is not filed, the report of the test results or the DNA record information shall be admissible into evidence without the need for foundation testimony or other proof of authenticity or accuracy.

(E) If a party intends to introduce into evidence invoices or other documents showing amounts expended to cover pregnancy and confinement and genetic testing, the party shall notify all other parties in writing of that intent and include copies of the invoices and documents. A party may object to the admission into evidence of the invoices or documents by filing a written objection with the court that is hearing the action no later than fourteen days after the notice and the copies of the invoices and documents are mailed to the attorney of record of each party or to each party.

If a party files a written objection, the invoices and other documents shall be admissible into evidence as provided by the Rules of Evidence. If a written objection is not filed, the invoices or other documents are admissible into evidence without the need for foundation testimony or other evidence of

authenticity or accuracy.

(F) A juvenile court or other court with jurisdiction under section 2101.022 or 2301.03 of the Revised Code shall give priority to actions under sections 3111.01 to 3111.18 of the Revised Code and shall issue an order determining the existence or nonexistence of a parent and child relationship no later than one hundred twenty days after the date on which the action was brought in the juvenile court or other court with jurisdiction.

Sec. 3111.90. (A) A non-spousal artificial insemination shall be performed by ~~a~~ one of the following:

(1) A physician ~~or a~~;

(2) A certified nurse-midwife;

(3) A clinical nurse specialist specializing in women's health;

(4) A certified nurse practitioner specializing in women's health;

(5) A person who is under the supervision and control of a ~~physician~~ person described in divisions (A)(1) to (4) of this section. ~~Supervision~~

(B) For purposes of division (A)(5) of this section, supervision requires the availability of a ~~physician for~~ person described in divisions (A)(1) to (4) of this section to provide consultation and direction, but does not necessarily require the personal presence of the physician or nurse who is providing the supervision.

Sec. 3111.93. (A) Prior to a non-spousal artificial insemination, the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner associated

with it shall do the following:

(1) Obtain the written consent of the recipient on a form that the physician or nurse shall provide. The written consent shall contain all of the following:

(a) The name and address of the recipient and, if married, her husband;

(b) The name of the physician or nurse;

(c) The proposed location of the performance of the artificial insemination;

(d) A statement that the recipient and, if married, her husband consent to the artificial insemination;

(e) If desired, a statement that the recipient and, if married, her husband consent to more than one artificial insemination if necessary;

(f) A statement that the donor shall not be advised by the physician, nurse, or another person performing the artificial insemination as to the identity of the recipient or, if married, her husband and that the recipient and, if married, her husband shall not be advised by the physician, nurse, or another person performing the artificial insemination as to the identity of the donor;

(g) A statement that the physician or nurse is to obtain necessary semen from a donor and, subject to any agreed upon provision as described in division (A)(1)(n) of this section, that the recipient and, if married, her husband shall rely upon the judgment and discretion of the physician or nurse in this regard;

(h) A statement that the recipient and, if married, her

husband understand that the physician or nurse cannot be responsible for the physical or mental characteristics of any child resulting from the artificial insemination;

(i) A statement that there is no guarantee that the recipient will become pregnant as a result of the artificial insemination;

(j) A statement that the artificial insemination shall occur in compliance with sections 3111.88 to 3111.96 of the Revised Code;

(k) A brief summary of the paternity consequences of the artificial insemination as set forth in section 3111.95 of the Revised Code;

(l) The signature of the recipient and, if married, her husband;

(m) If agreed to, a statement that the artificial insemination will be performed by a person who is under the supervision and control of the physician or nurse;

(n) Any other provision that the physician or nurse, the recipient, and, if married, her husband agree to include.

(2) Upon request, provide the recipient and, if married, her husband with the following information to the extent the physician or nurse has knowledge of it:

(a) The medical history of the donor, including, but not limited to, any available genetic history of the donor and persons related to him by consanguinity, the blood type of the donor, and whether he has an RH factor;

(b) The race, eye and hair color, age, height, and weight of the donor;

(c) The educational attainment and talents of the donor;

(d) The religious background of the donor;

(e) Any other information that the donor has indicated may be disclosed.

(B) After each non-spousal artificial insemination of a woman, the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner associated with it shall note the date of the artificial insemination in the physician's or nurse's records pertaining to the woman and the artificial insemination, and retain this information as provided in section 3111.94 of the Revised Code.

Sec. 3111.94. (A) The physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who is associated with a non-spousal artificial insemination shall place the written consent obtained pursuant to division (A)(1) of section 3111.93 of the Revised Code, information provided to the recipient and, if married, her husband pursuant to division (A)(2) of that section, other information concerning the donor that the physician or nurse possesses, and other matters concerning the artificial insemination in a file that shall bear the name of the recipient. This file shall be retained by the physician or nurse in the physician's or nurse's office separate from any regular medical chart of the recipient, and shall be confidential, except as provided in divisions (B) and (C) of this section. This file is not a public record under section 149.43 of the Revised Code.

(B) The written consent form and information provided to the recipient and, if married, her husband pursuant to division (A)(2) of section 3111.93 of the Revised Code shall be open to

inspection only until the child born as the result of the non-spousal artificial insemination is twenty-one years of age, and only to the recipient or, if married, her husband upon request to the physician.

(C) Information pertaining to the donor that was not provided to the recipient and, if married, her husband pursuant to division (A)(2) of section 3111.93 of the Revised Code and that the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner possesses shall be kept in the file pertaining to the non-spousal artificial insemination for at least five years from the date of the artificial insemination. At the expiration of this period, the physician or nurse may destroy such information or retain it in the file.

The physician or nurse shall not make this information available for inspection by any person during the five-year period or, if the physician or nurse retains the information after the expiration of that period, at any other time, unless the following apply:

(1) A child is born as a result of the artificial insemination, an action is filed by the recipient, her husband if she is married, or a guardian of the child in the domestic relations division or, if there is no domestic relations division, the general division of the court of common pleas of the county in which the office of the physician or nurse is located, the child is not twenty-one years of age or older, and the court pursuant to division (C)(2) of this section issues an order authorizing the inspection of specified types of information by the recipient, husband, or guardian;

(2) Prior to issuing an order authorizing an inspection of

information, the court shall determine, by clear and convincing evidence, that the information that the recipient, husband, or guardian wishes to inspect is necessary for or helpful in the medical treatment of the child born as a result of the artificial insemination, and shall determine which types of information in the file are germane to the medical treatment and are to be made available for inspection by the recipient, husband, or guardian in that regard. An order only shall authorize the inspection of information germane to the medical treatment of the child.

Sec. 3111.96. The failure of a physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or person under the supervision and control of a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to comply with the applicable requirements of sections 3111.88 to 3111.95 of the Revised Code shall not affect the legal status, rights, or obligations of a child conceived as a result of a non-spousal artificial insemination, a recipient, a husband who consented to the non-spousal artificial insemination of his wife, or the donor. If a recipient who is married and her husband make a good faith effort to execute a written consent that is in compliance with section 3111.93 of the Revised Code relative to a non-spousal artificial insemination, the failure of the written consent to so comply shall not affect the paternity consequences set forth in division (A) of section 3111.95 of the Revised Code.

Sec. 3119.05. When a court computes the amount of child support required to be paid under a court child support order or a child support enforcement agency computes the amount of child support to be paid pursuant to an administrative child support order, all of the following apply:

(A) The parents' current and past income and personal earnings shall be verified by electronic means or with suitable documents, including, but not limited to, paystubs, employer statements, receipts and expense vouchers related to self-generated income, tax returns, and all supporting documentation and schedules for the tax returns.

(B) The annual amount of any court-ordered spousal support actually paid, excluding any ordered payment on arrears, shall be deducted from the annual income of that parent to the extent that payment of that court-ordered spousal support is verified by supporting documentation.

(C) The court or agency shall adjust the amount of child support paid by a parent to give credit for children not included in the current calculation. When calculating the adjusted amount, the court or agency shall use the schedule and do the following:

(1) Determine the amount of child support that each parent would be ordered to pay for all children for whom the parent has the legal duty to support, according to each parent's annual income. If the number of children subject to the order is greater than six, multiply the amount for three children in accordance with division (C)(4) of this section to determine the amount of child support.

(2) Compute a child support credit amount for each parent's children who are not subject to this order by dividing the amount determined in division (C)(1) of this section by the total number of children whom the parent is obligated to support and multiplying that number by the number of the parent's children who are not subject to this order.

(3) Determine the adjusted income of the parents by subtracting the credit for minor children not subject to this order computed under division (C)(2) of this section, from the annual income of each parent for the children each has a duty to support that are not subject to this order.

(4) If the number of children is greater than six, multiply the amount for three children by:

(a) 1.440 for seven children;

(b) 1.540 for eight children;

(c) 1.638 for nine children;

(d) 1.734 for ten children;

(e) 1.827 for eleven children;

(f) 1.919 for twelve children;

(g) 2.008 for thirteen children;

(h) 2.096 for fourteen children;

(i) 2.182 for more than fourteen children.

(D) When the court or agency calculates the annual income of a parent, it shall include the lesser of the following as income from overtime and bonuses:

(1) The yearly average of all overtime, commissions, and bonuses received during the three years immediately prior to the time when the person's child support obligation is being computed;

(2) The total overtime, commissions, and bonuses received during the year immediately prior to the time when the person's child support obligation is being computed.

(E) When the court or agency calculates the annual income of a parent, it shall not include any income earned by the spouse of that parent.

(F) The court shall issue a separate medical support order for extraordinary medical expenses, including orthodontia, dental, optical, and psychological services.

If the court makes an order for payment of private education, and other appropriate expenses, it shall do so by issuing a separate order.

The court may consider these expenses in adjusting a child support order.

(G) When a court or agency calculates the amount of child support to be paid pursuant to a court child support order or an administrative child support order, the following shall apply:

(1) The court or agency shall apply the basic child support schedule to the parents' combined annual incomes and to each parent's individual income.

(2) If the combined annual income of both parents or the individual annual income of a parent is an amount that is between two amounts set forth in the first column of the schedule, the court or agency may use the basic child support obligation that corresponds to the higher of the two amounts in the first column of the schedule, use the basic child support obligation that corresponds to the lower of the two amounts in the first column of the schedule, or calculate a basic child support obligation that is between those two amounts and corresponds proportionally to the parents' actual combined annual income or the individual parent's annual income.

(3) If the annual individual income of either or both of

the parents is within the self-sufficiency reserve in the basic child support schedule, the court or agency shall do both of the following:

(a) Calculate the basic child support obligation for the parents using the schedule amount applicable to the combined annual income and the schedule amount applicable to the income in the self-sufficiency reserve;

(b) Determine the lesser of the following amounts to be the applicable basic child support obligation:

(i) The amount that results from using the combined annual income of the parents not in the self-sufficiency reserve of the schedule; or

(ii) The amount that results from using the individual parent's income within the self-sufficiency reserve of the schedule.

(H) When the court or agency calculates annual income, the court or agency, when appropriate, may average income over a reasonable period of years.

(I) Unless it would be unjust or inappropriate and therefore not in the best interests of the child, a court or agency shall not determine a parent to be voluntarily unemployed or underemployed and shall not impute income to that parent if any of the following conditions exist:

(1) The parent is receiving recurring monetary income from means-tested public assistance benefits, including cash assistance payments under the Ohio works first program established under Chapter 5107. of the Revised Code, general assistance under former Chapter 5113. of the Revised Code, supplemental security income, or means-tested veterans'

benefits;

(2) The parent is approved for social security disability insurance benefits because of a mental or physical disability, or the court or agency determines that the parent is unable to work based on medical documentation that includes ~~a physician's~~ the diagnosis of a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner and ~~a~~ the physician's or nurse's opinion regarding the parent's mental or physical disability and inability to work.

(3) The parent has proven that the parent has made continuous and diligent efforts without success to find and accept employment, including temporary employment, part-time employment, or employment at less than the parent's previous salary or wage.

(4) The parent is complying with court-ordered family reunification efforts in a child abuse, neglect, or dependency proceeding, to the extent that compliance with those efforts limits the parent's ability to earn income.

(5) The parent is institutionalized for a period of twelve months or more with no other available income or assets.

(J) When a court or agency calculates the income of a parent, it shall not determine a parent to be voluntarily unemployed or underemployed and shall not impute income to that parent if the parent is incarcerated.

(K) When a court or agency requires a parent to pay an amount for that parent's failure to support a child for a period of time prior to the date the court modifies or issues a court child support order or an agency modifies or issues an administrative child support order for the current support of

the child, the court or agency shall calculate that amount using the basic child support schedule, worksheets, and child support laws in effect, and the incomes of the parents as they existed, for that prior period of time.

(L) A court or agency may disregard a parent's additional income from overtime or additional employment when the court or agency finds that the additional income was generated primarily to support a new or additional family member or members, or under other appropriate circumstances.

(M) If both parents involved in the immediate child support determination have a prior order for support relative to a minor child or children born to both parents, the court or agency shall collect information about the existing order or orders and consider those together with the current calculation for support to ensure that the total of all orders for all children of the parties does not exceed the amount that would have been ordered if all children were addressed in a single judicial or administrative proceeding.

(N) A support obligation of a parent with annual income subject to the self-sufficiency reserve of the basic child support schedule shall not exceed the support obligation that would result from application of the schedule without the reserve.

(O) Any non-means tested benefit received by the child or children subject to the order resulting from the claims of either parent shall be deducted from that parent's annual child support obligation after all other adjustments have been made. If that non-means tested benefit exceeds the child support obligation of the parent from whose claim the benefit is realized, the child support obligation for that parent shall be

zero.

(P) As part of the child support calculation, the parents shall be ordered to share the costs of child care. Subject to the limitations in this division, a child support obligor shall pay an amount equal to the obligor's income share of the child care cost incurred for the child or children subject to the order.

(1) The child care cost used in the calculation:

(a) Shall be for the child determined to be necessary to allow a parent to work, or for activities related to employment training;

(b) Shall be verifiable by credible evidence as determined by a court or child support enforcement agency;

(c) Shall exclude any reimbursed or subsidized child care cost, including any state or federal tax credit for child care available to the parent or caretaker, whether or not claimed

(d) Shall not exceed the maximum state-wide average cost estimate as determined in accordance with 45 C.F.R. 98.45.

(2) When the annual income of the obligor is subject to the self-sufficiency reserve of the basic support schedule, the share of the child care cost paid by the obligor shall be equal to the lower of the obligor's income share of the child care cost, or fifty per cent of the child care cost.

(Q) As used in this section, a parent is considered "incarcerated" if the parent is confined under a sentence imposed for an offense or serving a term of imprisonment, jail, or local incarceration, or other term under a sentence imposed by a government entity authorized to order such confinement.

Sec. 3119.54. A party to a child support order issued in accordance with section 3119.30 of the Revised Code shall notify any physician, clinical nurse specialist, certified nurse practitioner, hospital, or other provider of medical services that provides medical services to the child who is the subject of the child support order of the number of any health insurance or health care policy, contract, or plan that covers the child if the child is eligible for medicaid. The party shall include in the notice the name and address of the insurer. Any physician, clinical nurse specialist, certified nurse practitioner, hospital, or other provider of medical services covered by the medicaid program who is notified under this section of the existence of a health insurance or health care policy, contract, or plan with coverage for children who are eligible for medicaid shall first bill the insurer for any services provided for those children. If the insurer fails to pay all or any part of a claim filed under this section and the services for which the claim is filed are covered by the medicaid program, the physician, clinical nurse specialist, certified nurse practitioner, hospital, or other medical services provider shall bill the remaining unpaid costs of the services to the medicaid program.

Sec. 3301.0711. (A) The department of education shall:

(1) Annually furnish to, grade, and score all assessments required by divisions (A)(1) and (B)(1) of section 3301.0710 of the Revised Code to be administered by city, local, exempted village, and joint vocational school districts, except that each district shall score any assessment administered pursuant to division (B)(10) of this section. Each assessment so furnished shall include the data verification code of the student to whom the assessment will be administered, as assigned pursuant to

division (D)(2) of section 3301.0714 of the Revised Code. In furnishing the practice versions of Ohio graduation tests prescribed by division (D) of section 3301.0710 of the Revised Code, the department shall make the tests available on its web site for reproduction by districts. In awarding contracts for grading assessments, the department shall give preference to Ohio-based entities employing Ohio residents.

(2) Adopt rules for the ethical use of assessments and prescribing the manner in which the assessments prescribed by section 3301.0710 of the Revised Code shall be administered to students.

(B) Except as provided in divisions (C) and (J) of this section, the board of education of each city, local, and exempted village school district shall, in accordance with rules adopted under division (A) of this section:

(1) Administer the English language arts assessments prescribed under division (A)(1)(a) of section 3301.0710 of the Revised Code twice annually to all students in the third grade who have not attained the score designated for that assessment under division (A)(2)(c) of section 3301.0710 of the Revised Code.

(2) Administer the mathematics assessment prescribed under division (A)(1)(a) of section 3301.0710 of the Revised Code at least once annually to all students in the third grade.

(3) Administer the assessments prescribed under division (A)(1)(b) of section 3301.0710 of the Revised Code at least once annually to all students in the fourth grade.

(4) Administer the assessments prescribed under division (A)(1)(c) of section 3301.0710 of the Revised Code at least once

annually to all students in the fifth grade.

(5) Administer the assessments prescribed under division (A)(1)(d) of section 3301.0710 of the Revised Code at least once annually to all students in the sixth grade.

(6) Administer the assessments prescribed under division (A)(1)(e) of section 3301.0710 of the Revised Code at least once annually to all students in the seventh grade.

(7) Administer the assessments prescribed under division (A)(1)(f) of section 3301.0710 of the Revised Code at least once annually to all students in the eighth grade.

(8) Except as provided in division (B)(9) of this section, administer any assessment prescribed under division (B)(1) of section 3301.0710 of the Revised Code as follows:

(a) At least once annually to all tenth grade students and at least twice annually to all students in eleventh or twelfth grade who have not yet attained the score on that assessment designated under that division;

(b) To any person who has successfully completed the curriculum in any high school or the individualized education program developed for the person by any high school pursuant to section 3323.08 of the Revised Code but has not received a high school diploma and who requests to take such assessment, at any time such assessment is administered in the district.

(9) In lieu of the board of education of any city, local, or exempted village school district in which the student is also enrolled, the board of a joint vocational school district shall administer any assessment prescribed under division (B)(1) of section 3301.0710 of the Revised Code at least twice annually to any student enrolled in the joint vocational school district who

has not yet attained the score on that assessment designated under that division. A board of a joint vocational school district may also administer such an assessment to any student described in division (B)(8)(b) of this section.

(10) If the district has a three-year average graduation rate of not more than seventy-five per cent, administer each assessment prescribed by division (D) of section 3301.0710 of the Revised Code in September to all ninth grade students who entered ninth grade prior to July 1, 2014.

Except as provided in section 3313.614 of the Revised Code for administration of an assessment to a person who has fulfilled the curriculum requirement for a high school diploma but has not passed one or more of the required assessments, the assessments prescribed under division (B)(1) of section 3301.0710 of the Revised Code shall not be administered after the date specified in the rules adopted by the state board of education under division (D)(1) of section 3301.0712 of the Revised Code.

(11)(a) Except as provided in divisions (B)(11)(b) and (c) of this section, administer the assessments prescribed by division (B)(2) of section 3301.0710 and section 3301.0712 of the Revised Code in accordance with the timeline and plan for implementation of those assessments prescribed by rule of the state board adopted under division (D)(1) of section 3301.0712 of the Revised Code;

(b) A student who has presented evidence to the district or school of having satisfied the condition prescribed by division (A)(1) of section 3313.618 of the Revised Code to qualify for a high school diploma prior to the date of the administration of the assessment prescribed under division (B)

(1) of section 3301.0712 of the Revised Code shall not be required to take that assessment. However, no board shall prohibit a student who is not required to take such assessment from taking the assessment.

(c) A student shall not be required to retake the Algebra I end-of-course examination or the English language arts II end-of-course examination prescribed under division (B)(2) of section 3301.0712 of the Revised Code in grades nine through twelve if the student demonstrates at least a proficient level of skill, as prescribed under division (B)(5)(a) of that section, or achieves a competency score, as prescribed under division (B)(10) of that section, in an administration of the examination prior to grade nine.

(C)(1)(a) In the case of a student receiving special education services under Chapter 3323. of the Revised Code, the individualized education program developed for the student under that chapter shall specify the manner in which the student will participate in the assessments administered under this section, except that a student with significant cognitive disabilities to whom an alternate assessment is administered in accordance with division (C)(1) of this section and a student determined to have a disability that includes an intellectual disability as outlined in guidance issued by the department shall not be required to take the assessment prescribed under division (B)(1) of section 3301.0712 of the Revised Code. The individualized education program may excuse the student from taking any particular assessment required to be administered under this section if it instead specifies an alternate assessment method approved by the department of education as conforming to requirements of federal law for receipt of federal funds for disadvantaged pupils. To the extent possible, the individualized

education program shall not excuse the student from taking an assessment unless no reasonable accommodation can be made to enable the student to take the assessment. No board shall prohibit a student who is not required to take an assessment under division (C)(1) of this section from taking the assessment.

(b) Any alternate assessment approved by the department for a student under this division shall produce measurable results comparable to those produced by the assessment it replaces in order to allow for the student's results to be included in the data compiled for a school district or building under section 3302.03 of the Revised Code.

(c)(i) Any student enrolled in a chartered nonpublic school who has been identified, based on an evaluation conducted in accordance with section 3323.03 of the Revised Code or section 504 of the "Rehabilitation Act of 1973," 87 Stat. 355, 29 U.S.C.A. 794, as amended, as a child with a disability shall be excused from taking any particular assessment required to be administered under this section if either of the following apply:

(I) A plan developed for the student pursuant to rules adopted by the state board excuses the student from taking that assessment.

(II) The chartered nonpublic school develops a written plan in which the school, in consultation with the student's parents, determines that an assessment or alternative assessment with accommodations does not accurately assess the student's academic performance. The plan shall include an academic profile of the student's academic performance and shall be reviewed annually to determine if the student's needs continue to require

excusal from taking the assessment.

(ii) A student with significant cognitive disabilities to whom an alternate assessment is administered in accordance with division (C)(1) of this section and a student determined to have a disability that includes an intellectual disability as outlined in guidance issued by the department shall not be required to take the assessment prescribed under division (B)(1) of section 3301.0712 of the Revised Code.

(iii) In the case of any student so excused from taking an assessment under division (C)(1)(c) of this section, the chartered nonpublic school shall not prohibit the student from taking the assessment.

(2) A district board may, for medical reasons or other good cause, excuse a student from taking an assessment administered under this section on the date scheduled, but that assessment shall be administered to the excused student not later than nine days following the scheduled date. The district board shall annually report the number of students who have not taken one or more of the assessments required by this section to the state board not later than the thirtieth day of June.

(3) As used in this division, "English learner" has the same meaning as in 20 U.S.C. 7801.

No school district board shall excuse any English learner from taking any particular assessment required to be administered under this section, except as follows:

(a) Any English learner who has been enrolled in United States schools for less than two years and for whom no appropriate accommodations are available based on guidance issued by the department shall not be required to take the

assessment prescribed under division (B)(1) of section 3301.0712 of the Revised Code.

(b) Any English learner who has been enrolled in United States schools for less than one full school year shall not be required to take any reading, writing, or English language arts assessment.

However, no board shall prohibit an English learner who is not required to take an assessment under division (C)(3) of this section from taking the assessment. A board may permit any English learner to take an assessment required to be administered under this section with appropriate accommodations, as determined by the department. For each English learner, each school district shall annually assess that student's progress in learning English, in accordance with procedures approved by the department.

(4)(a) The governing authority of a chartered nonpublic school may excuse an English learner from taking any assessment administered under this section.

(b) No governing authority shall require an English learner who has been enrolled in United States schools for less than two years and for whom no appropriate accommodations are available based on guidance issued by the department to take the assessment prescribed under division (B)(1) of section 3301.0712 of the Revised Code.

(c) No governing authority shall prohibit an English learner from taking an assessment from which the student was excused under division (C)(4) of this section.

(D)(1) In the school year next succeeding the school year in which the assessments prescribed by division (A)(1) or (B)(1)

of section 3301.0710 of the Revised Code or former division (A)(1), (A)(2), or (B) of section 3301.0710 of the Revised Code as it existed prior to September 11, 2001, are administered to any student, the board of education of any school district in which the student is enrolled in that year shall provide to the student intervention services commensurate with the student's performance, including any intensive intervention required under section 3313.608 of the Revised Code, in any skill in which the student failed to demonstrate at least a score at the proficient level on the assessment.

(2) Following any administration of the assessments prescribed by division (D) of section 3301.0710 of the Revised Code to ninth grade students, each school district that has a three-year average graduation rate of not more than seventy-five per cent shall determine for each high school in the district whether the school shall be required to provide intervention services to any students who took the assessments. In determining which high schools shall provide intervention services based on the resources available, the district shall consider each school's graduation rate and scores on the practice assessments. The district also shall consider the scores received by ninth grade students on the English language arts and mathematics assessments prescribed under division (A)(1)(f) of section 3301.0710 of the Revised Code in the eighth grade in determining which high schools shall provide intervention services.

Each high school selected to provide intervention services under this division shall provide intervention services to any student whose results indicate that the student is failing to make satisfactory progress toward being able to attain scores at the proficient level on the Ohio graduation tests. Intervention

services shall be provided in any skill in which a student demonstrates unsatisfactory progress and shall be commensurate with the student's performance. Schools shall provide the intervention services prior to the end of the school year, during the summer following the ninth grade, in the next succeeding school year, or at any combination of those times.

(E) Except as provided in section 3313.608 of the Revised Code and division (N) of this section, no school district board of education shall utilize any student's failure to attain a specified score on an assessment administered under this section as a factor in any decision to deny the student promotion to a higher grade level. However, a district board may choose not to promote to the next grade level any student who does not take an assessment administered under this section or make up an assessment as provided by division (C)(2) of this section and who is not exempt from the requirement to take the assessment under division (C)(3) of this section.

(F) No person shall be charged a fee for taking any assessment administered under this section.

(G)(1) Each school district board shall designate one location for the collection of assessments administered in the spring under division (B)(1) of this section and those administered under divisions (B)(2) to (7) of this section. Each district board shall submit the assessments to the entity with which the department contracts for the scoring of the assessments as follows:

(a) If the district's total enrollment in grades kindergarten through twelve during the first full school week of October was less than two thousand five hundred, not later than the Friday after all of the assessments have been administered;

(b) If the district's total enrollment in grades kindergarten through twelve during the first full school week of October was two thousand five hundred or more, but less than seven thousand, not later than the Monday after all of the assessments have been administered;

(c) If the district's total enrollment in grades kindergarten through twelve during the first full school week of October was seven thousand or more, not later than the Tuesday after all of the assessments have been administered.

However, any assessment that a student takes during the make-up period described in division (C)(2) of this section shall be submitted not later than the Friday following the day the student takes the assessment.

(2) The department or an entity with which the department contracts for the scoring of the assessment shall send to each school district board a list of the individual scores of all persons taking a state achievement assessment as follows:

(a) Except as provided in division (G)(2)(b) or (c) of this section, within forty-five days after the administration of the assessments prescribed by sections 3301.0710 and 3301.0712 of the Revised Code, but in no case shall the scores be returned later than the thirtieth day of June following the administration;

(b) In the case of the third-grade English language arts assessment, within forty-five days after the administration of that assessment, but in no case shall the scores be returned later than the fifteenth day of June following the administration;

(c) In the case of the writing component of an assessment

or end-of-course examination in the area of English language arts, except for the third-grade English language arts assessment, the results may be sent after forty-five days of the administration of the writing component, but in no case shall the scores be returned later than the thirtieth day of June following the administration.

(3) For assessments administered under this section by a joint vocational school district, the department or entity shall also send to each city, local, or exempted village school district a list of the individual scores of any students of such city, local, or exempted village school district who are attending school in the joint vocational school district.

(4) Beginning with the 2019-2020 school year, a school district, other public school, or chartered nonpublic school may administer the third-grade English language arts or mathematics assessment, or both, in a paper format in any school year for which the district board of education or school governing body adopts a resolution indicating that the district or school chooses to administer the assessment in a paper format. The board or governing body shall submit a copy of the resolution to the department of education not later than the first day of May prior to the school year for which it will apply. If the resolution is submitted, the district or school shall administer the assessment in a paper format to all students in the third grade, except that any student whose individualized education program or plan developed under section 504 of the "Rehabilitation Act of 1973," 87 Stat. 355, 29 U.S.C. 794, as amended, specifies that taking the assessment in an online format is an appropriate accommodation for the student may take the assessment in an online format.

(H) Individual scores on any assessments administered under this section shall be released by a district board only in accordance with section 3319.321 of the Revised Code and the rules adopted under division (A) of this section. No district board or its employees shall utilize individual or aggregate results in any manner that conflicts with rules for the ethical use of assessments adopted pursuant to division (A) of this section.

(I) Except as provided in division (G) of this section, the department or an entity with which the department contracts for the scoring of the assessment shall not release any individual scores on any assessment administered under this section. The state board shall adopt rules to ensure the protection of student confidentiality at all times. The rules may require the use of the data verification codes assigned to students pursuant to division (D)(2) of section 3301.0714 of the Revised Code to protect the confidentiality of student scores.

(J) Notwithstanding division (D) of section 3311.52 of the Revised Code, this section does not apply to the board of education of any cooperative education school district except as provided under rules adopted pursuant to this division.

(1) In accordance with rules that the state board shall adopt, the board of education of any city, exempted village, or local school district with territory in a cooperative education school district established pursuant to divisions (A) to (C) of section 3311.52 of the Revised Code may enter into an agreement with the board of education of the cooperative education school district for administering any assessment prescribed under this section to students of the city, exempted village, or local school district who are attending school in the cooperative

education school district.

(2) In accordance with rules that the state board shall adopt, the board of education of any city, exempted village, or local school district with territory in a cooperative education school district established pursuant to section 3311.521 of the Revised Code shall enter into an agreement with the cooperative district that provides for the administration of any assessment prescribed under this section to both of the following:

(a) Students who are attending school in the cooperative district and who, if the cooperative district were not established, would be entitled to attend school in the city, local, or exempted village school district pursuant to section 3313.64 or 3313.65 of the Revised Code;

(b) Persons described in division (B)(8)(b) of this section.

Any assessment of students pursuant to such an agreement shall be in lieu of any assessment of such students or persons pursuant to this section.

(K)(1)(a) Except as otherwise provided in division (K)(1) or (2) of this section, each chartered nonpublic school for which at least sixty-five per cent of its total enrollment is made up of students who are participating in state scholarship programs shall administer the assessments prescribed by division (A) of section 3301.0710 of the Revised Code or an alternative standardized assessment determined by the department. In accordance with procedures and deadlines prescribed by the department, the parent or guardian of a student enrolled in the school who is not participating in a state scholarship program may submit notice to the chief administrative officer of the

school that the parent or guardian does not wish to have the student take the assessments prescribed for the student's grade level under division (A) of section 3301.0710 of the Revised Code. If a parent or guardian submits an opt-out notice, the school shall not administer the assessments to that student. This option does not apply to any assessment required for a high school diploma under section 3313.612 of the Revised Code.

(b) Any chartered nonpublic school that enrolls students who are participating in state scholarship programs may administer an alternative standardized assessment determined by the department instead of the assessments prescribed by division (A) of section 3301.0710 of the Revised Code.

Each chartered nonpublic school subject to division (K)(1)(a) or (b) of this section shall report the results of each assessment administered under those divisions to the department.

(2) A chartered nonpublic school may submit to the superintendent of public instruction a request for a waiver from administering the elementary assessments prescribed by division (A) of section 3301.0710 of the Revised Code. The state superintendent shall approve or disapprove a request for a waiver submitted under division (K)(2) of this section. No waiver shall be approved for any school year prior to the 2015-2016 school year.

To be eligible to submit a request for a waiver, a chartered nonpublic school shall meet the following conditions:

(a) At least ninety-five per cent of the students enrolled in the school are ~~children~~ either of the following:

(i) Children with disabilities, as defined under section 3323.01 of the Revised Code~~, or~~;

(ii) Children who have received a diagnosis ~~by a school district or from a physician, including a neuropsychiatrist or psychiatrist, or a psychologist who is authorized to practice in this or another state~~ as having a condition that impairs academic performance, such as dyslexia, dyscalculia, attention deficit hyperactivity disorder, or Asperger's syndrome, and that diagnosis was received from a school district or one of the following professionals who is authorized to practice in this or another state: a physician, including a neuropsychiatrist or psychiatrist; a clinical nurse specialist; a certified nurse practitioner; or a psychologist.

(b) The school has solely served a student population described in division (K)(1)(a) of this section for at least ten years.

(c) The school provides to the department at least five years of records of internal testing conducted by the school that affords the department data required for accountability purposes, including diagnostic assessments and nationally standardized norm-referenced achievement assessments that measure reading and math skills.

(3) Any chartered nonpublic school that is not subject to division (K)(1) of this section may participate in the assessment program by administering any of the assessments prescribed by division (A) of section 3301.0710 of the Revised Code. The chief administrator of the school shall specify which assessments the school will administer. Such specification shall be made in writing to the superintendent of public instruction prior to the first day of August of any school year in which assessments are administered and shall include a pledge that the nonpublic school will administer the specified assessments in

the same manner as public schools are required to do under this section and rules adopted by the department.

(4) The department of education shall furnish the assessments prescribed by section 3301.0710 of the Revised Code to each chartered nonpublic school that is subject to division (K)(1) of this section or participates under division (K)(3) of this section.

(L) If a chartered nonpublic school is educating students in grades nine through twelve, the following shall apply:

(1) Except as provided in division (L)(4) of this section, for a student who is enrolled in a chartered nonpublic school that is accredited through the independent schools association of the central states and who is attending the school under a state scholarship program, the student shall either take all of the assessments prescribed by division (B) of section 3301.0712 of the Revised Code or take an alternative assessment approved by the department under section 3313.619 of the Revised Code. However, a student who is excused from taking an assessment under division (C) of this section or has presented evidence to the chartered nonpublic school of having satisfied the condition prescribed by division (A)(1) of section 3313.618 of the Revised Code to qualify for a high school diploma prior to the date of the administration of the assessment prescribed under division (B)(1) of section 3301.0712 of the Revised Code shall not be required to take that assessment. No governing authority of a chartered nonpublic school shall prohibit a student who is not required to take such assessment from taking the assessment.

(2) For a student who is enrolled in a chartered nonpublic school that is accredited through the independent schools association of the central states, and who is not attending the

school under a state scholarship program, the student shall not be required to take any assessment prescribed under section 3301.0712 or 3313.619 of the Revised Code.

(3)(a) Except as provided in divisions (L)(3)(b) and (4) of this section, for a student who is enrolled in a chartered nonpublic school that is not accredited through the independent schools association of the central states, regardless of whether the student is attending or is not attending the school under a state scholarship program, the student shall do one of the following:

(i) Take all of the assessments prescribed by division (B) of section 3301.0712 of the Revised Code;

(ii) Take only the assessment prescribed by division (B)(1) of section 3301.0712 of the Revised Code, provided that the student's school publishes the results of that assessment for each graduating class. The published results of that assessment shall include the overall composite scores, mean scores, twenty-fifth percentile scores, and seventy-fifth percentile scores for each subject area of the assessment.

(iii) Take an alternative assessment approved by the department under section 3313.619 of the Revised Code.

(b) A student who is excused from taking an assessment under division (C) of this section or has presented evidence to the chartered nonpublic school of having satisfied the condition prescribed by division (A)(1) of section 3313.618 of the Revised Code to qualify for a high school diploma prior to the date of the administration of the assessment prescribed under division (B)(1) of section 3301.0712 of the Revised Code shall not be required to take that assessment. No governing authority of a

chartered nonpublic school shall prohibit a student who is not required to take such assessment from taking the assessment.

(4) The assessments prescribed by sections 3301.0712 and 3313.619 of the Revised Code shall not be administered to any student attending the school, if the school meets all of the following conditions:

(a) At least ninety-five per cent of the students enrolled in the school are ~~children~~ either of the following:

(i) Children with disabilities, as defined under section 3323.01 of the Revised Code~~, or~~;

(ii) Children who have received a diagnosis ~~by a school district or from a physician, including a neuropsychologist or psychiatrist, or a psychologist who is authorized to practice in this or another state~~ as having a condition that impairs academic performance, such as dyslexia, dyscalculia, attention deficit hyperactivity disorder, or Asperger's syndrome, and that diagnosis was received from a school district or one of the following professionals who is authorized to practice in this or another state: a physician, including a neuropsychiatrist or psychiatrist; a clinical nurse specialist; a certified nurse practitioner; or a psychologist.

(b) The school has solely served a student population described in division (L)(4)(a) of this section for at least ten years.

(c) The school makes available to the department at least five years of records of internal testing conducted by the school that affords the department data required for accountability purposes, including growth in student achievement in reading or mathematics, or both, as measured by nationally

norm-referenced assessments that have developed appropriate standards for students.

Division (L)(4) of this section applies to any student attending such school regardless of whether the student receives special education or related services and regardless of whether the student is attending the school under a state scholarship program.

(M)(1) The superintendent of the state school for the blind and the superintendent of the state school for the deaf shall administer the assessments described by sections 3301.0710 and 3301.0712 of the Revised Code. Each superintendent shall administer the assessments in the same manner as district boards are required to do under this section and rules adopted by the department of education and in conformity with division (C)(1)(a) of this section.

(2) The department of education shall furnish the assessments described by sections 3301.0710 and 3301.0712 of the Revised Code to each superintendent.

(N) Notwithstanding division (E) of this section, a school district may use a student's failure to attain a score in at least the proficient range on the mathematics assessment described by division (A)(1)(a) of section 3301.0710 of the Revised Code or on an assessment described by division (A)(1)(b), (c), (d), (e), or (f) of section 3301.0710 of the Revised Code as a factor in retaining that student in the current grade level.

(O)(1) In the manner specified in divisions (O)(3), (4), (6), and (7) of this section, the assessments required by division (A)(1) of section 3301.0710 of the Revised Code shall

become public records pursuant to section 149.43 of the Revised Code on the thirty-first day of July following the school year that the assessments were administered.

(2) The department may field test proposed questions with samples of students to determine the validity, reliability, or appropriateness of questions for possible inclusion in a future year's assessment. The department also may use anchor questions on assessments to ensure that different versions of the same assessment are of comparable difficulty.

Field test questions and anchor questions shall not be considered in computing scores for individual students. Field test questions and anchor questions may be included as part of the administration of any assessment required by division (A)(1) or (B) of section 3301.0710 and division (B) of section 3301.0712 of the Revised Code.

(3) Any field test question or anchor question administered under division (O)(2) of this section shall not be a public record. Such field test questions and anchor questions shall be redacted from any assessments which are released as a public record pursuant to division (O)(1) of this section.

(4) This division applies to the assessments prescribed by division (A) of section 3301.0710 of the Revised Code.

(a) The first administration of each assessment, as specified in former section 3301.0712 of the Revised Code, shall be a public record.

(b) For subsequent administrations of each assessment prior to the 2011-2012 school year, not less than forty per cent of the questions on the assessment that are used to compute a student's score shall be a public record. The department shall

determine which questions will be needed for reuse on a future assessment and those questions shall not be public records and shall be redacted from the assessment prior to its release as a public record. However, for each redacted question, the department shall inform each city, local, and exempted village school district of the statewide academic standard adopted by the state board under section 3301.079 of the Revised Code and the corresponding benchmark to which the question relates. The preceding sentence does not apply to field test questions that are redacted under division (O)(3) of this section.

(c) The administrations of each assessment in the 2011-2012, 2012-2013, and 2013-2014 school years shall not be a public record.

(5) Each assessment prescribed by division (B)(1) of section 3301.0710 of the Revised Code shall not be a public record.

(6)(a) Except as provided in division (O)(6)(b) of this section, for the administrations in the 2014-2015, 2015-2016, and 2016-2017 school years, questions on the assessments prescribed under division (A) of section 3301.0710 and division (B)(2) of section 3301.0712 of the Revised Code and the corresponding preferred answers that are used to compute a student's score shall become a public record as follows:

(i) Forty per cent of the questions and preferred answers on the assessments on the thirty-first day of July following the administration of the assessment;

(ii) Twenty per cent of the questions and preferred answers on the assessment on the thirty-first day of July one year after the administration of the assessment;

(iii) The remaining forty per cent of the questions and preferred answers on the assessment on the thirty-first day of July two years after the administration of the assessment.

The entire content of an assessment shall become a public record within three years of its administration.

The department shall make the questions that become a public record under this division readily accessible to the public on the department's web site. Questions on the spring administration of each assessment shall be released on an annual basis, in accordance with this division.

(b) No questions and corresponding preferred answers shall become a public record under division (O)(6) of this section after July 31, 2017.

(7) Division (O)(7) of this section applies to the assessments prescribed by division (A) of section 3301.0710 and division (B)(2) of section 3301.0712 of the Revised Code.

Beginning with the assessments administered in the spring of the 2017-2018 school year, not less than forty per cent of the questions on each assessment that are used to compute a student's score shall be a public record. The department shall determine which questions will be needed for reuse on a future assessment and those questions shall not be public records and shall be redacted from the assessment prior to its release as a public record. However, for each redacted question, the department shall inform each city, local, and exempted village school district of the corresponding statewide academic standard adopted by the state board under section 3301.079 of the Revised Code and the corresponding benchmark to which the question relates. The department is not required to provide corresponding

standards and benchmarks to field test questions that are redacted under division (O)(3) of this section.

(P) As used in this section:

(1) "Three-year average" means the average of the most recent consecutive three school years of data.

(2) "Dropout" means a student who withdraws from school before completing course requirements for graduation and who is not enrolled in an education program approved by the state board of education or an education program outside the state. "Dropout" does not include a student who has departed the country.

(3) "Graduation rate" means the ratio of students receiving a diploma to the number of students who entered ninth grade four years earlier. Students who transfer into the district are added to the calculation. Students who transfer out of the district for reasons other than dropout are subtracted from the calculation. If a student who was a dropout in any previous year returns to the same school district, that student shall be entered into the calculation as if the student had entered ninth grade four years before the graduation year of the graduating class that the student joins.

(4) "State scholarship programs" means the educational choice scholarship pilot program established under sections 3310.01 to 3310.17 of the Revised Code, the autism scholarship program established under section 3310.41 of the Revised Code, the Jon Peterson special needs scholarship program established under sections 3310.51 to 3310.64 of the Revised Code, and the pilot project scholarship program established under sections 3313.974 to 3313.979 of the Revised Code.

(5) "Other public school" means a community school established under Chapter 3314., a STEM school established under Chapter 3326., or a college-preparatory boarding school established under Chapter 3328. of the Revised Code.

Sec. 3304.23. (A) As used in this section:

(1) "Communication disability" means a human condition involving an impairment in the human's ability to receive, send, process, or comprehend concepts or verbal, nonverbal, or graphic symbol systems that may result in a primary disability or may be secondary to other disabilities.

(2) "Disability that can impair communication" means a human condition with symptoms that can impair the human's ability to receive, send, process, or comprehend concepts or verbal, nonverbal, or graphic symbol systems.

(3) "Guardian" has the same meaning as in section 2111.01 of the Revised Code.

(4) "Physician" means a person licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code.

(5) "Psychiatrist" has the same meaning as in section 5122.01 of the Revised Code.

(6) "Psychologist" has the same meaning as in section 4732.01 of the Revised Code.

(B) The opportunities for Ohioans with disabilities agency shall develop a verification form for a person diagnosed with a communication disability or a disability that can impair communication to be submitted voluntarily to the department of public safety so that the person may be included in the database

established under section 5502.08 of the Revised Code. The same form shall be used to indicate that the person wishes to be removed from the database in accordance with division (F) of section 5502.08 of the Revised Code.

(C) The form shall include the following information:

(1) The name of the person diagnosed with a communication disability or a disability that can impair communication;

(2) The name of the person completing the form on behalf of the person diagnosed with a communication disability or a disability that can impair communication, if applicable;

(3) The relationship between the person completing the form and the person diagnosed with a communication disability or a disability that can impair communication, if applicable;

(4) The driver's license number or state identification card number issued to the person diagnosed with a communication disability or a disability that can impair communication, if that person has such a number;

(5) The license plate number of each vehicle owned, operated, or regularly occupied by the person diagnosed with a communication disability or a disability that can impair communication or registered in that person's name;

(6) A ~~physician, psychiatrist, or psychologist's signed~~ certification that the person has been diagnosed with a communication disability or a disability that can impair communication, signed by a physician, psychiatrist, psychologist, clinical nurse specialist, or certified nurse practitioner;

(7) The name, business address, business telephone number,

and ~~medical~~ professional license number of the physician, psychiatrist, ~~or~~ psychologist, or nurse making the certification described in division (C)(6) of this section;

(8) The signature of the person diagnosed with a communication disability or a disability that can impair communication or the signature of the person completing the form on behalf of such a person;

(9) A place where the person diagnosed with a communication disability or a disability that can impair communication or the person completing the form on behalf of such a person may indicate the desire to be removed from the database.

(D) Any of the following persons may complete the verification form:

(1) Any person diagnosed with a communication disability or a disability that can impair communication who is eighteen years of age or older;

(2) The parent or parents of a minor child diagnosed with a communication disability or a disability that can impair communication;

(3) The guardian of a person diagnosed with a communication disability or a disability that can impair communication, regardless of the age of the person.

(E) The opportunities for Ohioans with disabilities agency and the department of public safety shall make the verification form electronically available on each of their respective web sites.

Sec. 3309.22. (A)(1) As used in this division, "personal

history record" means information maintained in any format by the board on an individual who is a member, former member, contributor, former contributor, retirant, or beneficiary that includes the address, electronic mail address, telephone number, social security number, record of contributions, correspondence with the system, and other information the board determines to be confidential.

(2) The records of the board shall be open to public inspection and may be made available in printed or electronic format, except for the following, which shall be excluded, except with the written authorization of the individual concerned:

(a) The individual's statement of previous service and other information as provided for in section 3309.28 of the Revised Code;

(b) Any information identifying by name and address the amount of a monthly allowance or benefit paid to the individual;

(c) The individual's personal history record.

(B) All medical reports and recommendations required by the system are privileged except as follows:

(1) Copies of medical reports or recommendations shall be made available to the following:

(a) The individual concerned, on written request;

(b) The personal physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, attorney, or authorized agent of the individual concerned on written release received from the individual or the individual's agent;

(c) The board assigned physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner.

(2) Documentation required by section 2929.193 of the Revised Code shall be provided to a court holding a hearing under that section.

(C) Any person who is a contributor of the system shall be furnished, on written request, with a statement of the amount to the credit of the person's account. The board need not answer more than one such request of a person in any one year.

(D) Notwithstanding the exceptions to public inspection in division (A)(2) of this section, the board may furnish the following information:

(1) If a member, former member, contributor, former contributor, or retirant is subject to an order issued under section 2907.15 of the Revised Code or an order issued under division (A) or (B) of section 2929.192 of the Revised Code or is convicted of or pleads guilty to a violation of section 2921.41 of the Revised Code, on written request of a prosecutor as defined in section 2935.01 of the Revised Code, the board shall furnish to the prosecutor the information requested from the individual's personal history record.

(2) Pursuant to a court or administrative order issued under section 3119.80, 3119.81, 3121.02, 3121.03, or 3123.06 of the Revised Code, the board shall furnish to a court or child support enforcement agency the information required under that section.

(3) At the written request of any person, the board shall provide to the person a list of the names and addresses of members, former members, retirants, contributors, former

contributors, or beneficiaries. The costs of compiling, copying, and mailing the list shall be paid by such person.

(4) Within fourteen days after receiving from the director of job and family services a list of the names and social security numbers of recipients of public assistance pursuant to section 5101.181 of the Revised Code, the board shall inform the auditor of state of the name, current or most recent employer address, and social security number of each contributor whose name and social security number are the same as that of a person whose name or social security number was submitted by the director. The board and its employees shall, except for purposes of furnishing the auditor of state with information required by this section, preserve the confidentiality of recipients of public assistance in compliance with section 5101.181 of the Revised Code.

(5) The system shall comply with orders issued under section 3105.87 of the Revised Code.

On the written request of an alternate payee, as defined in section 3105.80 of the Revised Code, the system shall furnish to the alternate payee information on the amount and status of any amounts payable to the alternate payee under an order issued under section 3105.171 or 3105.65 of the Revised Code.

(6) At the request of any person, the board shall make available to the person copies of all documents, including resumes, in the board's possession regarding filling a vacancy of an employee member or retirant member of the board. The person who made the request shall pay the cost of compiling, copying, and mailing the documents. The information described in this division is a public record.

(7) The system shall provide the notice required by section 3309.673 of the Revised Code to the prosecutor assigned to the case.

(8) The system may provide information requested by the United States social security administration, United States centers for medicare and medicaid services, Ohio public employees deferred compensation program, Ohio police and fire pension fund, state teachers retirement system, public employees retirement system, state highway patrol retirement system, Cincinnati retirement system, or a third party that the school employees retirement board has contracted with for the purpose of administering any part of this chapter.

(E) A statement that contains information obtained from the system's records that is signed by an officer of the retirement system and to which the system's official seal is affixed, or copies of the system's records to which the signature and seal are attached, shall be received as true copies of the system's records in any court or before any officer of this state.

Sec. 3309.41. (A) Notwithstanding any contrary provisions in Chapter 124. or 3319. of the Revised Code:

(1) A disability benefit recipient whose benefit effective date was before ~~the effective date of this amendment~~ January 7, 2013, shall retain membership status and shall be considered on leave of absence from employment during the first five years following the effective date of a disability benefit.

(2) A disability benefit recipient whose benefit effective date is on or after ~~the effective date of this amendment~~ January 7, 2013, shall retain membership status and shall be considered

on leave of absence from employment during the first three years following the effective date of a disability benefit, except that, if the school employees retirement board has recommended medical treatment or vocational rehabilitation and the member is receiving treatment or rehabilitation acceptable to a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or consultant selected by the board, the board may permit the recipient to retain membership status and be considered on leave of absence from employment for up to five years following the effective date of a disability benefit.

(B) The board shall require a disability benefit recipient to undergo an annual medical examination, except that the board may waive the medical examination if one or more of the board's ~~physician or~~ physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners certify that the recipient's disability is ongoing. Should any disability benefit recipient refuse to submit to a medical examination, the recipient's disability benefit shall be suspended until withdrawal of the refusal. Should the refusal continue for one year, all the recipient's rights in and to the disability benefit shall be terminated as of the effective date of the original suspension.

(C) On completion of the examination by ~~an examining physician or~~ one or more physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners selected by the board, the physician or ~~physicians~~ nurse shall report and certify to the board whether the disability benefit recipient meets the applicable standard for termination of a disability benefit. If the recipient's benefit effective date is before ~~the effective date of this amendment~~ January 7, 2013, or the benefit effective date is after ~~the effective date of this~~

~~amendment~~ January 7, 2013, and the recipient is considered on a leave of absence under division (A)(2) of this section, the standard for termination is that the recipient is no longer physically and mentally incapable of resuming the service from which the recipient was found disabled. If the recipient's benefit effective date is on or after ~~the effective date of this amendment~~ January 7, 2013, and the recipient is not considered on a leave of absence under division (A)(2) of this section, the standard is that the recipient is not physically or mentally incapable of performing the duties of a position that meets all of the following criteria:

(1) Replaces not less than seventy-five per cent of the member's final average salary, adjusted each year by the actual average increase in the consumer price index prepared by the United States bureau of labor statistics (U.S. City Average for Urban Wage Earners and Clerical Workers: "All Items 1982-84=100");

(2) Is reasonably to be found in the member's regional job market;

(3) Is one that the member is qualified for by experience or education.

If the board concurs in the report that the disability benefit recipient meets the applicable standard for termination of a disability benefit, the payment of the disability benefit shall be terminated not later than three months after the date of the board's concurrence or upon employment as an employee. If the leave of absence has not expired, the retirement board shall certify to the disability benefit recipient's last employer before being found disabled that the recipient is no longer physically and mentally incapable of resuming service that is

the same or similar to that from which the recipient was found disabled. The employer shall restore the recipient to the recipient's previous position and salary or to a position and salary similar thereto not later than the first day of the first month following termination of the disability benefit, unless the recipient was dismissed or resigned in lieu of dismissal for dishonesty, misfeasance, malfeasance, or conviction of a felony.

(D) Each disability benefit recipient shall file with the board an annual statement of earnings, current medical information on the recipient's condition, and any other information required in rules adopted by the board. The board may waive the requirement that a disability benefit recipient file an annual statement of earnings or current medical information on the recipient's condition if one or more of the board's ~~physician or~~ physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners certify that the recipient's disability is ongoing.

The board shall annually examine the information submitted by the recipient. If a disability benefit recipient refuses to file the statement or information, the disability benefit shall be suspended until the statement and information are filed. If the refusal continues for one year, the recipient's right to the disability benefit shall be terminated as of the effective date of the original suspension.

(E) If a disability benefit recipient is employed by an employer covered by this chapter, the recipient's disability benefit shall cease.

(F) If disability retirement under section 3309.40 of the Revised Code is terminated for any reason, the annuity and pension reserves at that time in the annuity and pension reserve

fund shall be transferred to the employees' savings fund and the employers' trust fund, respectively. If the total disability benefit paid is less than the amount of the accumulated contributions of the member transferred into the annuity and pension reserve fund at the time of the member's disability retirement, the difference shall be transferred from the annuity and pension reserve fund to another fund as may be required. In determining the amount of a member's account following the termination of disability retirement for any reason, the amount paid shall be charged against the member's refundable account.

If a disability allowance paid under section 3309.401 of the Revised Code is terminated for any reason, the reserve on the allowance at that time in the annuity and pension reserve fund shall be transferred from that fund to the employers' trust fund.

The board may terminate a disability benefit at the request of the recipient.

(G) If a disability benefit is terminated and a former disability benefit recipient again becomes a contributor, other than as an other system retirant as defined in section 3309.341 of the Revised Code, to this system, the public employees retirement system, or the state teachers retirement system, and completes an additional two years of service credit after the termination of the disability benefit, the former disability benefit recipient shall be entitled to receive up to two years of service credit for the period as a disability benefit recipient and may purchase service for the remaining period of the disability benefit. Total service credit received and purchased under this section shall not exceed the period of the disability benefit.

For each year of credit purchased, the member shall pay to the system for credit to the member's accumulated account the sum of the following amounts:

(1) The employee contribution rate in effect at the time the disability benefit commenced multiplied by the member's annual disability benefit;

(2) The employer contribution rate in effect at the time the disability benefit commenced multiplied by the member's annual disability benefit;

(3) Compound interest at a rate established by the board from the date the member is eligible to purchase the credit to the date of payment.

The member may choose to purchase only part of such credit in any one payment, subject to board rules.

(H) If any employer employs any member who is receiving a disability benefit, the employer shall file notice of employment with the retirement board, designating the date of employment. In case the notice is not filed, the total amount of the benefit paid during the period of employment prior to notice shall be paid from amounts allocated under Chapter 3317. of the Revised Code prior to its distribution to the school district in which the disability benefit recipient was so employed.

Sec. 3309.45. Except as provided in division (C)(1) of this section, in lieu of accepting the payment of the accumulated account of a member who dies before service retirement, the beneficiary, as determined in section 3309.44 of the Revised Code, may elect to forfeit the accumulated account and to substitute certain other benefits either under division (A) or (B) of this section.

(A)(1) If a deceased member was eligible for a service retirement allowance as provided in section 3309.36 or 3309.381 of the Revised Code, a surviving spouse or other sole dependent beneficiary may elect to receive a monthly benefit computed as the joint-survivor allowance designated as "plan D" in section 3309.46 of the Revised Code, which the member would have received had the member retired on the last day of the month of death and had the member at that time selected such joint-survivor plan. Payment shall begin with the month subsequent to the member's death.

(2) Beginning on a date selected by the school employees retirement board, which shall be not later than July 1, 2004, a surviving spouse or other sole dependent beneficiary may elect, in lieu of a monthly payment under division (A)(1) of this section, a plan of payment consisting of both of the following:

(a) A lump sum in an amount the surviving spouse or other sole dependent beneficiary designates that constitutes a portion of the allowance that would be payable under division (A)(1) of this section;

(b) The remainder of that allowance in monthly payments.

The total amount paid as a lump sum and a monthly benefit shall be the actuarial equivalent of the amount that would have been paid had the lump sum not been selected.

The lump sum amount designated by the surviving spouse or other sole dependent beneficiary under division (A)(2)(a) of this section shall be not less than six times and not more than thirty-six times the monthly amount that would be payable to the surviving spouse or other sole dependent beneficiary under division (A)(1) of this section and shall not result in a

monthly benefit that is less than fifty per cent of that monthly amount.

(B) If the deceased member had completed at least one and one-half years of credit for Ohio service, with at least one-quarter year of Ohio contributing service credit within the two and one-half years prior to the date of death, or was receiving at the time of death a disability benefit as provided in section 3309.40 or 3309.401 of the Revised Code, qualified survivors who elect to receive monthly benefits shall receive the greater of the benefits provided in division (B)(1)(a) or (b) as allocated in accordance with division (B)(5) of this section.

	1	2	3
A	(1)(a) Number of Qualified survivors affecting the benefit	Annual Benefit as a Per Cent of Decedent's Final Average Salary	Or Monthly Benefit shall not be less than
B	1	25%	$95
C	2	40	186
D	3	50	236
E	4	55	236
F	5 or more	60	236

A	1 (b) Years of Service	2 Annual Benefit as a Per Cent of Member's Final Average Salary
B	20	29%
C	21	33
D	22	37
E	23	41
F	24	45
G	25	48
H	26	51
I	27	54
J	28	57
K	29 or more	60

(2) Benefits shall begin as qualified survivors meet eligibility requirements as follows:

(a) A qualified spouse is the surviving spouse of the deceased member who is age sixty-two, or regardless of age if the deceased member had ten or more years of Ohio service credit, or regardless of age if caring for a surviving child, or regardless of age if adjudged physically or mentally incompetent.

(b) A qualified child whose benefit began before January 7, 2013, is any child of the deceased member who has never been married and to whom one of the following applies:

(i) Is under age eighteen, or under age twenty-two if the child is attending an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full-time curriculum requirements of such institution and as further determined by board policy;

(ii) Regardless of age, is adjudged physically or mentally incompetent if the incompetence existed prior to the member's death and prior to the child attaining age eighteen, or age twenty-two if attending an institution described in division (B)(2)(b)(i) of this section.

(c) A qualified child whose benefit begins on or after January 7, 2013, is any child of the deceased member who has never been married and to whom one of the following applies:

(i) Is under age nineteen;

(ii) Regardless of age, is adjudged physically or mentally incompetent if the incompetence existed prior to the member's death and prior to the child attaining age nineteen.

(d) A qualified parent is a dependent parent aged sixty-five or older.

(3) "Physically or mentally incompetent" as used in this section may be determined by a court of jurisdiction, or by a physician<u>, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner</u> appointed by the retirement board. Incapability of earning a living because of a physically or mentally disabling condition shall meet the qualifications of

this division.

(4) Benefits to a qualified survivor shall terminate upon a first marriage, abandonment, adoption, or during active military service. Benefits to a deceased member's surviving spouse that were terminated under a former version of this section that required termination due to remarriage and were not resumed prior to September 16, 1998, shall resume on the first day of the month immediately following receipt by the board of an application on a form provided by the board.

Upon the death of any subsequent spouse who was a member of the public employees retirement system, state teachers retirement system, or school employees retirement system, the surviving spouse of such member may elect to continue receiving benefits under this division, or to receive survivor's benefits, based upon the subsequent spouse's membership in one or more of the systems, for which such surviving spouse is eligible under this section or section 145.45 or 3307.66 of the Revised Code. If the surviving spouse elects to continue receiving benefits under this division, such election shall not preclude the payment of benefits under this division to any other qualified survivor.

Benefits shall begin or resume on the first day of the month following the attainment of eligibility and shall terminate on the first day of the month following loss of eligibility.

(5)(a) If a benefit is payable under division (B)(1)(a) of this section, benefits to a qualified spouse shall be paid in the amount determined for the first qualifying survivor in division (B)(1)(a) of this section, but shall not be less than one hundred six dollars per month if the deceased member had ten

or more years of Ohio service credit. All other qualifying survivors shall share equally in the benefit or remaining portion thereof.

(b) All qualifying survivors shall share equally in a benefit payable under division (B)(1)(b) of this section, except that if there is a surviving spouse, the surviving spouse shall receive no less than the greater of the amount determined for the first qualifying survivor in division (B)(1)(a) of this section or one hundred six dollars per month.

(6) The beneficiary of a member who is also a member of the public employees retirement system, or of the state teachers retirement system, must forfeit the member's accumulated contributions in those systems, if the beneficiary takes a survivor benefit. Such benefit shall be exclusively governed by section 3309.35 of the Revised Code.

(C)(1) Regardless of whether the member is survived by a spouse or designated beneficiary, if the school employees retirement system receives notice that a deceased member described in division (A) or (B) of this section has one or more qualified children, all persons who are qualified survivors under division (B) of this section shall receive monthly benefits as provided in division (B) of this section.

If, after determining the monthly benefits to be paid under division (B) of this section, the system receives notice that there is a qualified survivor who was not considered when the determination was made, the system shall, notwithstanding section 3309.661 of the Revised Code, recalculate the monthly benefits with that qualified survivor included, even if the benefits to qualified survivors already receiving benefits are reduced as a result. The benefits shall be calculated as if the

qualified survivor who is the subject of the notice became eligible on the date the notice was received and shall be paid to qualified survivors effective on the first day of the first month following the system's receipt of the notice.

If the retirement system did not receive notice that a deceased member has one or more qualified children prior to making payment under section 3309.44 of the Revised Code to a beneficiary as determined by the retirement system, the payment is a full discharge and release of the system from any future claims under this section or section 3309.44 of the Revised Code.

(2) If benefits under division (C)(1) of this section to all persons, or to all persons other than a surviving spouse or other sole beneficiary, terminate, there are no qualified children, and the surviving spouse or beneficiary qualifies for benefits under division (A) of this section, the surviving spouse or beneficiary may elect to receive benefits under division (A) of this section. Benefits shall be effective on the first day of the month following receipt by the board of an application for benefits under division (A) of this section.

(D) The final average salary used in the calculation of a benefit payable pursuant to division (A) or (B) of this section to a survivor or beneficiary of a disability benefit recipient shall be adjusted for each year between the disability benefit's effective date and the recipient's date of death by the lesser of three per cent or the actual average percentage increase in the consumer price index prepared by the United States bureau of labor statistics (U.S. City Average for Urban Wage Earners and Clerical Workers: "All Items 1982-84=100").

(E) If the survivor benefits due and paid under this

section are in a total amount less than the member's accumulated account that was transferred from the employees' savings fund, the state teachers retirement fund, and the public employees retirement fund to the survivors' benefit fund, then the difference between the total amount of the benefits paid shall be paid to the beneficiary under section 3309.44 of the Revised Code.

Sec. 3313.64. (A) As used in this section and in section 3313.65 of the Revised Code:

(1)(a) Except as provided in division (A)(1)(b) of this section, "parent" means either parent, unless the parents are separated or divorced or their marriage has been dissolved or annulled, in which case "parent" means the parent who is the residential parent and legal custodian of the child. When a child is in the legal custody of a government agency or a person other than the child's natural or adoptive parent, "parent" means the parent with residual parental rights, privileges, and responsibilities. When a child is in the permanent custody of a government agency or a person other than the child's natural or adoptive parent, "parent" means the parent who was divested of parental rights and responsibilities for the care of the child and the right to have the child live with the parent and be the legal custodian of the child and all residual parental rights, privileges, and responsibilities.

(b) When a child is the subject of a power of attorney executed under sections 3109.51 to 3109.62 of the Revised Code, "parent" means the grandparent designated as attorney in fact under the power of attorney. When a child is the subject of a caretaker authorization affidavit executed under sections 3109.64 to 3109.73 of the Revised Code, "parent" means the

grandparent that executed the affidavit.

(2) "Legal custody," "permanent custody," and "residual parental rights, privileges, and responsibilities" have the same meanings as in section 2151.011 of the Revised Code.

(3) "School district" or "district" means a city, local, or exempted village school district and excludes any school operated in an institution maintained by the department of youth services.

(4) Except as used in division (C)(2) of this section, "home" means a home, institution, foster home, group home, or other residential facility in this state that receives and cares for children, to which any of the following applies:

(a) The home is licensed, certified, or approved for such purpose by the state or is maintained by the department of youth services.

(b) The home is operated by a person who is licensed, certified, or approved by the state to operate the home for such purpose.

(c) The home accepted the child through a placement by a person licensed, certified, or approved to place a child in such a home by the state.

(d) The home is a children's home created under section 5153.21 or 5153.36 of the Revised Code.

(5) "Agency" means all of the following:

(a) A public children services agency;

(b) An organization that holds a certificate issued by the Ohio department of job and family services in accordance with

the requirements of section 5103.03 of the Revised Code and assumes temporary or permanent custody of children through commitment, agreement, or surrender, and places children in family homes for the purpose of adoption;

(c) Comparable agencies of other states or countries that have complied with applicable requirements of section 2151.39 of the Revised Code or as applicable, sections 5103.20 to 5103.22 or 5103.23 to 5103.237 of the Revised Code.

(6) A child is placed for adoption if either of the following occurs:

(a) An agency to which the child has been permanently committed or surrendered enters into an agreement with a person pursuant to section 5103.16 of the Revised Code for the care and adoption of the child.

(b) The child's natural parent places the child pursuant to section 5103.16 of the Revised Code with a person who will care for and adopt the child.

(7) "Preschool child with a disability" has the same meaning as in section 3323.01 of the Revised Code.

(8) "Child," unless otherwise indicated, includes preschool children with disabilities.

(9) "Active duty" means active duty pursuant to an executive order of the president of the United States, an act of the congress of the United States, or section 5919.29 or 5923.21 of the Revised Code.

(B) Except as otherwise provided in section 3321.01 of the Revised Code for admittance to kindergarten and first grade, a child who is at least five but under twenty-two years of age and

any preschool child with a disability shall be admitted to school as provided in this division.

(1) A child shall be admitted to the schools of the school district in which the child's parent resides.

(2) Except as provided in division (B) of section 2151.362 and section 3317.30 of the Revised Code, a child who does not reside in the district where the child's parent resides shall be admitted to the schools of the district in which the child resides if any of the following applies:

(a) The child is in the legal or permanent custody of a government agency or a person other than the child's natural or adoptive parent.

(b) The child resides in a home.

(c) The child requires special education.

(3) A child who is not entitled under division (B)(2) of this section to be admitted to the schools of the district where the child resides and who is residing with a resident of this state with whom the child has been placed for adoption shall be admitted to the schools of the district where the child resides unless either of the following applies:

(a) The placement for adoption has been terminated.

(b) Another school district is required to admit the child under division (B)(1) of this section.

Division (B) of this section does not prohibit the board of education of a school district from placing a child with a disability who resides in the district in a special education program outside of the district or its schools in compliance with Chapter 3323. of the Revised Code.

(C) A district shall not charge tuition for children admitted under division (B)(1) or (3) of this section. If the district admits a child under division (B)(2) of this section, tuition shall be paid to the district that admits the child as provided in divisions (C)(1) to (3) of this section, unless division (C)(4) of this section applies to the child:

(1) If the child receives special education in accordance with Chapter 3323. of the Revised Code, the school district of residence, as defined in section 3323.01 of the Revised Code, shall pay tuition for the child in accordance with section 3323.091, 3323.13, 3323.14, or 3323.141 of the Revised Code regardless of who has custody of the child or whether the child resides in a home.

(2) For a child that does not receive special education in accordance with Chapter 3323. of the Revised Code, except as otherwise provided in division (C)(2)(d) of this section, if the child is in the permanent or legal custody of a government agency or person other than the child's parent, tuition shall be paid by:

(a) The district in which the child's parent resided at the time the court removed the child from home or at the time the court vested legal or permanent custody of the child in the person or government agency, whichever occurred first;

(b) If the parent's residence at the time the court removed the child from home or placed the child in the legal or permanent custody of the person or government agency is unknown, tuition shall be paid by the district in which the child resided at the time the child was removed from home or placed in legal or permanent custody, whichever occurred first;

(c) If a school district cannot be established under division (C)(2)(a) or (b) of this section, tuition shall be paid by the district determined as required by section 2151.362 of the Revised Code by the court at the time it vests custody of the child in the person or government agency;

(d) If at the time the court removed the child from home or vested legal or permanent custody of the child in the person or government agency, whichever occurred first, one parent was in a residential or correctional facility or a juvenile residential placement and the other parent, if living and not in such a facility or placement, was not known to reside in this state, tuition shall be paid by the district determined under division (D) of section 3313.65 of the Revised Code as the district required to pay any tuition while the parent was in such facility or placement;

(e) If the department of education has determined, pursuant to division (A)(2) of section 2151.362 of the Revised Code, that a school district other than the one named in the court's initial order, or in a prior determination of the department, is responsible to bear the cost of educating the child, the district so determined shall be responsible for that cost.

(3) If the child is not in the permanent or legal custody of a government agency or person other than the child's parent and the child resides in a home, tuition shall be paid by one of the following:

(a) The school district in which the child's parent resides;

(b) If the child's parent is not a resident of this state,

the home in which the child resides.

(4) Division (C)(4) of this section applies to any child who is admitted to a school district under division (B)(2) of this section, resides in a home that is not a foster home, a home maintained by the department of youth services, a detention facility established under section 2152.41 of the Revised Code, or a juvenile facility established under section 2151.65 of the Revised Code, and receives educational services at the home or facility in which the child resides pursuant to a contract between the home or facility and the school district providing those services.

If a child to whom division (C)(4) of this section applies is a special education student, a district may choose whether to receive a tuition payment for that child under division (C)(4) of this section or to receive a payment for that child under section 3323.14 of the Revised Code. If a district chooses to receive a payment for that child under section 3323.14 of the Revised Code, it shall not receive a tuition payment for that child under division (C)(4) of this section.

If a child to whom division (C)(4) of this section applies is not a special education student, a district shall receive a tuition payment for that child under division (C)(4) of this section.

In the case of a child to which division (C)(4) of this section applies, the total educational cost to be paid for the child shall be determined by a formula approved by the department of education, which formula shall be designed to calculate a per diem cost for the educational services provided to the child for each day the child is served and shall reflect the total actual cost incurred in providing those services. The

department shall certify the total educational cost to be paid for the child to both the school district providing the educational services and, if different, the school district that is responsible to pay tuition for the child. The department shall deduct the certified amount from the state basic aid funds payable under Chapter 3317. of the Revised Code to the district responsible to pay tuition and shall pay that amount to the district providing the educational services to the child.

(D) Tuition required to be paid under divisions (C)(2) and (3)(a) of this section shall be computed in accordance with section 3317.08 of the Revised Code. Tuition required to be paid under division (C)(3)(b) of this section shall be computed in accordance with section 3317.081 of the Revised Code. If a home fails to pay the tuition required by division (C)(3)(b) of this section, the board of education providing the education may recover in a civil action the tuition and the expenses incurred in prosecuting the action, including court costs and reasonable attorney's fees. If the prosecuting attorney or city director of law represents the board in such action, costs and reasonable attorney's fees awarded by the court, based upon the prosecuting attorney's, director's, or one of their designee's time spent preparing and presenting the case, shall be deposited in the county or city general fund.

(E) A board of education may enroll a child free of any tuition obligation for a period not to exceed sixty days, on the sworn statement of an adult resident of the district that the resident has initiated legal proceedings for custody of the child.

(F) In the case of any individual entitled to attend school under this division, no tuition shall be charged by the

school district of attendance and no other school district shall be required to pay tuition for the individual's attendance. Notwithstanding division (B), (C), or (E) of this section:

(1) All persons at least eighteen but under twenty-two years of age who live apart from their parents, support themselves by their own labor, and have not successfully completed the high school curriculum or the individualized education program developed for the person by the high school pursuant to section 3323.08 of the Revised Code, are entitled to attend school in the district in which they reside.

(2) Any child under eighteen years of age who is married is entitled to attend school in the child's district of residence.

(3) A child is entitled to attend school in the district in which either of the child's parents is employed if the child has a medical condition that may require emergency medical attention. The parent of a child entitled to attend school under division (F)(3) of this section shall submit to the board of education of the district in which the parent is employed a statement from the child's physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner certifying that the child's medical condition may require emergency medical attention. The statement shall be supported by such other evidence as the board may require.

(4) Any child residing with a person other than the child's parent is entitled, for a period not to exceed twelve months, to attend school in the district in which that person resides if the child's parent files an affidavit with the superintendent of the district in which the person with whom the child is living resides stating all of the following:

(a) That the parent is serving outside of the state in the armed services of the United States;

(b) That the parent intends to reside in the district upon returning to this state;

(c) The name and address of the person with whom the child is living while the parent is outside the state.

(5) Any child under the age of twenty-two years who, after the death of a parent, resides in a school district other than the district in which the child attended school at the time of the parent's death is entitled to continue to attend school in the district in which the child attended school at the time of the parent's death for the remainder of the school year, subject to approval of that district board.

(6) A child under the age of twenty-two years who resides with a parent who is having a new house built in a school district outside the district where the parent is residing is entitled to attend school for a period of time in the district where the new house is being built. In order to be entitled to such attendance, the parent shall provide the district superintendent with the following:

(a) A sworn statement explaining the situation, revealing the location of the house being built, and stating the parent's intention to reside there upon its completion;

(b) A statement from the builder confirming that a new house is being built for the parent and that the house is at the location indicated in the parent's statement.

(7) A child under the age of twenty-two years residing with a parent who has a contract to purchase a house in a school district outside the district where the parent is residing and

who is waiting upon the date of closing of the mortgage loan for the purchase of such house is entitled to attend school for a period of time in the district where the house is being purchased. In order to be entitled to such attendance, the parent shall provide the district superintendent with the following:

(a) A sworn statement explaining the situation, revealing the location of the house being purchased, and stating the parent's intent to reside there;

(b) A statement from a real estate broker or bank officer confirming that the parent has a contract to purchase the house, that the parent is waiting upon the date of closing of the mortgage loan, and that the house is at the location indicated in the parent's statement.

The district superintendent shall establish a period of time not to exceed ninety days during which the child entitled to attend school under division (F)(6) or (7) of this section may attend without tuition obligation. A student attending a school under division (F)(6) or (7) of this section shall be eligible to participate in interscholastic athletics under the auspices of that school, provided the board of education of the school district where the student's parent resides, by a formal action, releases the student to participate in interscholastic athletics at the school where the student is attending, and provided the student receives any authorization required by a public agency or private organization of which the school district is a member exercising authority over interscholastic sports.

(8) A child whose parent is a full-time employee of a city, local, or exempted village school district, or of an

educational service center, may be admitted to the schools of the district where the child's parent is employed, or in the case of a child whose parent is employed by an educational service center, in the district that serves the location where the parent's job is primarily located, provided the district board of education establishes such an admission policy by resolution adopted by a majority of its members. Any such policy shall take effect on the first day of the school year and the effective date of any amendment or repeal may not be prior to the first day of the subsequent school year. The policy shall be uniformly applied to all such children and shall provide for the admission of any such child upon request of the parent. No child may be admitted under this policy after the first day of classes of any school year.

(9) A child who is with the child's parent under the care of a shelter for victims of domestic violence, as defined in section 3113.33 of the Revised Code, is entitled to attend school free in the district in which the child is with the child's parent, and no other school district shall be required to pay tuition for the child's attendance in that school district.

The enrollment of a child in a school district under this division shall not be denied due to a delay in the school district's receipt of any records required under section 3313.672 of the Revised Code or any other records required for enrollment. Any days of attendance and any credits earned by a child while enrolled in a school district under this division shall be transferred to and accepted by any school district in which the child subsequently enrolls. The state board of education shall adopt rules to ensure compliance with this division.

(10) Any child under the age of twenty-two years whose parent has moved out of the school district after the commencement of classes in the child's senior year of high school is entitled, subject to the approval of that district board, to attend school in the district in which the child attended school at the time of the parental move for the remainder of the school year and for one additional semester or equivalent term. A district board may also adopt a policy specifying extenuating circumstances under which a student may continue to attend school under division (F)(10) of this section for an additional period of time in order to successfully complete the high school curriculum for the individualized education program developed for the student by the high school pursuant to section 3323.08 of the Revised Code.

(11) As used in this division, "grandparent" means a parent of a parent of a child. A child under the age of twenty-two years who is in the custody of the child's parent, resides with a grandparent, and does not require special education is entitled to attend the schools of the district in which the child's grandparent resides, provided that, prior to such attendance in any school year, the board of education of the school district in which the child's grandparent resides and the board of education of the school district in which the child's parent resides enter into a written agreement specifying that good cause exists for such attendance, describing the nature of this good cause, and consenting to such attendance.

In lieu of a consent form signed by a parent, a board of education may request the grandparent of a child attending school in the district in which the grandparent resides pursuant to division (F)(11) of this section to complete any consent form required by the district, including any authorization required

by sections 3313.712, 3313.713, 3313.716, and 3313.718 of the Revised Code. Upon request, the grandparent shall complete any consent form required by the district. A school district shall not incur any liability solely because of its receipt of a consent form from a grandparent in lieu of a parent.

Division (F)(11) of this section does not create, and shall not be construed as creating, a new cause of action or substantive legal right against a school district, a member of a board of education, or an employee of a school district. This section does not affect, and shall not be construed as affecting, any immunities from defenses to tort liability created or recognized by Chapter 2744. of the Revised Code for a school district, member, or employee.

(12) A child under the age of twenty-two years is entitled to attend school in a school district other than the district in which the child is entitled to attend school under division (B), (C), or (E) of this section provided that, prior to such attendance in any school year, both of the following occur:

(a) The superintendent of the district in which the child is entitled to attend school under division (B), (C), or (E) of this section contacts the superintendent of another district for purposes of this division;

(b) The superintendents of both districts enter into a written agreement that consents to the attendance and specifies that the purpose of such attendance is to protect the student's physical or mental well-being or to deal with other extenuating circumstances deemed appropriate by the superintendents.

While an agreement is in effect under this division for a student who is not receiving special education under Chapter

3323. of the Revised Code and notwithstanding Chapter 3327. of the Revised Code, the board of education of neither school district involved in the agreement is required to provide transportation for the student to and from the school where the student attends.

A student attending a school of a district pursuant to this division shall be allowed to participate in all student activities, including interscholastic athletics, at the school where the student is attending on the same basis as any student who has always attended the schools of that district while of compulsory school age.

(13) All school districts shall comply with the "McKinney-Vento Homeless Assistance Act," 42 U.S.C.A. 11431 et seq., for the education of homeless children. Each city, local, and exempted village school district shall comply with the requirements of that act governing the provision of a free, appropriate public education, including public preschool, to each homeless child.

When a child loses permanent housing and becomes a homeless person, as defined in 42 U.S.C.A. 11481(5), or when a child who is such a homeless person changes temporary living arrangements, the child's parent or guardian shall have the option of enrolling the child in either of the following:

(a) The child's school of origin, as defined in 42 U.S.C.A. 11432(g)(3)(C);

(b) The school that is operated by the school district in which the shelter where the child currently resides is located and that serves the geographic area in which the shelter is located.

(14) A child under the age of twenty-two years who resides with a person other than the child's parent is entitled to attend school in the school district in which that person resides if both of the following apply:

(a) That person has been appointed, through a military power of attorney executed under section 574(a) of the "National Defense Authorization Act for Fiscal Year 1994," 107 Stat. 1674 (1993), 10 U.S.C. 1044b, or through a comparable document necessary to complete a family care plan, as the parent's agent for the care, custody, and control of the child while the parent is on active duty as a member of the national guard or a reserve unit of the armed forces of the United States or because the parent is a member of the armed forces of the United States and is on a duty assignment away from the parent's residence.

(b) The military power of attorney or comparable document includes at least the authority to enroll the child in school.

The entitlement to attend school in the district in which the parent's agent under the military power of attorney or comparable document resides applies until the end of the school year in which the military power of attorney or comparable document expires.

(G) A board of education, after approving admission, may waive tuition for students who will temporarily reside in the district and who are either of the following:

(1) Residents or domiciliaries of a foreign nation who request admission as foreign exchange students;

(2) Residents or domiciliaries of the United States but not of Ohio who request admission as participants in an exchange program operated by a student exchange organization.

(H) Pursuant to sections 3311.211, 3313.90, 3319.01, 3323.04, 3327.04, and 3327.06 of the Revised Code, a child may attend school or participate in a special education program in a school district other than in the district where the child is entitled to attend school under division (B) of this section.

(I)(1) Notwithstanding anything to the contrary in this section or section 3313.65 of the Revised Code, a child under twenty-two years of age may attend school in the school district in which the child, at the end of the first full week of October of the school year, was entitled to attend school as otherwise provided under this section or section 3313.65 of the Revised Code, if at that time the child was enrolled in the schools of the district but since that time the child or the child's parent has relocated to a new address located outside of that school district and within the same county as the child's or parent's address immediately prior to the relocation. The child may continue to attend school in the district, and at the school to which the child was assigned at the end of the first full week of October of the current school year, for the balance of the school year. Division (I)(1) of this section applies only if both of the following conditions are satisfied:

(a) The board of education of the school district in which the child was entitled to attend school at the end of the first full week in October and of the district to which the child or child's parent has relocated each has adopted a policy to enroll children described in division (I)(1) of this section.

(b) The child's parent provides written notification of the relocation outside of the school district to the superintendent of each of the two school districts.

(2) At the beginning of the school year following the

school year in which the child or the child's parent relocated outside of the school district as described in division (I)(1) of this section, the child is not entitled to attend school in the school district under that division.

(3) Any person or entity owing tuition to the school district on behalf of the child at the end of the first full week in October, as provided in division (C) of this section, shall continue to owe such tuition to the district for the child's attendance under division (I)(1) of this section for the lesser of the balance of the school year or the balance of the time that the child attends school in the district under division (I)(1) of this section.

(4) A pupil who may attend school in the district under division (I)(1) of this section shall be entitled to transportation services pursuant to an agreement between the district and the district in which the child or child's parent has relocated unless the districts have not entered into such agreement, in which case the child shall be entitled to transportation services in the same manner as a pupil attending school in the district under interdistrict open enrollment as described in division (E) of section 3313.981 of the Revised Code, regardless of whether the district has adopted an open enrollment policy as described in division (B)(1)(b) or (c) of section 3313.98 of the Revised Code.

(J) This division does not apply to a child receiving special education.

A school district required to pay tuition pursuant to division (C)(2) or (3) of this section or section 3313.65 of the Revised Code shall have an amount deducted under division (C) of section 3317.023 of the Revised Code equal to its own tuition

rate for the same period of attendance. A school district entitled to receive tuition pursuant to division (C)(2) or (3) of this section or section 3313.65 of the Revised Code shall have an amount credited under division (C) of section 3317.023 of the Revised Code equal to its own tuition rate for the same period of attendance. If the tuition rate credited to the district of attendance exceeds the rate deducted from the district required to pay tuition, the department of education shall pay the district of attendance the difference from amounts deducted from all districts' payments under division (C) of section 3317.023 of the Revised Code but not credited to other school districts under such division and from appropriations made for such purpose. The treasurer of each school district shall, by the fifteenth day of January and July, furnish the superintendent of public instruction a report of the names of each child who attended the district's schools under divisions (C)(2) and (3) of this section or section 3313.65 of the Revised Code during the preceding six calendar months, the duration of the attendance of those children, the school district responsible for tuition on behalf of the child, and any other information that the superintendent requires.

Upon receipt of the report the superintendent, pursuant to division (C) of section 3317.023 of the Revised Code, shall deduct each district's tuition obligations under divisions (C)(2) and (3) of this section or section 3313.65 of the Revised Code and pay to the district of attendance that amount plus any amount required to be paid by the state.

(K) In the event of a disagreement, the superintendent of public instruction shall determine the school district in which the parent resides.

(L) Nothing in this section requires or authorizes, or shall be construed to require or authorize, the admission to a public school in this state of a pupil who has been permanently excluded from public school attendance by the superintendent of public instruction pursuant to sections 3301.121 and 3313.662 of the Revised Code.

(M) In accordance with division (B)(1) of this section, a child whose parent is a member of the national guard or a reserve unit of the armed forces of the United States and is called to active duty, or a child whose parent is a member of the armed forces of the United States and is ordered to a temporary duty assignment outside of the district, may continue to attend school in the district in which the child's parent lived before being called to active duty or ordered to a temporary duty assignment outside of the district, as long as the child's parent continues to be a resident of that district, and regardless of where the child lives as a result of the parent's active duty status or temporary duty assignment. However, the district is not responsible for providing transportation for the child if the child lives outside of the district as a result of the parent's active duty status or temporary duty assignment.

Sec. 3313.671. (A)(1) Except as otherwise provided in division (B) of this section, no pupil, at the time of initial entry or at the beginning of each school year, to an elementary or high school for which the state board of education prescribes minimum standards pursuant to division (D) of section 3301.07 of the Revised Code, shall be permitted to remain in school for more than fourteen days unless the pupil presents written evidence satisfactory to the person in charge of admission, that the pupil has been immunized by a method of immunization

approved by the department of health pursuant to section 3701.13 of the Revised Code against mumps, poliomyelitis, diphtheria, pertussis, tetanus, rubeola, and rubella or is in the process of being immunized.

(2) Except as provided in division (B) of this section, no pupil who begins kindergarten at an elementary school subject to the state board of education's minimum standards shall be permitted to remain in school for more than fourteen days unless the pupil presents written evidence satisfactory to the person in charge of admission that the pupil has been immunized by a department of health-approved method of immunization or is in the process of being immunized against both of the following:

(a) During or after the school year beginning in 1999, hepatitis B;

(b) During or after the school year beginning in 2006, chicken pox.

(3) Except as provided in division (B) of this section, during and after the school year beginning in 2016, no pupil who is the age or older than the age at which immunization against meningococcal disease is recommended by the state department of health shall be permitted to remain in a school subject to the state board of education's minimum standards for more than fourteen days unless the pupil presents written evidence satisfactory to the person in charge of admission that the pupil has been immunized by a department of health-approved method of immunization, or is in the process of being immunized, against meningococcal disease.

(4) As used in divisions (A)(1), (2), and (3) of this section, "in the process of being immunized" means the pupil has

been immunized against mumps, rubeola, rubella, and chicken pox, and if the pupil has not been immunized against poliomyelitis, diphtheria, pertussis, tetanus, hepatitis B, and meningococcal disease, the pupil has received at least the first dose of the immunization sequence, and presents written evidence to the pupil's building principal or chief administrative officer of each subsequent dose required to obtain immunization at the intervals prescribed by the director of health. Any student previously admitted under the "in process of being immunized" provision and who has not complied with the immunization intervals prescribed by the director of health shall be excluded from school on the fifteenth day of the following school year. Any student so excluded shall be readmitted upon showing evidence to the student's building principal or chief administrative officer of progress on the director of health's interval schedule.

(B)(1) A pupil who has had natural rubeola, and presents a signed statement from the pupil's parent, guardian, ~~or~~ physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to that effect, is not required to be immunized against rubeola.

(2) A pupil who has had natural mumps, and presents a signed statement from the pupil's parent, guardian, ~~or~~ physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to that effect, is not required to be immunized against mumps.

(3) A pupil who has had natural chicken pox, and presents a signed statement from the pupil's parent, guardian, ~~or~~ physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner to that effect, is not required

to be immunized against chicken pox.

(4) A pupil who presents a written statement of the pupil's parent or guardian in which the parent or guardian declines to have the pupil immunized for reasons of conscience, including religious convictions, is not required to be immunized.

(5) A child whose physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner certifies in writing that such immunization against any disease is medically contraindicated is not required to be immunized against that disease.

(C) As used in this division, "chicken pox epidemic" means the occurrence of cases of chicken pox in numbers greater than expected in the school's population or for a particular period of time.

Notwithstanding division (B) of this section, a school may deny admission to a pupil otherwise exempted from the chicken pox immunization requirement if the director of the state department of health notifies the school's principal or chief administrative officer that a chicken pox epidemic exists in the school's population. The denial of admission shall cease when the director notifies the principal or officer that the epidemic no longer exists.

The board of education or governing body of each school subject to this section shall adopt a policy that prescribes methods whereby the academic standing of a pupil who is denied admission during a chicken pox epidemic may be preserved.

(D) Boards of health, legislative authorities of municipal corporations, and boards of township trustees on application of

the board of education of the district or proper authority of any school affected by this section, shall provide at the public expense, without delay, the means of immunization against mumps, poliomyelitis, rubeola, rubella, diphtheria, pertussis, tetanus, and hepatitis B to pupils who are not so provided by their parents or guardians.

(E) The department of health shall specify the age at which immunization against meningococcal disease, as required by division (A)(3) of this section, is recommended, and approve a method of immunization against meningococcal disease.

Sec. 3313.71. School physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners may make examinations, which shall include tests to determine the existence of hearing defects, and diagnoses of all children referred to them. They may make such examination of teachers and other school employees and inspection of school buildings as in their opinion the protection of health of the pupils, teachers, and other school employees requires.

Boards of education shall require and provide, in accordance with section 3313.67 of the Revised Code, such tests and examinations for tuberculosis of pupils in selected grades and of school employees as may be required by the director of health.

Boards may require annual tuberculin tests of any grades. All pupils with positive reactions to the test shall have chest x-rays and all positive reactions and x-ray findings shall be reported promptly to the county record bureau of tuberculosis cases provided for in section 339.74 of the Revised Code. Boards shall waive the required test where a pupil presents a written statement from the pupil's ~~family physician~~ primary care

provider certifying that such test has been given and that such pupil is free from tuberculosis in a communicable stage, or that such test is inadvisable for medical reasons, or from the pupil's parent or guardian objecting to such test because of religious convictions.

Whenever a pupil, teacher, or other school employee is found to be ill or suffering from tuberculosis in a communicable stage or other communicable disease, the school physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner shall promptly send such pupil, teacher, or other school employee home, with a statement, in the case of a pupil, to the pupil's parents or guardian, briefly setting forth the discovered facts, and advising that the ~~family physician~~ primary care provider be consulted. School physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners shall keep accurate card-index records of all examinations, and said records, that they may be uniform throughout the state, shall be according to the form prescribed by the state board of education, and the reports shall be made according to the method of said form. If the parent or guardian of any pupil or any teacher or other school employee, after notice from the board of education, furnishes within two weeks thereafter the written certificate of any reputable physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner that the pupil, teacher, or other school employee has been examined, in such cases the service of the school physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner shall be dispensed with, and such certificate shall be furnished by such parent or guardian, as required by the board of education. Such individual records shall not be open to the public and shall be solely for

the use of the boards of education and boards of health officer. If any teacher or other school employee is found to have tuberculosis in a communicable stage or other communicable disease, the teacher's or employee's employment shall be discontinued or suspended upon such terms as to salary as the board deems just until the school physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has certified to a recovery from such disease. The methods of making the tuberculin tests and chest x-rays required by this section shall be such as are approved by the director of health.

This section shall apply to all elementary and high schools for which the state board of education sets minimum standards pursuant to section 3301.07 of the Revised Code.

Sec. 3313.712. As used in this section, "parent" means parent as defined in section 3321.01 of the Revised Code.

(A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, provide to the parent of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide ~~his~~ the pupil's parent, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section. When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a

city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of ~~his~~ a pupil's parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

If a parent does not wish to give such written permission, ~~he~~ the parent shall indicate in the proper place on the form the procedure ~~he~~ the parent wishes school authorities to follow in the event of a medical emergency involving ~~his~~ the parent's child.

Even if a parent gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the authorities of ~~his~~ the pupil's school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the pupil's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows:

"EMERGENCY MEDICAL AUTHORIZATION

School _____ Student Name _____

_____ Address _____

_____ _____

_____ Telephone _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Childcare Provider

_____ Relationship _____

Address _____ Phone _____

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

~~Doctor~~ Primary Care Provider_____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the

administration of any treatment deemed necessary by above-named ~~doctor~~primary care provider, or, in the event the designated preferred practitioner is not available, by another licensed physician, certified nurse practitioner, clinical nurse specialist, or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, certified nurse practitioners, clinical nurse specialists, or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician, certified nurse practitioner, or clinical nurse specialist should be alerted:

Date _____ Signature of

Parent/Guardian

_____

Address _____

_____

PART II - REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____ Signature of

Parent/Guardian

_____

Address

_____

_____"

Sec. 3313.716. (A) Notwithstanding section 3313.713 of the Revised Code or any policy adopted under that section, a student of a school operated by a city, local, exempted village, or joint vocational school district or a student of a chartered nonpublic school may possess and use a metered dose inhaler or a dry powder inhaler to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms, if both of the following conditions are satisfied:

(1) The student has the written approval of the student's physician, clinical nurse specialist, or certified nurse practitioner and, if the student is a minor, the written approval of the parent, guardian, or other person having care or charge of the student. The physician's or nurse's written approval shall include at least all of the following information:

(a) The student's name and address;

(b) The names and dose of the medication contained in the inhaler;

(c) The date the administration of the medication is to begin;

(d) The date, if known, that the administration of the medication is to cease;

(e) Written instructions that outline procedures school

personnel should follow in the event that the asthma medication does not produce the expected relief from the student's asthma attack;

(f) Any severe adverse reactions that may occur to the child using the inhaler and that should be reported to the physician or nurse;

(g) Any severe adverse reactions that may occur to another child, for whom the inhaler is not prescribed, should such a child receive a dose of the medication;

(h) At least one emergency telephone number for contacting the physician or nurse in an emergency;

(i) At least one emergency telephone number for contacting the parent, guardian, or other person having care or charge of the student in an emergency;

(j) Any other special instructions from the physician or nurse.

(2) The school principal and, if a school nurse is assigned to the student's school building, the school nurse has received copies of the written approvals required by division (A)(1) of this section.

If these conditions are satisfied, the student may possess and use the inhaler at school or at any activity, event, or program sponsored by or in which the student's school is a participant.

(B)(1) A school district, member of a school district board of education, or school district employee is not liable in damages in a civil action for injury, death, or loss to person or property allegedly arising from a district employee's

prohibiting a student from using an inhaler because of the employee's good faith belief that the conditions of divisions (A)(1) and (2) of this section had not been satisfied. A school district, member of a school district board of education, or school district employee is not liable in damages in a civil action for injury, death, or loss to person or property allegedly arising from a district employee's permitting a student to use an inhaler because of the employee's good faith belief that the conditions of divisions (A)(1) and (2) of this section had been satisfied. Furthermore, when a school district is required by this section to permit a student to possess and use an inhaler because the conditions of divisions (A)(1) and (2) of this section have been satisfied, the school district, any member of the school district board of education, or any school district employee is not liable in damages in a civil action for injury, death, or loss to person or property allegedly arising from the use of the inhaler by a student for whom it was not prescribed.

This section does not eliminate, limit, or reduce any other immunity or defense that a school district, member of a school district board of education, or school district employee may be entitled to under Chapter 2744. or any other provision of the Revised Code or under the common law of this state.

(2) A chartered nonpublic school or any officer, director, or employee of the school is not liable in damages in a civil action for injury, death, or loss to person or property allegedly arising from a school employee's prohibiting a student from using an inhaler because of the employee's good faith belief that the conditions of divisions (A)(1) and (2) of this section had not been satisfied. A chartered nonpublic school or any officer, director, or employee of the school is not liable

in damages in a civil action for injury, death, or loss to person or property allegedly arising from a school employee's permitting a student to use an inhaler because of the employee's good faith belief that the conditions of divisions (A)(1) and (2) of this section had been satisfied. Furthermore, when a chartered nonpublic school is required by this section to permit a student to possess and use an inhaler because the conditions of divisions (A)(1) and (2) of this section have been satisfied, the chartered nonpublic school or any officer, director, or employee of the school is not liable in damages in a civil action for injury, death, or loss to person or property allegedly arising from the use of the inhaler by a student for whom it was not prescribed.

Sec. 3313.72. The board of education of a city, exempted village, or local school district may enter into a contract with a health district for the purpose of providing the services of a school physician, dentist, or nurse, including a clinical nurse specialist or certified nurse practitioner. The board may also enter into a contract under section 3313.721 of the Revised Code for the purpose of providing health care services to students.

Sec. 3313.73. If the board of education of a city, exempted village, or local school district has not employed a school physician, clinical nurse specialist, or certified nurse practitioner, the board of health shall conduct the health examination of all school children in the health district and shall report the findings of such examination and make such recommendations to the parents or guardians as are deemed necessary for the correction of such defects as need correction. This section does not require any school child to receive a medical examination or receive medical treatment whose parent or guardian objects thereto.

Sec. 3319.141. Each person who is employed by any board of education in this state, except for substitutes, adult education instructors who are scheduled to work the full-time equivalent of less than one hundred twenty days per school year, or persons who are employed on an as-needed, seasonal, or intermittent basis, shall be entitled to fifteen days sick leave with pay, for each year under contract, which shall be credited at the rate of one and one-fourth days per month. Teachers and regular nonteaching school employees, upon approval of the responsible administrative officer of the school district, may use sick leave for absence due to personal illness, pregnancy, injury, exposure to contagious disease which could be communicated to others, and for absence due to illness, injury, or death in the employee's immediate family. Unused sick leave shall be cumulative up to one hundred twenty work days, unless more than one hundred twenty days are approved by the employing board of education. The previously accumulated sick leave of a person who has been separated from public service, whether accumulated pursuant to section 124.38 of the Revised Code or pursuant to this section, shall be placed to the person's credit upon re-employment in the public service, provided that such re-employment takes place within ten years of the date of the last termination from public service. A teacher or nonteaching school employee who transfers from one public agency to another shall be credited with the unused balance of the teacher's or nonteaching employee's accumulated sick leave up to the maximum of the sick leave accumulation permitted in the public agency to which the employee transfers. Teachers and nonteaching school employees who render regular part-time, per diem, or hourly service shall be entitled to sick leave for the time actually worked at the same rate as that granted like full-time employees, calculated in the same manner as the ratio of sick

leave granted to hours of service established by section 124.38 of the Revised Code. Each board of education may establish regulations for the entitlement, crediting and use of sick leave by those substitute teachers employed by such board pursuant to section 3319.10 of the Revised Code who are not otherwise entitled to sick leave pursuant to such section. A board of education shall require a teacher or nonteaching school employee to furnish a written, signed statement on forms prescribed by such board to justify the use of sick leave. If medical attention is required, the employee's statement shall list the name and address of the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner and the dates when the physician or nurse was consulted. Nothing in this section shall be construed to waive the physician-patient or advanced practice registered nurse-patient privilege provided by section 2317.02 of the Revised Code. Falsification of a statement is grounds for suspension or termination of employment under sections 3311.82, 3319.081, and 3319.16 of the Revised Code. No sick leave shall be granted or credited to a teacher after the teacher's retirement or termination of employment.

Except to the extent used as sick leave, leave granted under regulations adopted by a board of education pursuant to section 3311.77 or 3319.08 of the Revised Code shall not be charged against sick leave earned or earnable under this section. Nothing in this section shall be construed to affect in any other way the granting of leave pursuant to section 3311.77 or 3319.08 of the Revised Code and any granting of sick leave pursuant to such section shall be charged against sick leave accumulated pursuant to this section.

This section shall not be construed to interfere with any

unused sick leave credit in any agency of government where attendance records are maintained and credit has been given for unused sick leave. Unused sick leave accumulated by teachers and nonteaching school employees under section 124.38 of the Revised Code shall continue to be credited toward the maximum accumulation permitted in accordance with this section. Each newly hired regular nonteaching and each regular nonteaching employee of any board of education who has exhausted the employee's accumulated sick leave shall be entitled to an advancement of not less than five days of sick leave each year, as authorized by rules which each board shall adopt, to be charged against the sick leave the employee subsequently accumulates under this section.

This section shall be uniformly administered.

Sec. 3319.143. Notwithstanding section 3319.141 of the Revised Code, the board of education of a city, exempted village, local or joint vocational school district may adopt a policy of assault leave by which an employee who is absent due to physical disability resulting from an assault which occurs in the course of board employment will be maintained on full pay status during the period of such absence. A board of education electing to effect such a policy of assault leave shall establish rules for the entitlement, crediting, and use of assault leave and file a copy of same with the state board of education. A board of education adopting this policy shall require an employee to furnish a signed statement on forms prescribed by such board to justify the use of assault leave. If medical attention is required, a certificate from a licensed physician<u>, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner</u> stating the nature of the disability and its duration shall be required before assault

leave can be approved for payment. Falsification of either a signed statement or a physician's or nurse's certificate is ground for suspension or termination of employment under section 3311.82 or 3319.16 of the Revised Code.

Assault leave granted under rules adopted by a board of education pursuant to this section shall not be charged against sick leave earned or earnable under section 3319.141 of the Revised Code or leave granted under rules adopted by a board of education pursuant to section 3311.77 or 3319.08 of the Revised Code. This section shall be uniformly administered in those districts where such policy is adopted.

Sec. 3321.04. Notwithstanding division (D) of section 3311.19 and division (D) of section 3311.52 of the Revised Code, this section does not apply to any joint vocational or cooperative education school district or its superintendent.

Every parent of any child of compulsory school age who is not employed under an age and schooling certificate must send such child to a school or a special education program that conforms to the minimum standards prescribed by the state board of education, for the full time the school or program attended is in session, which shall not be for less than thirty-two weeks per school year. Such attendance must begin within the first week of the school term or program or within one week of the date on which the child begins to reside in the district or within one week after the child's withdrawal from employment.

For the purpose of operating a school or program on a trimester plan, "full time the school attended is in session," as used in this section means the two trimesters to which the child is assigned by the board of education. For the purpose of operating a school or program on a quarterly plan, "full time

the school attended is in session," as used in this section, means the three quarters to which the child is assigned by the board of education. For the purpose of operating a school or program on a pentamester plan, "full time the school is in session," as used in this section, means the four pentamesters to which the child is assigned by the board of education.

Excuses from future attendance at or past absence from school or a special education program may be granted for the causes, by the authorities, and under the following conditions:

(A) The superintendent of the school district in which the child resides may excuse the child from attendance for any part of the remainder of the current school year upon satisfactory showing of either of the following facts:

(1) That the child's bodily or mental condition does not permit attendance at school or a special education program during such period; this fact is certified in writing by a licensed physician, clinical nurse specialist, or certified nurse practitioner or, in the case of a mental condition, by a licensed physician, a licensed clinical nurse specialist or certified nurse practitioner certified as a psychiatric-mental health CNS or psychiatric-mental health NP by the American nurses credentialing center, a licensed psychologist, a licensed school psychologist, or a certificated school psychologist; and provision is made for appropriate instruction of the child, in accordance with Chapter 3323. of the Revised Code;

(2) That the child is being instructed at home by a person qualified to teach the branches in which instruction is required, and such additional branches, as the advancement and needs of the child may, in the opinion of such superintendent, require. In each such case the issuing superintendent shall file

in the superintendent's office, with a copy of the excuse, papers showing how the inability of the child to attend school or a special education program or the qualifications of the person instructing the child at home were determined. All such excuses shall become void and subject to recall upon the removal of the disability of the child or the cessation of proper home instruction; and thereupon the child or the child's parents may be proceeded against after due notice whether such excuse be recalled or not.

(B) The state board of education may adopt rules authorizing the superintendent of schools of the district in which the child resides to excuse a child over fourteen years of age from attendance for a future limited period for the purpose of performing necessary work directly and exclusively for the child's parents or legal guardians.

All excuses provided for in divisions (A) and (B) of this section shall be in writing and shall show the reason for excusing the child. A copy thereof shall be sent to the person in charge of the child.

(C) The board of education of the school district or the governing authorities of a private or parochial school may in the rules governing the discipline in such schools, prescribe the authority by which and the manner in which any child may be excused for absence from such school for good and sufficient reasons.

The state board of education may by rule prescribe conditions governing the issuance of excuses, which shall be binding upon the authorities empowered to issue them.

Sec. 3354.21. The multipurpose center established under

section 3354.20 of the Revised Code may provide and may enter into an agreement with a public or private nonprofit agency or person to provide displaced homemakers with services. These services may include, but not be limited to, the following:

(A) Job counseling, specifically designed for a person reentering the job market after a number of years as a homemaker, and utilizing peer counseling;

(B) Job training developed cooperatively with the director of job and family services, local government agencies, and private employers, for available employment in the public and private sectors. The job training program shall provide a stipend for trainees. As opportunities for the employment of such skills in the community are identified or developed, the center's program shall include training for:

(1) Employment counselors in social service agencies;

(2) Home health technicians with skills in nutrition, basic health care, and nursing for the disabled and elderly;

(3) Health care counselors, for employment in hospital outpatient and community clinics, especially in the counseling of middle-aged patients.

(C) Assistance in finding employment. In its job-finding program, the staff shall work with the director of job and family services, and any other appropriate public or private agency in the area where the center is located.

(D) Health service programs, including a clinic based on principles of preventive health care and consumer health education. The clinic shall provide basic physical and gynecological examinations, information and referral to physicians, clinical nurse specialists, certified nurse

practitioners, and clinics, discussion and activity groups on common health problems of older persons, and alcohol and drug addiction programs.

(E) Money management courses;

(F) Information concerning government assistance programs;

(G) Educational programs, including courses offering credit through community colleges or leading to a high school equivalency diploma;

(H) Counseling for the purpose of lessening or resolving emotional problems, temporary stress, or impaired social functioning.

Sec. 3501.382. (A)(1) A registered voter who, by reason of disability, is unable to physically sign the voter's name as a candidate, signer, or circulator on a declaration of candidacy and petition, nominating petition, other petition, or other document under Title XXXV of the Revised Code may authorize a legally competent resident of this state who is eighteen years of age or older as an attorney in fact to sign that voter's name to the petition or other election document, at the voter's direction and in the voter's presence, in accordance with either of the following procedures:

(a) The voter may file with the board of elections of the voter's county of residence a notarized form that includes or has attached all of the following:

(i) The name of the voter who is authorizing an attorney in fact to sign petitions or other election documents on that voter's behalf, at the voter's direction and in the voter's presence;

(ii) An attestation of the voter that the voter, by reason of disability, is unable to sign physically petitions or other election documents and that the voter desires the attorney in fact to sign them on the voter's behalf, at the direction of the voter and in the voter's presence;

(iii) The name, residence address, date of birth, and, if applicable, Ohio supreme court registration number of the attorney in fact authorized to sign on the voter's behalf, at the voter's direction and in the voter's presence. A photocopy of the attorney in fact's driver's license or state identification card issued under section 4507.50 of the Revised Code shall be attached to the notarized form.

(iv) The form of the signature that the attorney in fact will use in signing petitions or other election documents on the voter's behalf, at the voter's direction and in the voter's presence.

(b) The voter may acknowledge, before an election official, and file with the board of elections of the voter's county of residence a form that includes or has attached all of the following:

(i) The name of the voter who is authorizing an attorney in fact to sign petitions or other election documents on that voter's behalf, at the voter's direction and in the voter's presence;

(ii) An attestation of the voter that the voter, by reason of disability, is physically unable to sign petitions or other election documents and that the voter desires the attorney in fact to sign them on the voter's behalf, at the direction of the voter and in the voter's presence;

(iii) An attestation from a licensed physician, clinical nurse specialist, or certified nurse practitioner that the voter is disabled and, by reason of that disability, is physically unable to sign petitions or other election documents;

(iv) The name, residence address, date of birth, and, if applicable, Ohio supreme court registration number of the attorney in fact authorized to sign on the voter's behalf, at the voter's direction and in the voter's presence. A photocopy of the attorney in fact's driver's license or state identification card issued under section 4507.50 of the Revised Code shall be attached to the notarized form.

(v) The form of the signature that the attorney in fact will use in signing petitions or other election documents on the voter's behalf, at the voter's direction and in the voter's presence.

(2) In addition to performing customary notarial acts with respect to the power of attorney form described in division (A)(1)(a) of this section, the notary public shall acknowledge that the voter in question affirmed in the presence of the notary public the information listed in divisions (A)(1)(a)(i), (ii), and (iii) of this section. A notary public shall not perform any notarial acts with respect to such a power of attorney form unless the voter first gives such an affirmation. Only a notary public satisfying the requirements of section 147.01 of the Revised Code may perform notarial acts with respect to such a power of attorney form.

(B) A board of elections that receives a form under division (A)(1) of this section from a voter shall do both of the following:

(1) Use the signature provided in accordance with division (A)(1)(a)(iv) or (A)(1)(b)(v) of this section for the purpose of verifying the voter's signature on all declarations of candidacy and petitions, nominating petitions, other petitions, or other documents signed by that voter under Title XXXV of the Revised Code;

(2) Cause the poll list or signature pollbook for the relevant precinct to identify the voter in question as having authorized an attorney in fact to sign petitions or other election documents on the voter's behalf, at the voter's direction and in the voter's presence.

(C) Notwithstanding division (D) of section 3501.38 or any other provision of the Revised Code to the contrary, an attorney in fact authorized to sign petitions or other election documents on a disabled voter's behalf, at the direction of and in the presence of that voter, in accordance with division (A) of this section may sign that voter's name to any petition or other election document under Title XXXV of the Revised Code after the power of attorney has been filed with the board of elections in accordance with division (A)(1) of this section. The signature shall be deemed to be that of the disabled voter, and the voter shall be deemed to be the signer.

(D)(1) Notwithstanding division (F) of section 3501.38 or any other provision of the Revised Code to the contrary, the circulator of a petition may knowingly permit an attorney in fact to sign the petition on a disabled voter's behalf, at the direction of and in the presence of that voter, in accordance with division (A)(1) of this section.

(2) Notwithstanding division (F) of section 3501.38 or any other provision of the Revised Code to the contrary, no petition

paper shall be invalidated on the ground that the circulator knowingly permitted an attorney in fact to write a name other than the attorney in fact's own name on a petition paper, if that attorney in fact signed the petition on a disabled voter's behalf, at the direction of and in the presence of that voter, in accordance with division (C) of this section.

(E) The secretary of state shall prescribe the form and content of the form for the power of attorney prescribed under division (A)(1) of this section and also shall prescribe the form and content of a distinct form to revoke such a power of attorney.

(F) As used in this section, "unable to physically sign" means that the person with a disability cannot comply with the provisions of section 3501.011 of the Revised Code. A person is not "unable to physically sign" if the person is able to comply with section 3501.011 through reasonable accommodation, including the use of assistive technology or augmentative devices.

Sec. 3701.01. As used in sections 3701.01, 3701.04, 3701.08, 3701.09, and 3701.37 to 3701.45 of the Revised Code:

(A) "The federal act" means Title VI of the "Public Health Service Act," 60 Stat. 1041 (1946), 42 U.S.C. 291, as amended.

(B) "The surgeon general" means the surgeon general of the public health service of the United States or such other officer or employee of the United States responsible for administration of the federal act.

(C) "Hospital" includes public health centers and general, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, outpatient

departments, nurses' home facilities, extended care facilities, self-care units, and central service facilities operated in connection with hospitals, and also includes education and training facilities for health professions personnel operated as an integral part of a hospital, but does not include any hospital furnishing primarily domiciliary care.

(D) "Public health center" means a publicly owned facility for the housing of the public health services of a community and one which makes available equipment to aid physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners in the prevention, diagnosis, and treatment of disease.

(E) "Nonprofit hospital," or "nonprofit" as applied to a facility, means any hospital or facility owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(F) "Medical facilities" means outpatient facilities, rehabilitation facilities, and facilities for long-term care, including nursing homes, as those terms are defined in the federal act, and such other facilities for which federal aid may be authorized under the federal act.

Sec. 3701.031. (A) The director of health shall accept and administer grants received from the federal government or other sources, public or private, that are made available for use in monitoring, studying, and preventing pregnancy losses. To the extent that funding from grants is available, the director shall do the following:

(1) Establish a population-based pregnancy loss registry

to monitor the incidence of various types of pregnancy losses that occur in this state, make appropriate epidemiological studies to determine any causal relations of the pregnancy losses with occupational, nutritional, environmental, genetic, or infectious conditions, and determine what can be done to prevent such losses;

(2) Advise, consult, cooperate with, and assist, by contract or otherwise, agencies of the state and federal government, agencies of governments of other states, agencies of political subdivisions of this state, universities, private organizations, corporations, and associations for the purpose of division (A)(1) of this section.

(B) The director may adopt rules pursuant to Chapter 119. of the Revised Code to specify the reporting requirements for physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners as necessary to accomplish the purposes of this section.

(C) As used in this section, "~~Pregnancy~~ pregnancy loss" means a termination of pregnancy within the first twenty weeks of pregnancy either spontaneously or by means other than the purposeful termination of a pregnancy as described in section 2919.11 of the Revised Code.

Sec. 3701.046. The director of health is authorized to make grants for women's health services from funds appropriated for that purpose by the general assembly.

None of the funds received through grants for women's health services shall be used to provide abortion services. None of the funds received through these grants shall be used for counseling for or referrals for abortion, except in the case of

a medical emergency. These funds shall be distributed by the director to programs that the department of health determines will provide services that are physically and financially separate from abortion-providing and abortion-promoting activities, and that do not include counseling for or referrals for abortion, other than in the case of medical emergency.

These women's health services include and are limited to the following: pelvic examinations and laboratory testing; breast examinations and patient education on breast cancer; screening for cervical cancer; screening and treatment for sexually transmitted diseases and HIV screening; voluntary choice of contraception, including abstinence and natural family planning; patient education and pre-pregnancy counseling on the dangers of smoking, alcohol, and drug use during pregnancy; education on sexual coercion and violence in relationships; and prenatal care or referral for prenatal care. These health care services shall be provided in a medical clinic setting by persons authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; authorized under Chapter 4730. of the Revised Code to practice as a physician assistant; licensed under Chapter 4723. of the Revised Code as a registered nurse, including an advanced practice registered nurse, or as a licensed practical nurse; or licensed under Chapter 4757. of the Revised Code as a social worker, independent social worker, licensed professional clinical counselor, or licensed professional counselor.

The director shall adopt rules under Chapter 119. of the Revised Code specifying reasonable eligibility standards that must be met to receive the state funding and provide reasonable methods by which a grantee wishing to be eligible for federal funding may comply with these requirements for state funding

without losing its eligibility for federal funding.

Each applicant for these funds shall provide sufficient assurance to the director of all of the following:

(A) The program shall not discriminate in the provision of services based on an individual's religion, race, national origin, handicapping condition, age, sex, number of pregnancies, or marital status;

(B) The program shall provide services without subjecting individuals to any coercion to accept services or to employ any particular methods of family planning;

(C) Acceptance of services shall be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other service, assistance from, or participation in, any other program of the service provider;

(D) Any charges for services provided by the program shall be based on the patient's ability to pay and priority in the provision of services shall be given to persons from low-income families.

In distributing these grant funds, the director shall give priority to grant requests from local departments of health for women's health services to be provided directly by personnel of the local department of health. The director shall issue a single request for proposals for all grants for women's health services. The director shall send a notification of this request for proposals to every local department of health in this state and shall place a notification on the department's web site. The director shall allow at least thirty days after issuing this notification before closing the period to receive applications.

After the closing date for receiving grant applications,

the director shall first consider grant applications from local departments of health that apply for grants for women's health services to be provided directly by personnel of the local department of health. Local departments of health that apply for grants for women's health services to be provided directly by personnel of the local department of health need not provide all the listed women's health services in order to qualify for a grant. However, in prioritizing awards among local departments of health that qualify for funding under this paragraph, the director may consider, among other reasonable factors, the comprehensiveness of the women's health services to be offered, provided that no local department of health shall be discriminated against in the process of awarding these grant funds because the applicant does not provide contraception.

If funds remain after awarding grants to all local departments of health that qualify for the priority, the director may make grants to other applicants. Awards to other applicants may be made to those applicants that will offer all eight of the listed women's health services or that will offer all of the services except contraception. No applicant shall be discriminated against in the process of awarding these grant funds because the applicant does not provide contraception.

Sec. 3701.144. (A) As used in this section, "cost sharing" has the same meaning as in section 3923.85 of the Revised Code.

(B) The department of health shall administer the state's participation in the national breast and cervical cancer early detection program (NBCCEDP), which shall be known as the Ohio breast and cervical cancer project. The project shall be administered in accordance with Title XV of the "Public Health Service Act," 42 U.S.C. 300k et seq., and the department's

NBCCEDP grant agreement with the United States centers for disease control and prevention.

(C) In administering the project, the department shall set eligibility requirements for services provided through the project as follows:

(1) The woman must have countable family income not exceeding three hundred per cent of the federal poverty line.

(2) One of the following must be the case:

(a) The woman is not covered by health insurance.

(b) The woman is covered by health insurance that does not include the screening or diagnostic services the woman seeks through the project.

(c) The woman is covered by health insurance that imposes cost sharing for the screening or diagnostic services the woman seeks through the project that exceeds the limit specified ~~by the director of health~~ in rules adopted under division (D) of this section.

(3) In the case of a woman seeking cervical cancer screening and diagnostic services through the project, the woman must be at least twenty-one and less than sixty-five years of age.

(4) In the case of a woman seeking breast cancer screening and diagnostic services through the project, either of the following must be the case:

(a) The woman is at least forty years of age.

(b) The woman is at least twenty-one and less than forty years of age and has been determined by a physician, certified

nurse-midwife, clinical nurse specialist, or certified nurse practitioner to need breast cancer screening and diagnostic services due to the results of a clinical breast examination, the woman's family history, or other factors.

(D) The director of health shall adopt rules for purposes of division (C)(2)(c) of this section specifying the cost sharing limit for each screening and diagnostic service that may be obtained through the project. The director may adopt other rules as necessary to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 3701.146. (A) In taking actions regarding tuberculosis, the director of health has all of the following duties and powers:

(1) The director shall maintain registries of hospitals, clinics, physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, or other care providers to whom the director shall refer persons who make inquiries to the department of health regarding possible exposure to tuberculosis.

(2) The director shall engage in tuberculosis surveillance activities, including the collection and analysis of epidemiological information relative to the frequency of tuberculosis infection, demographic and geographic distribution of tuberculosis cases, and trends pertaining to tuberculosis.

(3) The director shall maintain a tuberculosis registry to record the incidence of tuberculosis in this state.

(4) The director may appoint physicians, certified nurse-midwives, clinical nurse specialists, or certified nurse practitioners to serve as tuberculosis consultants for

geographic regions of the state specified by the director. Each tuberculosis consultant shall act in accordance with rules the director establishes and shall be responsible for advising and assisting physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, and other health care practitioners who participate in tuberculosis control activities and for reviewing medical records pertaining to the treatment provided to individuals with tuberculosis.

(B)(1) The director shall adopt rules establishing standards for the following:

(a) Performing tuberculosis screenings;

(b) Performing examinations of individuals who have been exposed to tuberculosis and individuals who are suspected of having tuberculosis;

(c) Providing treatment to individuals with tuberculosis;

(d) Preventing individuals with communicable tuberculosis from infecting other individuals;

(e) Performing laboratory tests for tuberculosis and studies of the resistance of tuberculosis to one or more drugs;

(f) Selecting laboratories that provide in a timely fashion the results of a laboratory test for tuberculosis. The standards shall include a requirement that first consideration be given to laboratories located in this state.

(2) Rules adopted pursuant to this section shall be adopted in accordance with Chapter 119. of the Revised Code and may be consistent with any recommendations or guidelines on tuberculosis issued by the United States centers for disease control and prevention or by the American thoracic society. The

rules shall apply to county or district tuberculosis control units, physicians, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners who examine and treat individuals for tuberculosis, and laboratories that perform tests for tuberculosis.

Sec. 3701.162. Any licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner practicing in this state, or the superintendent of any state or county institution, may receive without charge the quantities of antitoxin as the physician, nurse, or superintendent requires for the treatment or prevention of diphtheria in indigent persons, provided such antitoxin shall be used only for persons residing in the state, and that a sufficient supply is available for distribution.

Sec. 3701.243. (A) Except as provided in this section or section 3701.248 of the Revised Code, no person or agency of state or local government that acquires the information while providing any health care service or while in the employ of a health care facility or health care provider shall disclose or compel another to disclose any of the following:

(1) The identity of any individual on whom an HIV test is performed;

(2) The results of an HIV test in a form that identifies the individual tested;

(3) The identity of any individual diagnosed as having AIDS or an AIDS-related condition.

(B)(1) Except as provided in divisions (B)(2), (C), (D), and (F) of this section, the results of an HIV test or the identity of an individual on whom an HIV test is performed or

who is diagnosed as having AIDS or an AIDS-related condition may be disclosed only to the following:

(a) The individual who was tested or the individual's legal guardian, and the individual's spouse or any sexual partner;

(b) A person to whom disclosure is authorized by a written release, executed by the individual tested or by the individual's legal guardian and specifying to whom disclosure of the test results or diagnosis is authorized and the time period during which the release is to be effective;

(c) Any physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner who treats the individual;

(d) The department of health or a health commissioner to which reports are made under section 3701.24 of the Revised Code;

(e) A health care facility or provider that procures, processes, distributes, or uses a human body part from a deceased individual, donated for a purpose specified in Chapter 2108. of the Revised Code, and that needs medical information about the deceased individual to ensure that the body part is medically acceptable for its intended purpose;

(f) Health care facility staff committees or accreditation or oversight review organizations conducting program monitoring, program evaluation, or service reviews;

(g) A health care provider, emergency medical services worker, or peace officer who sustained a significant exposure to the body fluids of another individual, if that individual was tested pursuant to division (E)(6) of section 3701.242 of the

Revised Code, except that the identity of the individual tested shall not be revealed;

(h) To law enforcement authorities pursuant to a search warrant or a subpoena issued by or at the request of a grand jury, a prosecuting attorney, a city director of law or similar chief legal officer of a municipal corporation, or a village solicitor, in connection with a criminal investigation or prosecution.

(2) The results of an HIV test or a diagnosis of AIDS or an AIDS-related condition may be disclosed to a health care provider, or an authorized agent or employee of a health care facility or a health care provider, if the provider, agent, or employee has a medical need to know the information and is participating in the diagnosis, care, or treatment of the individual on whom the test was performed or who has been diagnosed as having AIDS or an AIDS-related condition.

This division does not impose a standard of disclosure different from the standard for disclosure of all other specific information about a patient to health care providers and facilities. Disclosure may not be requested or made solely for the purpose of identifying an individual who has a positive HIV test result or has been diagnosed as having AIDS or an AIDS-related condition in order to refuse to treat the individual. Referral of an individual to another health care provider or facility based on reasonable professional judgment does not constitute refusal to treat the individual.

(3) Not later than ninety days after November 1, 1989, each health care facility in this state shall establish a protocol to be followed by employees and individuals affiliated with the facility in making disclosures authorized by division

(B)(2) of this section. A person employed by or affiliated with a health care facility who determines in accordance with the protocol established by the facility that a disclosure is authorized by division (B)(2) of this section is immune from liability to any person in a civil action for damages for injury, death, or loss to person or property resulting from the disclosure.

(C)(1) Any person or government agency may seek access to or authority to disclose the HIV test records of an individual in accordance with the following provisions:

(a) The person or government agency shall bring an action in a court of common pleas requesting disclosure of or authority to disclose the results of an HIV test of a specific individual, who shall be identified in the complaint by a pseudonym but whose name shall be communicated to the court confidentially, pursuant to a court order restricting the use of the name. The court shall provide the individual with notice and an opportunity to participate in the proceedings if the individual is not named as a party. Proceedings shall be conducted in chambers unless the individual agrees to a hearing in open court.

(b) The court may issue an order granting the plaintiff access to or authority to disclose the test results only if the court finds by clear and convincing evidence that the plaintiff has demonstrated a compelling need for disclosure of the information that cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for disclosure against the privacy right of the individual tested and against any disservice to the public interest that might result from the disclosure, such as discrimination against the

individual or the deterrence of others from being tested.

(c) If the court issues an order, it shall guard against unauthorized disclosure by specifying the persons who may have access to the information, the purposes for which the information shall be used, and prohibitions against future disclosure.

(2) A person or government agency that considers it necessary to disclose the results of an HIV test of a specific individual in an action in which it is a party may seek authority for the disclosure by filing an in camera motion with the court in which the action is being heard. In hearing the motion, the court shall employ procedures for confidentiality similar to those specified in division (C)(1) of this section. The court shall grant the motion only if it finds by clear and convincing evidence that a compelling need for the disclosure has been demonstrated.

(3) Except for an order issued in a criminal prosecution or an order under division (C)(1) or (2) of this section granting disclosure of the result of an HIV test of a specific individual, a court shall not compel a blood bank, hospital blood center, or blood collection facility to disclose the result of HIV tests performed on the blood of voluntary donors in a way that reveals the identity of any donor.

(4) In a civil action in which the plaintiff seeks to recover damages from an individual defendant based on an allegation that the plaintiff contracted the HIV virus as a result of actions of the defendant, the prohibitions against disclosure in this section do not bar discovery of the results of any HIV test given to the defendant or any diagnosis that the defendant suffers from AIDS or an AIDS-related condition.

(D) The results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed to a federal, state, or local government agency, or the official representative of such an agency, for purposes of the medicaid program, the medicare program, or any other public assistance program.

(E) Any disclosure pursuant to this section shall be in writing and accompanied by a written statement that includes the following or substantially similar language: "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses."

(F) An individual who knows that the individual has received a positive result on an HIV test or has been diagnosed as having AIDS or an AIDS-related condition shall disclose this information to any other person with whom the individual intends to make common use of a hypodermic needle or engage in sexual conduct as defined in section 2907.01 of the Revised Code. An individual's compliance with this division does not prohibit a prosecution of the individual for a violation of division (B) of section 2903.11 of the Revised Code.

(G) Nothing in this section prohibits the introduction of evidence concerning an HIV test of a specific individual in a criminal proceeding.

Sec. 3701.245. (A) No state agency as defined in section 1.60 of the Revised Code, political subdivision, agency of local government, or private nonprofit corporation receiving state or local government funds shall refuse to admit as a patient, or to provide services to, any individual solely because ~~he~~ the individual refuses to consent to an HIV test or to disclose HIV test results.

(B) The prohibition contained in division (A) of this section does not prevent a physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or a person licensed to practice dentistry under Chapter 4715. of the Revised Code from referring an individual ~~he~~ the physician, nurse, or dentist has reason to believe may have AIDS or an AIDS-related condition to an appropriate health care provider or facility, if the referral is based on reasonable professional judgment and not solely on grounds of the refusal of the individual to consent to an HIV test or to disclose the result of an HIV test.

Sec. 3701.262. (A) As used in this section:

(1) "Physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(2) "Dentist" means a person who is licensed under Chapter 4715. of the Revised Code to practice dentistry.

(3) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(4) "Cancer" includes those diseases specified by rule of the director of health under division (B)(2) of this section.

(B) The director of health shall adopt rules in accordance

with Chapter 119. of the Revised Code to do all of the following:

(1) Establish the Ohio cancer incidence surveillance system required by section 3701.261 of the Revised Code;

(2) Specify the types of cancer and other tumorous and precancerous diseases to be reported to the department of health under division (D) of this section;

(3) Establish reporting requirements for information concerning diagnosed cancer cases as the director considers necessary to conduct epidemiologic surveys of cancer in this state;

(4) Establish standards that must be met by research projects to be eligible to receive information concerning individual cancer patients from the department of health.

(C) The department of health shall record in the registry all reports of cancer received by it. In the development and administration of the cancer registry the department may use information compiled by public or private cancer registries and may contract for the collection and analysis of, and research related to, the information recorded under this section.

(D)(1) Each physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer shall report each case of cancer to the department. Any person required to report pursuant to this section may elect to report to the department through an existing cancer registry if the registry meets the reporting standards established by the director and reports to the department.

(2) No person shall fail to make the cancer reports required by division (D)(1) of this section.

(E) All physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, dentists, hospitals, or persons providing diagnostic or treatment services to patients with cancer shall grant to the department or its authorized representative access to all records that identify cases of cancer or establish characteristics of cancer, the treatment of cancer, or the medical status of any identified cancer patient.

(F) The Arthur G. James cancer hospital and Richard J. Solove research institute of the Ohio state university, shall analyze and evaluate the cancer reports collected pursuant to this section. The department shall publish and make available to the public reports summarizing the information collected. Reports shall be made on a calendar year basis and published not later than ninety days after the end of each calendar year.

(G) Furnishing information, including records, reports, statements, notes, memoranda, or other information, to the department of health, either voluntarily or as required by this section, or to a person or governmental entity designated as a medical research project by the department, does not subject a physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, dentist, hospital, or person providing diagnostic or treatment services to patients with cancer to liability in an action for damages or other relief for furnishing the information.

(H) This section does not affect the authority of any person or facility providing diagnostic or treatment services to patients with cancer to maintain facility-based tumor

registries, in addition to complying with the reporting requirements of this section.

Sec. 3701.47. As used in sections 3701.46 to 3701.50 of the Revised Code, the standard tests for syphilis and gonorrhea are tests approved by the department of health, and shall be made at a laboratory approved to make such tests by the department. Such tests as are required shall, on request of the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner submitting the specimens, be made without charge by the department.

Sec. 3701.48. The approved laboratory making the standard tests for syphilis and gonorrhea shall make a report to the physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or health commissioner submitting the specimens. Such laboratory shall forthwith report any reactive syphilis test or positive gonorrhea test to the department of health on forms prescribed and furnished by the director of health.

Sec. 3701.50. Every physician, certified nurse-midwife, or certified nurse practitioner who attends any pregnant woman for conditions relating to pregnancy during the period of gestation shall take specimens of such woman at the time of first examination or within ten days thereof, and shall submit such specimens to an approved laboratory for standard syphilis and gonorrhea tests. If, in the opinion of the physician or nurse attending such woman, her condition does not permit the taking of specimens for submission to an approved laboratory, then no specimens shall be taken prior to delivery. If no specimens are taken prior to delivery because of the woman's condition, then such specimens shall be taken as soon after delivery as the

physician or nurse deems it advisable.

The health commissioner of the city or general health district, wherein any person required to be tested for syphilis and gonorrhea under this section or section 3701.49 of the Revised Code resides, may waive the requirements of such sections if the commissioner is satisfied by written affidavit or other written proof that the tests required are contrary to the tenets or practices of the religious creed of which the person is an adherent, and that the public health and welfare would not be injuriously affected by such waiver.

Sec. 3701.505. (A)(1) Each hospital and each freestanding birthing center shall do all of the following:

(a) Conduct a hearing screening on each newborn or infant born in the hospital or center unless the newborn or infant is transferred to another hospital;

(b) Promptly notify the newborn's or infant's attending physician, certified nurse-midwife, or certified nurse practitioner of the screening results;

(c) Notify the department of health of the screening results for each newborn or infant screened.

(2) A hearing screening conducted under this section shall be conducted under the direction of an audiologist ~~or~~, physician, certified nurse-midwife, or certified nurse practitioner or in collaboration with a physician, certified nurse-midwife, or certified nurse practitioner. Notwithstanding the licensure requirements of Chapter 4753. of the Revised Code, a screening may be conducted by a person who is not licensed under that chapter.

(3) Each hospital and freestanding birthing center shall

take the actions required by divisions (A)(1) and (2) of this section in accordance with the rules adopted under section 3701.508 of the Revised Code. A hospital or freestanding birthing center may commence taking these actions at any time after the effective date of the rules but not later than June 30, 2004, unless an extension is granted. The director may grant an extension to delay for up to one year after June 30, 2004, the requirement of compliance with the rules if the hospital or freestanding birthing center requesting the extension demonstrates justifiable cause for the extension. Justifiable cause may include having ordered but not yet received hearing screening equipment, ongoing efforts to obtain financing for the equipment, or any other cause accepted by the director.

(B) Any hospital or freestanding birthing center providing a hearing screening in accordance with division (A) of this section shall be reimbursed by the department of health at a rate determined by the director of health, if both of the following are the case:

(1) The screening is performed before the newborn or infant is discharged from the hospital or freestanding birthing center.

(2) The parent, guardian, or custodian is financially unable to pay for the hearing screening and the hospital or freestanding birthing center is not reimbursed by a third-party payer as determined pursuant to rules adopted under section 3701.508 of the Revised Code.

(C) A hospital, clinic, or other health care facility at which a hearing evaluation is performed on a newborn or infant shall report the results of the evaluation to the attending physician, certified nurse-midwife, or certified nurse

practitioner of the newborn or infant.

Sec. 3701.5010. (A) As used in this section:

(1) "Critical congenital heart defects screening" means the identification of a newborn that may have a critical congenital heart defect, through the use of a physiologic test.

(2) "Freestanding birthing center" has the same meaning as in section 3702.141 of the Revised Code.

(3) "Hospital," "maternity unit," "newborn," and "physician" have the same meanings as in section 3701.503 of the Revised Code.

(4) "Pulse oximetry" means a noninvasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

(B) Except as provided in division (C) of this section, each hospital and each freestanding birthing center shall conduct a critical congenital heart defects screening on each newborn born in the hospital or center, unless the newborn is being transferred to another hospital. The screening shall be performed before discharge. If the newborn is transferred to another hospital, that hospital shall conduct the screening when determined to be medically appropriate. The hospital or center shall promptly notify the newborn's parent, guardian, or custodian and attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner of the screening results.

(C) A hospital or freestanding birthing center shall not conduct a critical congenital heart defects screening if the newborn's parent objects on the grounds that the screening conflicts with the parent's religious tenets and practices.

(D)(1) The director of health shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards and procedures for the screening required by this section, including all of the following:

(a) Designating the person or persons responsible for causing the screening to be performed;

(b) Specifying screening equipment and methods;

(c) Identifying when the screening should be performed;

(d) Providing notice of the required screening to the newborn's parent, guardian, or custodian;

(e) Communicating screening results to the newborn's parent, guardian, or custodian and attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner;

(f) Reporting screening results to the department of health;

(g) Referring newborns that receive abnormal screening results to providers of follow-up services.

(2) In adopting rules under division (D)(1)(b) of this section, the director shall specify screening equipment and methods that include the use of pulse oximetry or other screening equipment and methods that detect critical congenital heart defects at least as accurately as pulse oximetry. The screening equipment and methods specified shall be consistent with recommendations issued by nationally recognized organizations that advocate on behalf of medical professionals or individuals with cardiovascular conditions.

Sec. 3701.59. (A) As used in this section:

(1) "Addiction services" and "alcohol and drug addiction services" have the same meanings as in section 5119.01 of the Revised Code.

(2) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

(B) Any of the following health care professionals who attends a pregnant woman for conditions relating to pregnancy before the end of the twentieth week of pregnancy and who has reason to believe that the woman is using or has used a controlled substance in a manner that may place the woman's fetus in jeopardy shall encourage the woman to enroll in a drug treatment program offered by a provider of addiction services or alcohol and drug addiction services:

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

(2) Registered nurses, including certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners, and licensed practical nurses licensed under Chapter 4723. of the Revised Code;

(3) Physician assistants licensed under Chapter 4730. of the Revised Code.

(C) A health care professional is immune from civil liability and is not subject to criminal prosecution with regard to both of the following:

(1) Failure to recognize that a pregnant woman has used or is using a controlled substance in a manner that may place the woman's fetus in jeopardy;

(2) Any action taken in good faith compliance with this section.

Sec. 3701.60. Every hospital agency, as defined in section 140.01 of the Revised Code, may offer a uterine cytologic examination for cancer to every female in-patient twenty-one years of age or over unless contrary orders are given by the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner or unless the examination has been performed within the preceding year. Any female in-patient may refuse the examination. If the examination is offered, the hospital agency shall maintain records to show the examination results or that the examination was refused.

Sec. 3701.74. (A) As used in this section and section 3701.741 of the Revised Code:

(1) "Ambulatory care facility" means a facility that provides medical, diagnostic, or surgical treatment to patients who do not require hospitalization, including a dialysis center, ambulatory surgical facility, cardiac catheterization facility, diagnostic imaging center, extracorporeal shock wave lithotripsy center, home health agency, inpatient hospice, birthing center, radiation therapy center, emergency facility, and an urgent care center. "Ambulatory care facility" does not include the private office of a physician, advanced practice registered nurse, or dentist, whether the office is for an individual or group practice.

(2) "Chiropractor" means an individual licensed under Chapter 4734. of the Revised Code to practice chiropractic.

(3) "Emergency facility" means a hospital emergency department or any other facility that provides emergency medical

services.

(4) "Health care practitioner" means all of the following:

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

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

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

(d) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code;

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

(f) A physician;

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

(h) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;

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

(j) A chiropractor;

(k) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;

(l) A speech-language pathologist or audiologist licensed

under Chapter 4753. of the Revised Code;

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

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

(o) A licensed professional clinical counselor, licensed professional counselor, social worker, independent social worker, independent marriage and family therapist, or marriage and family therapist licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code;

(p) A dietitian licensed under Chapter 4759. of the Revised Code;

(q) A respiratory care professional licensed under Chapter 4761. of the Revised Code;

(r) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.

(5) "Health care provider" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner.

(6) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(7) "Long-term care facility" means a nursing home, residential care facility, or home for the aging, as those terms are defined in section 3721.01 of the Revised Code; a residential facility licensed under section 5119.34 of the Revised Code that provides accommodations, supervision, and

personal care services for three to sixteen unrelated adults; a nursing facility, as defined in section 5165.01 of the Revised Code; a skilled nursing facility, as defined in section 5165.01 of the Revised Code; and an intermediate care facility for individuals with intellectual disabilities, as defined in section 5124.01 of the Revised Code.

(8) "Medical record" means data in any form that pertains to a patient's medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient's health care treatment.

(9) "Medical records company" means a person who stores, locates, or copies medical records for a health care provider, or is compensated for doing so by a health care provider, and charges a fee for providing medical records to a patient or patient's representative.

(10) "Patient" means either of the following:

(a) An individual who received health care treatment from a health care provider;

(b) A guardian, as defined in section 1337.11 of the Revised Code, of an individual described in division (A)(10)(a) of this section.

(11) "Patient's personal representative" means a minor patient's parent or other person acting in loco parentis, a court-appointed guardian, or a person with durable power of attorney for health care for a patient, the executor or administrator of the patient's estate, or the person responsible for the patient's estate if it is not to be probated. "Patient's personal representative" does not include an insurer authorized under Title XXXIX of the Revised Code to do the business of

sickness and accident insurance in this state, a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code, or any other person not named in this division.

(12) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

(13) "Physician" means a person authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(14) "Authorized person" means a person to whom a patient has given written authorization to act on the patient's behalf regarding the patient's medical record.

(15) "Advanced practice registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

(B) A patient, a patient's personal representative, or an authorized person who wishes to examine or obtain a copy of part or all of a medical record shall submit to the health care provider a written request signed by the patient, personal representative, or authorized person dated not more than one year before the date on which it is submitted. The request shall indicate whether the copy is to be sent to the requestor, sent to a physician, advanced practice registered nurse, or chiropractor, or held for the requestor at the office of the health care provider. Within a reasonable time after receiving a request that meets the requirements of this division and includes sufficient information to identify the record requested, a health care provider that has the patient's medical records shall permit the patient to examine the record during

regular business hours without charge or, on request, shall provide a copy of the record in accordance with section 3701.741 of the Revised Code, except that if a physician, advanced practice registered nurse, psychologist, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, or chiropractor who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, the health care provider shall provide the record to a physician, advanced practice registered nurse, psychologist, licensed professional clinical counselor, licensed professional counselor, independent social worker, social worker, independent marriage and family therapist, marriage and family therapist, or chiropractor designated by the patient. The health care provider shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of the patient's record.

(C) If a health care provider fails to furnish a medical record as required by division (B) of this section, the patient, personal representative, or authorized person who requested the record may bring a civil action to enforce the patient's right of access to the record.

(D)(1) This section does not apply to medical records whose release is covered by section 173.20 or 3721.13 of the Revised Code, by Chapter 1347., 5119., or 5122. of the Revised Code, by 42 C.F.R. part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," or by 42 C.F.R. 483.10.

(2) Nothing in this section is intended to supersede the confidentiality provisions of sections 2305.24, 2305.25,

2305.251, and 2305.252 of the Revised Code.

Sec. 3701.76. (A) The director of health shall establish and maintain a statewide public information campaign on the effects of diethylstilbestrol or other nonsteroidal synthetic estrogens for the purpose of educating the public concerning the potential hazards related to exposure to diethylstilbestrol or other nonsteroidal synthetic estrogens and encouraging persons exposed to diethylstilbestrol or other nonsteroidal synthetic estrogens, including those exposed before birth, to seek medical attention for the identification and treatment of any conditions resulting from this exposure.

(B) The director shall maintain a registry of hospitals, clinics, physicians, clinical nurse specialists, certified nurse practitioners, or other health care providers to whom the director shall refer persons who make inquiries to the department of health regarding possible exposure to diethylstilbestrol or other nonsteroidal synthetic estrogens. In order to be eligible for listing in the registry, a health care provider shall make an application to the director, and shall have the necessary experience, facilities, and equipment to make examinations for possible effects of diethylstilbestrol or other nonsteroidal synthetic estrogens.

(C) The director shall maintain a registry of persons who have been exposed to diethylstilbestrol or other nonsteroidal synthetic estrogens, including persons exposed before birth, for the purpose of studying and monitoring conditions caused by exposure to diethylstilbestrol or other nonsteroidal synthetic estrogen. No person shall be listed in the registry without the director's consent.

(D) The director shall make an annual report to the

general assembly on the effectiveness of the programs established under this section, and shall make recommendations concerning the programs and possible legislation relating to them.

(E) No insurance company doing business under Title XXXIX and no health insuring 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. 3705.01. As used in this chapter:

(A) "Live birth" means the complete expulsion or extraction from its mother of a product of human conception that after such expulsion or extraction breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

(B)(1) "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which after such expulsion or extraction does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

(2) "Stillborn" means that an infant of at least twenty

weeks of gestation suffered a fetal death.

(C) "Dead body" means a human body or part of a human body from the condition of which it reasonably may be concluded that death recently occurred.

(D) "Physician" means a person licensed pursuant to Chapter 4731. of the Revised Code to practice medicine or surgery or osteopathic medicine and surgery.

(E) "Attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner" means the physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner in charge of the patient's care for the illness or condition that resulted in death.

(F) "Institution" means any establishment, public or private, that provides medical, surgical, or diagnostic care or treatment, or domiciliary care, to two or more unrelated individuals, or to persons committed by law.

(G) "Funeral director" has the meaning given in section 4717.01 of the Revised Code.

(H) "State registrar" means the head of the office of vital statistics in the department of health.

(I) "Medical certification" means completion of the medical certification portion of the certificate of death or fetal death as to the cause of death or fetal death.

(J) "Final disposition" means the interment, cremation, removal from the state, donation, or other authorized disposition of a dead body or a fetal death.

(K) "Interment" means the final disposition of the remains

of a dead body by burial or entombment.

(L) "Cremation" means the reduction to ashes of a dead body.

(M) "Donation" means gift of a dead body to a research institution or medical school.

(N) "System of vital statistics" means the registration, collection, preservation, amendment, and certification of vital records, the collection of other reports required by this chapter, and activities related thereto.

(O) "Vital records" means certificates or reports of birth, death, fetal death, marriage, divorce, dissolution of marriage, annulment, and data related thereto and other documents maintained as required by statute.

(P) "File" means the presentation of vital records for registration by the office of vital statistics.

(Q) "Registration" means the acceptance by the office of vital statistics and the incorporation of vital records into its official records.

(R) "Birth record" means a birth certificate that has been registered with the office of vital statistics; or, if registered prior to March 16, 1989, with the division of vital statistics; or, if registered prior to the establishment of the division of vital statistics, with the department of health or a local registrar.

(S) "Certification of birth" means a document issued by the director of health or state registrar or a local registrar under division (B) of section 3705.23 of the Revised Code.

(T) "Certified nurse-midwife" has the same meaning as in

section 4723.01 of the Revised Code.

Sec. 3705.15. Whoever claims to have been born in this state, and whose registration of birth is not recorded, or has been lost or destroyed, or has not been properly and accurately recorded, may file an application for registration of birth or correction of the birth record in the probate court of the county of the person's birth or residence or the county in which the person's mother resided at the time of the person's birth. If the person is a minor the application shall be signed by either parent or the person's guardian.

(A) An application to correct a birth record shall set forth all of the available facts required on a birth record and the reasons for making the application, and shall be verified by the applicant. Upon the filing of the application the court may fix a date for a hearing, which shall not be less than seven days after the filing date. The court may require one publication of notice of the hearing in a newspaper of general circulation in the county at least seven days prior to the date of the hearing. The application shall be supported by the affidavit of the physician or certified nurse-midwife in attendance. If an affidavit is not available, the application shall be supported by the affidavits of at least two persons having knowledge of the facts stated in the application, by documentary evidence, or by other evidence the court deems sufficient.

The probate judge, if satisfied that the facts are as stated, shall make an order correcting the birth record, except that in the case of an application to correct the date of birth, the judge shall make the order only if any date shown as the date the ~~attending~~ physician or certified nurse-midwife in

attendance signed the birth record or the date the local registrar filed the record is consistent with the corrected date of birth. If supported by sufficient evidence, the judge may include in an order correcting the date of birth an order correcting the date the ~~attending~~ physician or certified nurse-midwife in attendance signed the birth record or the date the local registrar filed the record.

(B) An application of a person whose registration of birth is not recorded, or has been lost or destroyed, must comply with division (A) of this section. Upon the filing of the application the court may fix a date for a hearing, which shall be not less than seven days after the filing date. The court may require one publication of notice of the hearing in a newspaper of general circulation in the county at least seven days prior to the date of the hearing. The probate judge, or a special master commissioner, shall personally examine the applicant in open court and shall take sworn testimony on the application which shall include the testimony of at least two credible witnesses, or clear and convincing documentary evidence. The probate court may conduct any necessary investigation, and shall permit the applicant and all witnesses presented to be cross-examined by any interested person, or by the prosecuting attorney of the county. When a witness or the applicant is unable to appear in open court, the court may authorize the taking of the witness's or applicant's deposition. The court may cause a complete record to be taken of the hearing, shall file it with the other papers in the case, and may order the transcript of the testimony to be filed and made a matter of record in the court. Upon being satisfied that notice of the hearing on the application has been given by publication, if required, and that the claim of the applicant is true, the court shall make a finding upon all the

facts required on a birth record, and shall order the registration of the birth of the applicant. The court shall forthwith transmit to the director of health a certified summary of its finding and order, on a form prescribed by the director, who shall file it in the records of the central division of vital statistics.

(C) The director may forward a copy of the summary for the registration of a birth in the director's office to the appropriate local registrar of vital statistics.

A certified copy of the birth record corrected or registered by court order as provided in this section shall have the same legal effect for all purposes as an original birth record.

The application, affidavits, findings, and orders of the court, together with a transcript of the testimony if ordered by the court, for the correction of a birth record or for the registration of a birth, shall be recorded in a book kept for that purpose and shall be properly indexed. The book shall become a part of the records of the probate court.

(D)(1) Except as provided in division (D)(2) of this section, whenever a correction is ordered in a birth record under division (A) of this section, the court ordering the correction shall forthwith forward to the department of health a certified copy of the order containing such information as will enable the department to prepare a new birth record. Thereupon, the department shall record a new birth record using the correct information supplied by the court and the new birth record shall have the same overall appearance as the original record which would have been issued under this chapter. Where handwriting is required to effect that appearance, the department shall supply

it. Upon the preparation and filing of the new birth record, the original birth record and index references shall cease to be a public record. The original record and all other information pertaining to it shall be placed in an envelope which shall be sealed by the department, and its contents shall not be open to inspection or copy unless so ordered by the probate court of the county that ordered the correction.

The department shall promptly forward a copy of the new birth record to the local registrar of vital statistics of the district in which the birth occurred and the local registrar shall file a copy of the new birth record along with and in the same manner as the other copies of birth records in the local registrar's possession. All copies of the original birth record, as well as any and all other papers, documents, and index references pertaining to it, in the possession of the local registrar shall be destroyed. The probate court shall retain permanently in the file of its proceedings such information as will enable the court to identify both the original birth record and the new birth record.

The new birth record, as well as any certified copies of it when properly authenticated by a duly authorized person, shall be prima-facie evidence in all courts and places of the facts therein stated.

(2) If the correction ordered in the birth record under division (A) of this section involves a change in the date of birth of the applicant and the department of health determines that the corrected date of birth is inconsistent with the date shown as the date the ~~attending~~ physician or certified nurse-midwife in attendance signed the birth record or the date the local registrar filed the record, the department shall request

that the court reconsider the order and, if appropriate, make a new order in which the dates are consistent. If the court does not make a new order within a reasonable time, instead of issuing a new birth record, the department shall file and record the court's order in the same manner as other birth records and make a cross-reference on the original and on the corrected record.

(E) The probate court shall assess costs of registering a birth or correcting a birth record under this section against the person who makes application for the registration or correction.

Sec. 3705.16. (A) For purposes of this section notwithstanding section 3705.01 of the Revised Code, "fetal death" does not include death of the product of human conception prior to twenty weeks of gestation.

(B) Each death or fetal death that occurs in this state shall be registered with the local registrar of vital statistics of the district in which the death or fetal death occurred, by the funeral director or other person in charge of the final disposition of the remains. The personal and statistical information in the death or fetal death certificate shall be obtained from the best qualified persons or sources available, by the funeral director or other person in charge of the final disposition of the remains. The statement of facts relating to the disposition of the body and information relative to the armed services referred to in section 3705.19 of the Revised Code shall be signed by the funeral director or other person in charge of the final disposition of the remains.

~~(C)~~ (C)(1) The funeral director or other person in charge of the final disposition of the remains shall present the death

or fetal death certificate to the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner of the decedent, the coroner, or the medical examiner, as appropriate for certification of the cause of death~~. If~~, in accordance with the following:

(a) If a death or fetal death occurs under any circumstances mentioned in section 313.12 of the Revised Code, the coroner in the county in which the death occurs, or a deputy coroner, medical examiner, or deputy medical examiner serving in ~~an equivalent~~ a capacity equivalent to the coroner, shall certify the cause of death unless that death was reported to the coroner, deputy coroner, medical examiner, or deputy medical examiner and that person, after a preliminary examination, declined to assert jurisdiction with respect to the death or fetal death. ~~A~~

(b) The following persons may certify only those deaths that occur under natural circumstances:

(i) A physician other than the coroner in the county in which a death or fetal death occurs~~,~~ or a physician other than a deputy coroner, medical examiner, or deputy medical examiner serving in ~~an~~ a capacity equivalent~~ capacity, may certify only those deaths that occur under natural circumstances~~ to the coroner;

(ii) A certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner.

(2) The medical certificate of death shall be completed and signed by the attending physician~~ who attended~~, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner of the decedent or by the coroner or medical

examiner, as appropriate, within forty-eight hours after the death or fetal death. ~~A~~ In the case of a coroner or medical examiner, the coroner or medical examiner may satisfy the requirement of signing a medical certificate showing the cause of death or fetal death as pending either by stamping it with a stamp of the coroner's or medical examiner's signature or by signing it in the coroner's or medical examiner's own hand, but the coroner or medical examiner shall sign any other medical certificate of death or supplementary medical certification in the coroner's or medical examiner's own hand.

(D) Any death certificate registered pursuant to this section shall contain the social security number of the decedent, if available. A social security number obtained under this section is a public record under section 149.43 of the Revised Code.

Sec. 3705.17. The body of a person whose death occurs in this state shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of by a funeral director until a burial permit is issued by a local registrar or sub-registrar of vital statistics. No such permit shall be issued by a local registrar or sub-registrar until a satisfactory death, fetal death, or provisional death certificate is filed with the local registrar or sub-registrar. When the medical certification as to the cause of death cannot be provided by the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner or by the coroner prior to burial, for sufficient cause, as determined by rule of the director of health, the funeral director may file a provisional death certificate with the local registrar or sub-registrar for the purpose of securing a burial or burial-transit permit. When the funeral director files a provisional death certificate to

secure a burial or burial-transit permit, the funeral director shall file a satisfactory and complete death certificate within five days after the date of death. The director of health, by rule, may provide additional time for filing a satisfactory death certificate. A burial permit authorizing cremation shall not be issued upon the filing of a provisional certificate of death.

When a funeral director or other person obtains a burial permit from a local registrar or sub-registrar, the registrar or sub-registrar shall charge a fee of three dollars for the issuance of the burial permit. Two dollars and fifty cents of each fee collected for a burial permit shall be paid into the state treasury to the credit of the division of real estate in the department of commerce to be used by the division in discharging its duties prescribed in Chapter 4767. of the Revised Code and the Ohio cemetery dispute resolution commission created by section 4767.05 of the Revised Code. A local registrar or sub-registrar shall transmit payments of that portion of the amount of each fee collected under this section to the treasurer of state on a quarterly basis or more frequently, if possible. The director of health, by rule, shall provide for the issuance of a burial permit without the payment of the fee required by this section if the total cost of the burial will be paid by an agency or instrumentality of the United States, the state or a state agency, or a political subdivision of the state.

The director of commerce may by rule adopted in accordance with Chapter 119. of the Revised Code reduce the total amount of the fee required by this section and that portion of the amount of the fee required to be paid to the credit of the division of real estate for the use of the division and the Ohio cemetery

dispute resolution commission, if the director determines that the total amount of funds the fee is generating at the amount required by this section exceeds the amount of funds the division of real estate and the commission need to carry out their powers and duties prescribed in Chapter 4767. of the Revised Code.

No person in charge of any premises in which interments or cremations are made shall inter or cremate or otherwise dispose of a body, unless it is accompanied by a burial permit. Each person in charge of a cemetery, crematory, or other place of disposal shall indorse upon a burial permit the date of interment, cremation, or other disposal and shall retain such permits for a period of at least five years. The person in charge shall keep an accurate record of all interments, cremations, or other disposal of dead bodies, made in the premises under the person's charge, stating the name of the deceased person, place of death, date of burial, cremation, or other disposal, and name and address of the funeral director. Such record shall at all times be open to public inspection.

Sec. 3705.22. Whenever it is alleged that the facts stated in any birth, fetal death, or death record filed in the department of health are not true, the director may require satisfactory evidence to be presented in the form of affidavits, amended records, or certificates to establish the alleged facts. When established, the original record or certificate shall be supplemented by the affidavit or the amended certificate or record information.

An affidavit in a form prescribed by the director shall be sworn to by a person having personal knowledge of the matter sought to be corrected. Medical certifications contained on

fetal death or death records may be corrected only by the person whose name appears on the original record as attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner or by the coroner of the county in which the death occurred.

The amended birth record shall be signed by the person who attended the birth and the informant or informants whose names appear on the original record. The amended death or fetal death record shall be signed by the following persons whose names appear on the original record: the physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or coroner~~,~~; funeral director~~,~~; and informant ~~whose names appear on the original record~~.

An affidavit or amended record for the correction of the given name of a person shall have the signature of the person, if the person is age eighteen or older, or of both parents if the person is under eighteen, except that in the case of a child born out of wedlock, the mother's signature will suffice; in the case of the death or incapacity of either parent, the signature of the other parent will suffice; in the case of a child not in the custody of ~~his~~ the child's parents, the signature of the guardian or agency having the custody of the child will suffice; and in the case of a child whose parents are deceased, the signature of another person who knows the child will suffice.

Once a correction or amendment of an item is made on a vital record, that item shall not be corrected or amended again except on the order of a court of this state or the request of a court of another state or jurisdiction.

The director may refuse to accept an affidavit or amended certificate or record that appears to be submitted for the

purpose of falsifying the certificate or record.

A certified copy of a certificate or record issued by the department of health shall show the information as originally given and the corrected information, except that an electronically produced copy need indicate only that the certificate or record was corrected and the item that was corrected.

Sec. 3705.29. (A) No person shall do any of the following:

(1) Purposely make any false statement in a certificate, record, or report required by this chapter or in an application or amendment of it, or purposely supply false information with the intent that that information be used in the preparation of any such report, record, or certificate, or amendment of it;

(2) Without lawful authority and with intent to deceive, counterfeit, alter, amend, or mutilate any certificate, record, or report required by this chapter or any certified copy of it;

(3) Purposely obtain, possess, use, sell, furnish, or attempt to obtain, possess, use, sell, or furnish to another for the purpose of deception any certificate, record, or report required by this chapter or any certified copy of it, or any certificate, record, or report that is counterfeit, altered, or amended or false in whole or part;

(4) Purposely obtain, possess, use, sell, furnish, or attempt to obtain, possess, use, sell, or furnish to another for the purpose of deception any certificate, record, or report required by this chapter, or any certified copy of it, that relates to the birth of another person, whether living or dead;

(5) Without lawful authority, possess any certificate, record, or report required by this chapter or any copy of such a

certificate, record, or report, knowing it to have been stolen or otherwise unlawfully obtained.

(B) No person employed by the office of vital statistics or a local registrar shall purposely furnish or possess a birth record or certified copy of a birth record with intent that it be used for deception.

(C) No person shall do any of the following:

(1) Purposely refuse to provide information required by this chapter or rules adopted under it;

(2) Purposely transport out of this state or accept for interment or other disposition a dead body without a permit required by this chapter;

(3) Knowingly prepare, issue, sell, or give any record or certificate that is alleged to be an original vital record or a certified copy of a vital record if the person knows or has reason to know that it is not an original vital record or a certified copy of a vital record;

(4) Refuse to comply with the requirements of this chapter or violate any of the provisions of this chapter.

(D) No officer or employee of the department of health shall knowingly reveal or provide any information contained in an adoption file maintained by the department under section 3705.12, 3705.121, 3705.122, 3705.123, or 3705.124 of the Revised Code to any person, or knowingly reveal or provide the contents of an adoption file to any person, unless authorized to do so by section 3705.126 of the Revised Code.

(E) If a death, or a fetal death of at least twenty weeks of gestation, occurs under any circumstances mentioned in

section 313.12 of the Revised Code, the coroner of the county in which the death or fetal death occurs, or a deputy coroner, medical examiner, or deputy medical examiner serving in ~~an equivalent~~ a capacity equivalent to the coroner, shall certify the cause of that death unless the death was reported to the coroner, deputy coroner, medical examiner, or deputy medical examiner and that person, after a preliminary examination, declined to assert jurisdiction with respect to the death or fetal death.

(F) No physician other than the coroner in the county in which a death, or a fetal death of at least twenty weeks of gestation, occurs~~,~~ or a physician other than a deputy coroner, medical examiner, or deputy medical examiner serving in ~~an equivalent~~ a capacity equivalent to the coroner, and no certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, may certify any death or fetal death that occurs under any circumstances other than natural.

(G) If a death, or a fetal death of at least twenty weeks of gestation, occurs under any circumstances mentioned in section 313.12 of the Revised Code, no person shall knowingly present a death or fetal death certificate for the purpose of obtaining certification of the cause of death to any ~~physician~~ person other than the coroner in the county in which the death or fetal death occurred~~,~~ or ~~to~~ a deputy coroner, medical examiner, or deputy medical examiner serving in ~~an equivalent~~ a capacity equivalent to the coroner, unless that death or fetal death was reported to the coroner, deputy coroner, medical examiner, or deputy medical examiner and that person, after a preliminary examination, declined to assert jurisdiction with respect to the death or fetal death.

(H) No person, with intent to defraud or knowing that the person is facilitating a fraud, shall do either of the following:

(1) Certify a cause of death in violation of the prohibition of division (E) or (F) of this section;

(2) Obtain or attempt to obtain a certification of the cause of a death or fetal death in violation of the prohibition of division (G) of this section.

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

(1) "Freestanding birthing center" has the same meaning as in section 3702.141 of the Revised Code.

(2) "Hospital" means a hospital classified under section 3701.07 of the Revised Code as a general hospital or children's hospital.

(3) "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, <u>certified nurse-midwife, clinical nurse specialist, certified nurse practitioner,</u> 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 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 licensed as a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner; 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~~ 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 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. 3715.02. (A) The director of agriculture shall adopt rules in accordance with Chapter 119. of the Revised Code that establish, when otherwise not established by a law of this state, definitions for a food or class of food and standards for the following items as they pertain to the food or class of food:

(1) Quality, identity, purity, grade, and strength;

(2) Packaging and labeling;

(3) Food processing equipment;

(4) Processing procedures;

(5) Fill of containers.

The standards and definitions, where applicable, shall conform to the standards for foods adopted by the United States department of agriculture and the United States food and drug administration. Portions of Titles 7, 9, and 21 of the Code of Federal Regulations or the regulations adopted for the enforcement of the "Federal Food, Drug, and Cosmetic Act," 52 Stat. 1040 (1938), 21 U.S.C.A. 301 et seq., as amended, may be adopted as rules by referencing the federal regulations, subject to the approval of the joint committee on agency rule review.

In adopting rules that establish definitions and standards

of identity for a food or class of food in which only a limited number of optional ingredients are permitted, the director shall designate the optional ingredients that must be listed on the label.

(B) The director shall adopt rules in accordance with Chapter 119. of the Revised Code that establish procedures for the performance of sample analyses of food, food additives, and food packaging materials. The circumstances under which a sample analysis may be required include the following:

(1) When a food, food additive, or food packaging material is the subject of a consumer complaint;

(2) When requested by a consumer after a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has isolated an organism from the consumer as the physician's or nurse's patient;

(3) When a food, food additive, or food packaging material is suspected of having caused an illness;

(4) When a food, food additive, or food packaging material is suspected of being adulterated or misbranded;

(5) When a food, food additive, or food packaging material is subject to verification of food labeling and standards of identity;

(6) At any other time the director considers a sample analysis necessary.

(C) In foodborne illness investigations, the director of agriculture shall cooperate and consult with the public health laboratory maintained by the department of health under section 3701.22 of the Revised Code.

(D) The director or the director's designee shall do all of the following:

(1) Inspect drugs, food, or drink manufactured, stored, or offered for sale in this state;

(2) Prosecute or cause to be prosecuted each person engaged in the unlawful manufacture or sale of an adulterated drug or article of food or drink, in violation of law;

(3) Enforce all laws against fraud, adulteration, or impurities in drugs, foods, or drinks and unlawful labeling within this state.

(E) The director may appoint or contract for one or more qualified persons to enforce the provisions of this chapter.

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<u>, including advanced practice registered nurses,</u> and licensed practical nurses licensed under Chapter 4723. of the Revised Code;

(3) Physician assistants authorized to practice 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 donating, giving, accepting, or dispensing drugs under the drug repository program, all of the following apply:

(1) Any person, including a pharmacy, drug manufacturer, or health care facility, or any government entity that donates or gives drugs to the drug repository program 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 dispenses 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 or dispenses drugs under the program on behalf of a pharmacy, hospital, or nonprofit clinic, 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 and the director of health 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 or director constitutes willful

and wanton misconduct.

(C) In addition to the immunity granted under division (B)(1) of this section, any person, including a pharmacy, drug manufacturer, or health care facility, and any government entity that donates or gives drugs to the program shall not be subject to criminal prosecution for the donation, giving, acceptance, or dispensing of drugs under the program, unless an action or omission of the person or government entity does not comply with the provisions of this chapter or the rules adopted under it.

(D) In the case of a drug manufacturer, the immunities granted under divisions (B)(1) and (C) of this section apply with respect to any drug manufactured by the drug manufacturer that is donated or given by any person or government entity under the program, including but not limited to liability for failure to transfer or communicate product or consumer information or the expiration date of the drug 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 care of pediatric respite 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, 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.

(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, 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 physically impaired but mentally alert resident, 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<u>, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner</u>;

(c) Unless the individual's personal physician<u>, certified</u>

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 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, 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, 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, including an advanced practice registered nurse, or licensed practical nurse licensed under Chapter 4723. of the Revised Code;

(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, 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) "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, 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, 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 sanitarian or sanitarian-in-training under Chapter 4736. 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 physicians<u>, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners</u>;

(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, 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 or certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner within the preceding calendar year 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;

(5) A representative of the development services agency;

(6) A representative of the Ohio apartment owner's association;

(7) A representative of the Ohio healthy homes network;

(8) A representative of the Ohio environmental health association;

(9) An Ohio representative of the American coatings association;

(10) A representative from Ohio realtors;

(11) A representative of the Ohio housing finance agency;

(12) A physician knowledgeable in the field of lead poisoning prevention;

(13) A certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner knowledgeable in the field of lead poisoning prevention;

(14) 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 ~~the effective date of this amendment~~ 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) "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 office of thrift supervision, the national credit union administration, or the office of the comptroller of the currency.

(W)(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, a clinical nurse specialist who is certified as a psychiatric-mental health CNS by the American nurses credentialing center, or a certified nurse practitioner who is certified as a psychiatric-mental health NP by the American nurses credentialing center 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, clinical nurse specialist, or certified nurse practitioner.

Sec. 3923.52. (A) As used in this section and section 3923.53 of the Revised Code, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) Every policy of individual or group sickness and accident insurance that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician or a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (D)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in

an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (D)(1) of this section, except for approved deductibles and copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

(G) This section does not apply to any policy that

provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, or other policy that offers only supplemental benefits.

Sec. 3923.53. (A) Every public employee benefit plan that is established or modified in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(B) The benefits provided under division (A)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician or a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(C) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include

digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (C)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (A)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (A)(1) of this section, the total benefit for a screening mammography shall not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (C)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (C)(1) of this section, except for approved deductibles and copayments.

(D) The benefits provided under division (A)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology

mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The benefits provided under division (A)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3923.54. (A) As used in this section, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) Each employer in this state that provides, in whole or in part, health care benefits for its employees under a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code shall also provide to its employees benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) An employer may comply with division (B) of this section in any of the following ways:

(1) By providing the benefits under a health insuring corporation contract issued in accordance with Chapter 1751. of the Revised Code or a policy of sickness and accident insurance issued in accordance with Chapter 3923. of the Revised Code;

(2) By reimbursing the employee for the direct health care provider charges associated with receipt of the covered service;

(3) By making any other arrangement that provides the benefits described in division (B) of this section.

(D) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician or a certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(E) As used in this division, "medicare reimbursement rate" means the reimbursement rate paid in this state under the medicare program for screening mammography that does not include

digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

(1) Subject to divisions (E)(2) and (3) of this section, if a provider, hospital, or other health care facility provides a service that is a component of the screening mammography benefit in division (B)(1) of this section and submits a separate claim for that component, a separate payment shall be made to the provider, hospital, or other health care facility in an amount that corresponds to the ratio paid by medicare in this state for that component.

(2) Regardless of whether separate payments are made for the benefit provided under division (B)(1) of this section, the total benefit for a screening mammography need not exceed one hundred thirty per cent of the medicare reimbursement rate in this state for screening mammography. If there is more than one medicare reimbursement rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty per cent of the lowest medicare reimbursement rate in this state.

(3) The benefit paid in accordance with division (E)(1) of this section shall constitute full payment. No provider, hospital, or other health care facility shall seek or receive compensation in excess of the payment made in accordance with division (E)(1) of this section, except for approved deductibles and copayments.

(F) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology

mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 3923.55. (A) As used in this section and section 3923.56 of the Revised Code:

(1) "Child health supervision services" means periodic review of a child's physical and emotional status performed by a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, by a health care professional under the supervision of a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, or, in the case of hearing screening, by an individual acting in accordance with section 3701.505 of the Revised Code.

(2) "Periodic review" means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

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

(B) Notwithstanding section 3901.71 of the Revised Code, each policy of individual or group sickness and accident insurance delivered, issued for delivery, or renewed in this state on or after ~~the effective date of this amendment~~ November

24, 1995, that provides coverage for family members of the insured shall provide, with respect to that coverage, that any benefits applicable for children shall include benefits for child health supervision services from the moment of birth until age nine.

(C) A policy that provides the benefits described in division (B) of this section may limit the benefits to cover only the expenses of child health supervision services that are performed during the course of any one visit by one physician ~~or~~, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner or by a health care professional under the supervision of one physician ~~during the course of any one visit~~, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner.

(D) Copayments and deductibles shall be reasonable and shall not be a barrier to the necessary utilization of child health supervision services by covered persons.

(E) Benefits for child health supervision services that are provided to a child during the period from birth to age one shall not exceed a maximum limit of five hundred dollars, including benefits for the hearing screening required by the program established under section 3701.504 of the Revised Code. The benefits for the hearing screening shall not exceed a maximum limit of seventy-five dollars. Benefits for child health supervision services that are provided to a child during any year thereafter shall not exceed a maximum limit of one hundred fifty dollars per year.

(F) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, or other policy

that offers only supplemental benefits.

Sec. 3923.56. (A) Notwithstanding section 3901.71 of the Revised Code, each employee benefit plan established or maintained in this state on or after ~~the effective date of this amendment~~ November 24, 1995, that provides coverage for family members of the employee shall provide, with respect to that coverage, that any benefits applicable for children shall include benefits for child health supervision services from the moment of birth until age nine.

(B) A plan that provides the benefits described in division (A) of this section may limit the benefits to cover only the expenses of child health supervision services that are performed during the course of any one visit by one physician ~~or~~, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner or by a health care professional under the supervision of one physician ~~during the course of any one visit~~, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner.

(C) Copayments and deductibles shall be reasonable and shall not be a barrier to the necessary utilization of child health supervision services by covered persons.

(D) Benefits for child health supervision services that are provided to a child during the period from birth to age one shall not exceed a maximum limit of five hundred dollars, including benefits for the hearing screening required by the program established under section 3701.504 of the Revised Code. The benefits for the hearing screening shall not exceed a maximum limit of seventy-five dollars. Benefits for child health supervision services that are provided to a child during any year thereafter shall not exceed a maximum limit of one hundred

fifty dollars per year.

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 licensed psychologist, psychiatrist or other physician, clinical nurse specialist or certified nurse practitioner certified as a psychiatric-mental health CNS or psychiatric-mental health NP by the American nurses credentialing center, 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 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 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 clinical nurse specialist or certified nurse practitioner certified as a psychiatric-mental health CNS or psychiatric-mental health NP by the American nurses credentialing center who is licensed in the state in which the psychiatrist or nurse practices.

(7) "Psychological care" means direct or consultative

services provided by a psychologist licensed in the state in which the psychologist practices.

(8) "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) "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, or certified nurse practitioner specializing in pediatric health who determines the care 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, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, 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 certified or accredited in accordance with Chapter 3727. of the Revised Code;

(3) An injunction against the hospital has been granted under section 3727.05 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 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 to furnish to the employee or former employee or their 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. 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<u>, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner</u> 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 <u>or nurse</u> 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 stenographic deposition filed in court and of copies of the stenographic 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 <u>or nurse</u> 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 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 medical section of the bureau of workers' compensation shall 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 and request that the bureau schedule the claimant for such an examination.

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 handicap or disability resulting from the loss of

fingers, or loss of use of fingers, exceeds the normal handicap 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, 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, 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) The employer of a claimant who is injured or disabled in the course of ~~his~~ the claimant's employment may require, without the approval of the administrator or the industrial commission, that the claimant be examined by a physician, clinical nurse specialist, or certified nurse practitioner of the employer's choice one time upon any issue asserted by the employee or a physician, clinical nurse specialist, or certified nurse practitioner of the employee's

choice or which is to be considered by the commission. 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 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 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 ~~his~~ the claimant's representative upon request.

(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, ~~his~~ the employee's right to have ~~his~~ the employee's claim for compensation or benefits considered, if ~~his~~ 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 be suffering from 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, 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, 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. 4303.21. Permit G may be issued to the owner of a pharmacy in charge of a licensed pharmacist to be named in the permit for the sale at retail of alcohol for medicinal purposes in quantities at each sale of not more than one gallon upon the written prescription of a physician, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or dentist who is lawfully and regularly engaged in the practice of the physician's, nurse's, or dentist's profession in this state, and for the sale of industrial alcohol for mechanical, chemical, or scientific purposes to a person known by the seller to be engaged in mechanical, chemical, or scientific pursuits; all subject to section 4303.34 of the Revised Code. The fee for this permit is one hundred dollars.

Sec. 4503.066. (A)(1) To obtain a tax reduction under section 4503.065 of the Revised Code, the owner of the home shall file an application with the county auditor of the county in which the home is located. An application for reduction in taxes based upon a physical disability shall be accompanied by a certificate signed by a physician, clinical nurse specialist, or certified nurse practitioner, and an application for reduction in taxes based upon a mental disability shall be accompanied by a certificate signed by one of the following licensed to practice in this state: a physician, a clinical nurse specialist or certified nurse practitioner who is certified as a psychiatric-mental health CNS or psychiatric-mental health NP by the American nurses credentialing center, or psychologist ~~licensed to practice in this state~~. The certificate shall attest to the fact that the applicant is permanently and totally disabled, shall be in a form that the department of taxation requires, and shall include the definition of totally and permanently disabled as set forth in section 4503.064 of the Revised Code. An application for reduction in taxes based upon a disability certified as permanent and total by a state or federal agency having the function of so classifying persons shall be accompanied by a certificate from that agency.

An application by a disabled veteran for the reduction under division (B) of section 4503.065 of the Revised Code shall be accompanied by a letter or other written confirmation from the United States department of veterans affairs, or its predecessor or successor agency, showing that the veteran qualifies as a disabled veteran.

An application by the surviving spouse of a public service officer killed in the line of duty for the reduction under division (C) of section 4503.065 of the Revised Code shall be

accompanied by a letter or other written confirmation from an officer or employee of the board of trustees of a retirement or pension fund in this state or another state or from the chief or other chief executive of the department, agency, or other employer for which the public service officer served when killed in the line of duty affirming that the public service officer was killed in the line of duty.

(2) Each application shall constitute a continuing application for a reduction in taxes for each year in which the manufactured or mobile home is occupied by the applicant. Failure to receive a new application or notification under division (B) of this section after an application for reduction has been approved is prima-facie evidence that the original applicant is entitled to the reduction calculated on the basis of the information contained in the original application. The original application and any subsequent application shall be in the form of a signed statement and shall be filed on or before the thirty-first day of December of the year preceding the year for which the reduction is sought. The statement shall be on a form, devised and supplied by the tax commissioner, that shall require no more information than is necessary to establish the applicant's eligibility for the reduction in taxes and the amount of the reduction to which the applicant is entitled. The form shall contain a statement that signing such application constitutes a delegation of authority by the applicant to the tax commissioner or the county auditor, individually or in consultation with each other, to examine any tax or financial records that relate to the income of the applicant as stated on the application for the purpose of determining eligibility under, or possible violation of, division (C) or (D) of this section. The form also shall contain a statement that conviction

of willfully falsifying information to obtain a reduction in taxes or failing to comply with division (B) of this section shall result in the revocation of the right to the reduction for a period of three years.

(3) A late application for a reduction in taxes for the year preceding the year for which an original application is filed may be filed with an original application. If the auditor determines that the information contained in the late application is correct, the auditor shall determine both the amount of the reduction in taxes to which the applicant would have been entitled for the current tax year had the application been timely filed and approved in the preceding year, and the amount the taxes levied under section 4503.06 of the Revised Code for the current year would have been reduced as a result of the reduction. When an applicant is permanently and totally disabled on the first day of January of the year in which the applicant files a late application, the auditor, in making the determination of the amounts of the reduction in taxes under division (A)(3) of this section, is not required to determine that the applicant was permanently and totally disabled on the first day of January of the preceding year.

The amount of the reduction in taxes pursuant to a late application shall be treated as an overpayment of taxes by the applicant. The auditor shall credit the amount of the overpayment against the amount of the taxes or penalties then due from the applicant, and, at the next succeeding settlement, the amount of the credit shall be deducted from the amount of any taxes or penalties distributable to the county or any taxing unit in the county that has received the benefit of the taxes or penalties previously overpaid, in proportion to the benefits previously received. If, after the credit has been made, there

remains a balance of the overpayment, or if there are no taxes or penalties due from the applicant, the auditor shall refund that balance to the applicant by a warrant drawn on the county treasurer in favor of the applicant. The treasurer shall pay the warrant from the general fund of the county. If there is insufficient money in the general fund to make the payment, the treasurer shall pay the warrant out of any undivided manufactured or mobile home taxes subsequently received by the treasurer for distribution to the county or taxing district in the county that received the benefit of the overpaid taxes, in proportion to the benefits previously received, and the amount paid from the undivided funds shall be deducted from the money otherwise distributable to the county or taxing district in the county at the next or any succeeding distribution. At the next or any succeeding distribution after making the refund, the treasurer shall reimburse the general fund for any payment made from that fund by deducting the amount of that payment from the money distributable to the county or other taxing unit in the county that has received the benefit of the taxes, in proportion to the benefits previously received. On the second Monday in September of each year, the county auditor shall certify the total amount of the reductions in taxes made in the current year under division (A)(3) of this section to the tax commissioner who shall treat that amount as a reduction in taxes for the current tax year and shall make reimbursement to the county of that amount in the manner prescribed in section 4503.068 of the Revised Code, from moneys appropriated for that purpose.

(B)(1) If in any year for which an application for reduction in taxes has been approved the owner no longer qualifies for the reduction, the owner shall notify the county auditor that the owner is not qualified for a reduction in

taxes.

(2) If the county auditor or county treasurer discovers that an owner not entitled to the reduction in manufactured home taxes under section 4503.065 of the Revised Code failed to notify the county auditor as required by division (B)(1) of this section, a charge shall be imposed against the manufactured or mobile home in the amount by which taxes were reduced under that section for each tax year the county auditor ascertains that the manufactured or mobile home was not entitled to the reduction and was owned by the current owner. Interest shall accrue in the manner prescribed by division (G)(2) of section 4503.06 of the Revised Code on the amount by which taxes were reduced for each such tax year as if the reduction became delinquent taxes at the close of the last day the second installment of taxes for that tax year could be paid without penalty. The county auditor shall notify the owner, by ordinary mail, of the charge, of the owner's right to appeal the charge, and of the manner in which the owner may appeal. The owner may appeal the imposition of the charge and interest by filing an appeal with the county board of revision not later than the last day prescribed for payment of manufactured home taxes under section 4503.06 of the Revised Code following receipt of the notice and occurring at least ninety days after receipt of the notice. The appeal shall be treated in the same manner as a complaint relating to the valuation or assessment of manufactured or mobile homes under section 5715.19 of the Revised Code. The charge and any interest shall be collected as other delinquent taxes.

(3) During January of each year, the county auditor shall furnish each person whose application for reduction has been approved, by ordinary mail, a form on which to report any changes in total income, ownership, occupancy, disability, and

other information earlier furnished the auditor relative to the application. The form shall be completed and returned to the auditor not later than the thirty-first day of December if the changes would affect the person's eligibility for the reduction.

(C) No person shall knowingly make a false statement for the purpose of obtaining a reduction in taxes under section 4503.065 of the Revised Code.

(D) No person shall knowingly fail to notify the county auditor of any change required by division (B) of this section that has the effect of maintaining or securing a reduction in taxes under section 4503.065 of the Revised Code.

(E) No person shall knowingly make a false statement or certification attesting to any person's physical or mental condition for purposes of qualifying such person for tax relief pursuant to sections 4503.064 to 4503.069 of the Revised Code.

(F) Whoever violates division (C), (D), or (E) of this section is guilty of a misdemeanor of the fourth degree.

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 is afflicted with or suffering from 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, 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 is suffering from 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, 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 in color 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 is an alcoholic, 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, is afflicted with or suffering from 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, 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, by certified mail and 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, and shall be evidenced by a validation sticker. The renewal validation sticker shall be in a form prescribed by the registrar and shall be affixed to the license.

(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, 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, shall be in not less than duplicate, and shall contain any other information the registrar considers necessary. The duplicate copy of the statement may be retained by the person requesting the license renewal and, when in the person's immediate possession and used in conjunction with the original license, shall entitle the person to operate a motor vehicle during a period of no more than thirty days following the date of submission of the statement to the registrar, except when the registrar denies the request for the license renewal and so notifies the person.

(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 signed statement from the applicant's personal physician,

certified nurse-midwife, 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, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, 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, certified nurse-midwife's, clinical nurse specialist's, or certified nurse practitioner'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 day-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 ~~(K)(1)~~ (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. 4723.436. (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. 4723.4812. (A) A 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) A clinical nurse specialist or certified nurse practitioner may authorize one or more pharmacists and any of the pharmacy interns supervised by the pharmacist or pharmacists to use the protocol developed pursuant to rules adopted under section 4729.44 of the Revised Code for the purpose of dispensing naloxone under section 4729.44 of the Revised Code.

(C) 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.

(D) 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. 4725.14. (A) The following apply to an optometrist

licensed on or before May 19, 1992, who is seeking a therapeutic pharmaceutical agents certificate under division (A)(3) of section 4725.13 of the Revised Code:

(1) If the optometrist does not hold a valid topical ocular pharmaceutical agents certificate, the optometrist shall complete the course of study in general and ocular pharmacology prescribed by the board under division (B)(1) of this section, a three clock-hour course in cardiopulmonary resuscitation, and pass the portion of the optometry licensing examination accepted by the board under section 4725.11 of the Revised Code that pertains to the treatment and management of ocular disease.

(2) If the optometrist holds a valid topical ocular pharmaceutical agents certificate, the optometrist shall complete the course of study in general and ocular pharmacology prescribed under division (B)(2) of this section and pass the portion of the optometry licensing examination accepted by the board under section 4725.11 of the Revised Code that pertains to the treatment and management of ocular disease.

(B) The board shall prescribe by rule the following courses of study:

(1) An eighty-seven clock-hour course of study to be completed at an institution accredited by a post-secondary education accrediting organization recognized by the board. The course of study shall include instruction in at least the following:

(a) General and ocular pharmacology, including the nature of adverse reactions caused by pharmaceutical agents and emergency steps to be taken in such cases;

(b) Signs, symptoms, and treatment of ocular disease,

injury, or abnormality;

(c) Ocular signs and symptoms of systemic disease;

(d) Appropriate criteria for referrals to physicians, clinical nurse specialists, or certified nurse practitioners.

(2) A thirty clock-hour course of study that emphasizes the treatment of ocular disease to be completed at an institution accredited by a post-secondary education accreditation organization that is recognized by the board.

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 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.

(I) A physician, 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, and 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, may do any of the following:

(a) In the case of an individual who is seven years of age or older but not more than thirteen years of age, administer to the individual an immunization for any of the following:

(i) Influenza;

(ii) COVID-19;

(iii) Any other disease, but only pursuant to a prescription.

(b) In the case of an individual who is thirteen years of age or older, administer to the individual 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 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 or pharmacy intern.

(B) For a pharmacist or pharmacy intern to be authorized to engage in the administration of immunizations, the pharmacist or pharmacy intern 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 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 or pharmacy intern 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 or pharmacy intern 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, diphenhydramine, or both, to an individual who has an adverse reaction to an immunization administered by the pharmacist or a pharmacy intern.

(b) For each immunization administered to an individual by a pharmacist or pharmacy intern, other than an immunization for influenza administered to an individual eighteen years of age or older, the pharmacist or pharmacy intern 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 or pharmacy intern to an individual younger than eighteen years of age, the pharmacist or a pharmacy intern shall obtain permission from the individual's parent or legal guardian in accordance with the procedures specified in rules adopted under this section.

(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.

(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 and pharmacy interns in engaging in the administration of immunizations;

(c) Procedures to be followed by pharmacists and pharmacy interns 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 and pharmacy interns 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. 4729.44. (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 the protocol developed pursuant to rules adopted under division (G) of this section has been authorized under section 3707.56, 4723.4812, or 4731.942 of the Revised Code, a pharmacist or pharmacy intern may dispense naloxone without a prescription to either of the following in accordance with that protocol:

(1) An individual who there is reason to believe is experiencing or at risk of experiencing an opioid-related overdose;

(2) A family member, friend, or other individual in a position to assist an individual who there is reason to believe is at risk of experiencing an opioid-related overdose.

(C) A pharmacist or pharmacy intern who dispenses naloxone under this section shall instruct the individual to whom naloxone is dispensed to summon emergency services as soon as practicable either before or after administering naloxone.

(D) A pharmacist may document on a prescription form the dispensing of naloxone by the pharmacist or a pharmacy intern supervised by the pharmacist. 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 naloxone.

(F) A board of health that in good faith authorizes a pharmacist or pharmacy intern to dispense naloxone 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 naloxone is dispensed:

damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

A physician, clinical nurse specialist, or certified nurse practitioner who in good faith authorizes a pharmacist or pharmacy intern to dispense naloxone 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 naloxone 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 naloxone 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 naloxone is dispensed: damages in any civil action, prosecution in any criminal proceeding, or professional disciplinary action.

(G) The state board of pharmacy shall, after consulting with the department of health ~~and~~, state medical board, and board of nursing, adopt rules to implement this section. The rules shall specify a protocol under which pharmacists or pharmacy interns may dispense naloxone without a prescription.

All rules adopted under this section shall be adopted in accordance with Chapter 119. of the Revised Code.

(H)(1) The state board of pharmacy shall develop a program to educate all of the following about the authority of a pharmacist or pharmacy intern to dispense naloxone without a prescription:

(a) Holders of licenses issued under this chapter that engage in the sale or dispensing of naloxone pursuant to this section;

(b) Registered pharmacy technicians, certified pharmacy technicians, and pharmacy technician trainees registered under this chapter who engage in the sale of naloxone pursuant to this section;

(c) Individuals who are not licensed or registered under this chapter but are employed by license holders described in division (H)(1)(a) of this section.

(2) As part of the program, the board also shall educate the license holders, pharmacy technicians, and employees described in division (H)(1) of this section about maintaining an adequate supply of naloxone and methods for determining a pharmacy's stock of the drug.

(3) The board may use its web site to share information under the program.

Sec. 4729.45. (A) As used in this section, "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<u>, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner</u> 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~~ April 8, 2019, 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. 5119.93. (A) A person may initiate proceedings for treatment for an individual suffering from alcohol and other drug abuse by filing a verified petition in the probate court. The petition and all subsequent court documents shall be entitled: "In the interest of (name of respondent)." A spouse, relative, or guardian of the individual concerning whom the petition is filed shall file the petition. A petition filed under this division shall be kept confidential and shall not be disclosed by any person, except as needed for purposes of this

section or when disclosure is ordered by a court.

(B) A petition filed under division (A) of this section shall set forth all of the following:

(1) The petitioner's relationship to the respondent;

(2) The respondent's name, residence address, and current location, if known;

(3) The name and residence of the respondent's parents, if living and if known, or of the respondent's legal guardian, if any and if known;

(4) The name and residence of the respondent's spouse, if any and if known;

(5) The name and residence of the person having custody of the respondent, if any, or if no such person is known, the name and residence of a near relative or a statement that the person is unknown;

(6) The petitioner's belief, including the factual basis for the belief, that the respondent is suffering from alcohol and other drug abuse and presents an imminent danger or imminent threat of danger to self, family, or others if not treated for alcohol or other drug abuse;

(7) If the petitioner's belief specified in division (B)(6) of this section is that the respondent is suffering from opioid or opiate abuse, the information provided in the petition under that division also shall include any evidence that the respondent has overdosed and been revived one or more times by an opioid antagonist, overdosed in a vehicle, or overdosed in the presence of a minor.

(C)(1) Any petition filed pursuant to divisions (A) and

(B) of this section shall be accompanied by a certificate ~~of a physician~~ signed by one of the following who has examined the respondent within two days prior to the day that the petition is filed in the probate court: a physician, a clinical nurse specialist certified as a psychiatric-mental health CNS by the American nurses credentialing center, or a certified nurse practitioner certified as a psychiatric-mental health NP by the American nurses credentialing center. The signing physician shall be authorized to practice medicine and surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code. The signing clinical nurse specialist or certified nurse practitioner shall hold a current, valid license issued under Chapter 4723. of the Revised Code that authorizes the practice of nursing as an advanced practice registered nurse. A physician, clinical nurse specialist, or certified nurse practitioner who is responsible for admitting persons into treatment, if that physician or nurse examines the respondent, may be the physician or nurse who ~~completes~~ signs the certificate. ~~The~~

The physician's, clinical nurse specialist's, or certified nurse practitioner's certificate shall set forth the physician's or nurse's findings in support of the need to treat the respondent for alcohol or other drug abuse. The certificate shall indicate if the respondent presents an imminent danger or imminent threat of danger to self, family, or others if not treated. Further, the certificate shall indicate the type and length of treatment required and if the respondent can reasonably benefit from treatment. If the ~~physician's~~ certificate indicates that inpatient treatment is required, the certificate shall identify any inpatient facilities known to the physician or nurse who signs the certificate that are able and

willing to provide the recommended inpatient treatment.

If the respondent refuses to undergo an examination with a physician or a clinical nurse specialist or certified nurse practitioner certified as a psychiatric-mental health CNS or psychiatric-mental health NP by the American nurses credentialing center concerning the respondent's possible need for treatment for alcohol or other drug abuse, the petition shall state that the respondent has refused all requests made by the petitioner to undergo ~~a physician's~~ such an examination. In that case, the petitioner shall not be required to provide a physician's, clinical nurse specialist's, or certified nurse practitioner's certificate with the petition.

(2) Any petition filed pursuant to divisions (A) and (B) of this section shall contain a statement that the petitioner has arranged for treatment of the respondent. Further, the petition shall be accompanied by a statement from the person or facility who has agreed to provide the treatment that verifies that the person or facility has agreed to provide the treatment and the estimated cost of the treatment.

(D) Any petition filed pursuant to divisions (A) and (B) of this section shall be accompanied by both of the following:

(1) One of the following:

(a) A security deposit to be deposited with the clerk of the probate court that will cover half of the estimated cost of treatment of the respondent;

(b) Documentation establishing that insurance coverage of the petitioner or respondent will cover at least half of the estimated cost of treatment of the respondent;

(c) Other evidence to the satisfaction of the court

establishing that the petitioner or respondent will be able to cover some of the estimated cost of treatment of the respondent.

(2) One of the following:

(a) A guarantee, signed by the petitioner or another person authorized to file the petition, obligating the guarantor to pay the costs of the examinations of the respondent conducted ~~by the physician and qualified health professional~~ under ~~division (B)(5) of~~ this section or section 5119.94 of the Revised Code by a physician, clinical nurse specialist, certified nurse practitioner, or qualified health professional, the costs of the respondent that are associated with a hearing conducted in accordance with section 5119.94 of the Revised Code and that the court determines to be appropriate, and the costs of any treatment ordered by the court;

(b) Documentation establishing that insurance coverage of the petitioner or respondent will cover the costs described in division (D)(2)(a) of this section;

(c) Documentation establishing that, consistent with the evidence described in division (D)(1)(c) of this section, the petitioner or respondent will cover some of the costs described in division (D)(2)(a) of this section.

Sec. 5119.94. (A) Upon receipt of a petition filed under section 5119.93 of the Revised Code, the probate court shall examine the petitioner under oath as to the contents of the petition.

(B) If, after reviewing the allegations contained in the petition and examining the petitioner under oath, it appears to the probate court that there is probable cause to believe the respondent may reasonably benefit from treatment, the court

shall do all of the following:

(1) Schedule a hearing to be held within seven days to determine if there is clear and convincing evidence that the respondent may reasonably benefit from treatment for alcohol and other drug abuse;

(2) Notify the respondent, the legal guardian, if any and if known, and the spouse, parents, or nearest relative or friend of the respondent concerning the allegations and contents of the petition and of the date and purpose of the hearing;

(3) Notify the respondent that the respondent may retain counsel and, if the person is unable to obtain an attorney, that the respondent may be represented by court-appointed counsel at public expense if the person is indigent. Upon the appointment of an attorney to represent an indigent respondent, the court shall notify the respondent of the name, address, and telephone number of the attorney appointed to represent the respondent.

(4) Notify the respondent that the court shall cause the respondent to be examined not later than twenty-four hours before the hearing date by a physician<u>, clinical nurse specialist, or certified nurse practitioner</u> for the purpose of a physical examination and by a qualified health professional for the purpose of a drug and alcohol addiction assessment and diagnosis. In addition, the court shall notify the respondent that the respondent may have an independent expert evaluation of the person's physical and mental condition conducted at the respondent's own expense.

(5) Cause the respondent to be examined not later than twenty-four hours before the hearing date by a qualified health professional for the purpose of a drug and alcohol addiction

assessment and diagnosis;

(6) Conduct the hearing.

(C) The qualified health professional who examines the respondent pursuant to division (B)(5) of this section or who is obtained by the respondent at the respondent's own expense shall certify the professional's findings to the court within twenty-four hours of the examination. The findings of each qualified health professional shall include a recommendation for treatment if the qualified health professional determines that treatment is necessary.

(D)(1) If upon completion of the hearing held under this section the probate court finds by clear and convincing evidence that the respondent may reasonably benefit from treatment, the court shall order the treatment after considering the qualified health professionals' recommendations for treatment that have been submitted to the court under division (C) of this section. Evidence that the respondent has overdosed and been revived one or more times by an opioid antagonist, overdosed in a vehicle, or overdosed in the presence of a minor is sufficient to satisfy this evidentiary requirement. If the court orders the treatment under this division, the order shall specify the type of treatment to be provided, the type of required aftercare, and the duration of the required aftercare which shall be at least three months and shall not exceed six months, and the court shall order the treatment to be provided through a community addiction services provider or by an individual licensed or certified by the state medical board under Chapter 4731. of the Revised Code, the chemical dependency professionals board under Chapter 4758. of the Revised Code, the counselor, social worker, and marriage and family therapist board under Chapter 4757. of

the Revised Code, or a similar board of another state authorized to provide substance abuse treatment. In addition, the court also may order that the respondent submit to periodic examinations by a qualified mental health professional to determine if the treatment remains necessary.

(2)(a) Failure of a respondent to undergo and complete any treatment ordered pursuant to this division is contempt of court. Any community addiction services provider or person providing treatment under this division shall notify the probate court of a respondent's failure to undergo or complete the ordered treatment.

(b) In addition to and separate from the sanction specified in division (D)(2)(a) of this section, if a respondent fails to undergo and complete any treatment ordered pursuant to this section, the court may issue a summons. The summons shall be directed to the respondent and shall command the respondent to appear at a time and place specified in the summons. If a respondent who has been summoned under this division fails to appear at the specified time and place, the court may order a peace officer, as defined in section 2935.01 of the Revised Code, to transport the respondent to a place described in division (D)(1) of this section for treatment. The peace officer, with the approval of the officer's agency, may provide for the transportation of the respondent by a private entity. The transportation costs of the peace officer or the private entity shall be included within the costs of treatment.

(E) If, at any time after a petition is filed under section 5119.93 of the Revised Code, the probate court finds that there is not probable cause to continue treatment or if the petitioner withdraws the petition, then the court shall dismiss

the proceedings against the respondent.

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) "Mentally ill person subject to hospitalization" means a mentally ill person 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 a mentally ill inmate 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 a mentally ill inmate 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 by the American nurses credentialing center;

(b) A certified nurse practitioner who is certified as a psychiatric-mental health NP by the American nurses credentialing center.

(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 mentally ill person 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 mentally ill person 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 mentally ill person 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 mentally ill

person 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 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 is mentally ill, 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 mentally ill person 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~~ That physician or 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 mentally ill person 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 mentally ill person 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 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 mentally ill person 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 mentally ill person 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 a mentally ill inmate 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.

(2) Disclosure is required by a court order signed by a judge.

(3) An inmate patient seeks access to the inmate patient's own psychiatric and medical records, unless access is specifically restricted in the treatment plan for clear treatment reasons.

(4) Hospitals and other institutions and facilities within the department of rehabilitation and correction may exchange psychiatric records and other pertinent information with other hospitals, institutions, and facilities of the department, but the information that may be released about an inmate patient is limited to medication history, physical health status and history, summary of course of treatment in the hospital, summary of treatment needs, and a discharge summary, if any.

(5) An inmate patient's family member who is involved in planning, providing, and monitoring services to the inmate patient may receive medication information, a summary of the inmate patient's diagnosis and prognosis, and a list of the services and personnel available to assist the inmate patient

and family if the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner determines that disclosure would be in the best interest of the inmate patient. No disclosure shall be made under this division unless the inmate patient is notified of the possible disclosure, receives the information to be disclosed, and does not object to the disclosure.

(6) The department of rehabilitation and correction may exchange psychiatric hospitalization records, other mental health treatment records, and other pertinent information with county sheriffs' offices, hospitals, institutions, and facilities of the department of mental health and addiction services and with community mental health services providers and boards of alcohol, drug addiction, and mental health services with which the department of mental health and addiction services has a current agreement for patient care or services to ensure continuity of care. Disclosure under this division is limited to records regarding a mentally ill inmate's medication history, physical health status and history, summary of course of treatment, summary of treatment needs, and a discharge summary, if any. No office, department, agency, provider, or board shall disclose the records and other information unless one of the following applies:

(a) The mentally ill inmate is notified of the possible disclosure and consents to the disclosure.

(b) The mentally ill inmate is notified of the possible disclosure, an attempt to gain the consent of the inmate is made, and the office, department, agency, or board documents the attempt to gain consent, the inmate's objections, if any, and the reasons for disclosure in spite of the inmate's objections.

(7) Information may be disclosed to staff members designated by the director of rehabilitation and correction for the purpose of evaluating the quality, effectiveness, and efficiency of services and determining if the services meet minimum standards.

The name of an inmate patient shall not be retained with the information obtained during the evaluations.

(L) The director of rehabilitation and correction may adopt rules setting forth guidelines for the procedures required under divisions (B), (C)(1), and (C)(2) of this section.

Sec. 5120.21. (A) The department of rehabilitation and correction shall keep in its office, accessible only to its employees, except by the consent of the department or the order of the judge of a court of record, and except as provided in division (C) of this section, a record showing the name, residence, sex, age, nativity, occupation, condition, and date of entrance or commitment of every inmate in the several institutions governed by it. The record also shall include the date, cause, and terms of discharge and the condition of such person at the time of leaving, a record of all transfers from one institution to another, and, if such inmate is dead, the date and cause of death. These and other facts that the department requires shall be furnished by the managing officer of each institution within ten days after the commitment, entrance, death, or discharge of an inmate.

(B) In case of an accident or injury or peculiar death of an inmate, the managing officer shall make a special report to the department within twenty-four hours thereafter, giving the circumstances as fully as possible.

(C)(1) As used in this division, "medical record" means any document or combination of documents that pertains to the medical history, diagnosis, prognosis, or medical condition of a patient and that is generated and maintained in the process of medical treatment.

(2) A separate medical record of every inmate in an institution governed by the department shall be compiled, maintained, and kept apart from and independently of any other record pertaining to the inmate. Upon the signed written request of the inmate to whom the record pertains together with the written request of a person the inmate designates who is either a licensed attorney at law or a licensed physician ~~designated by the inmate~~, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, the department shall make the inmate's medical record available to the designated attorney ~~or~~, physician, or nurse. The record may be inspected or copied by the inmate's designated attorney ~~or~~, physician, or nurse. The department may establish a reasonable fee for the copying of any medical record. If a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner concludes that presentation of all or any part of the medical record directly to the inmate will result in serious medical harm to the inmate, the physician or nurse shall so indicate on the medical record. An inmate's medical record shall be made available to a physician ~~or to an~~, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or attorney designated in writing by the inmate not more than once every twelve months.

(D) Except as otherwise provided by a law of this state or the United States, the department and the officers of its institutions shall keep confidential and accessible only to its

employees, except by the consent of the department or the order of a judge of a court of record, all of the following:

(1) Architectural, engineering, or construction diagrams, drawings, or plans of a correctional institution;

(2) Plans for hostage negotiation, for disturbance control, for the control and location of keys, and for dealing with escapes;

(3) Statements made by inmate informants;

(4) Records that are maintained by the department of youth services, that pertain to children in its custody, and that are released to the department of rehabilitation and correction by the department of youth services pursuant to section 5139.05 of the Revised Code;

(5) Victim impact statements and information provided by victims of crimes that the department considers when determining the security level assignment, program participation, and release eligibility of inmates;

(6) Information and data of any kind or medium pertaining to groups that pose a security threat;

(7) Conversations recorded from the monitored inmate telephones that involve nonprivileged communications.

(E) Except as otherwise provided by a law of this state or the United States, the department of rehabilitation and correction may release inmate records to the department of youth services or a court of record, and the department of youth services or the court of record may use those records for the limited purpose of carrying out the duties of the department of youth services or the court of record. Inmate records released

by the department of rehabilitation and correction to the department of youth services or a court of record shall remain confidential and shall not be considered public records as defined in section 149.43 of the Revised Code.

(F) Except as otherwise provided in division (C) of this section, records of inmates committed to the department of rehabilitation and correction as well as records of persons under the supervision of the adult parole authority shall not be considered public records as defined in section 149.43 of the Revised Code.

Sec. 5122.01. As used in this chapter and Chapter 5119. of the Revised Code:

(A) "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.

(B) "Mentally ill person subject to court order" means a mentally ill person who, because of the person's illness:

(1) Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;

(2) 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;

(3) Represents a substantial and immediate risk of serious physical impairment or injury to self 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 community;

(4) Would benefit from treatment for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person;

(5)(a) Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:

(i) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.

(ii) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:

(I) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the thirty-six-month period.

(II) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight-month

period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.

(iii) The person, as a result of the person's mental illness, is unlikely to voluntarily participate in necessary treatment.

(iv) In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.

(b) An individual who meets only the criteria described in division (B)(5)(a) of this section is not subject to hospitalization.

(C)(1) "Patient" means, subject to division (C)(2) of this section, a person who is admitted either voluntarily or involuntarily to a hospital or other place under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code subsequent to a finding of not guilty by reason of insanity or incompetence to stand trial or under this chapter, who is under observation or receiving treatment in such place.

(2) "Patient" does not include a person admitted to a hospital or other place under section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code to the extent that the reference in this chapter to patient, or the context in which the reference occurs, is in conflict with any provision of sections 2945.37 to 2945.402 of the Revised Code.

(D) "Licensed physician" means a person licensed under the laws of this state to practice medicine or a medical officer of the government of the United States while in this state in the

performance of the person's official duties.

(E) "Psychiatrist" means a licensed physician who has satisfactorily completed a residency training program in psychiatry, as approved by the residency review committee of the American medical association, the committee on post-graduate education of the American osteopathic association, or the American osteopathic board of neurology and psychiatry, or who on July 1, 1989, has been recognized as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association on the basis of formal training and five or more years of medical practice limited to psychiatry.

(F) "Hospital" means a hospital or inpatient unit licensed by the department of mental health and addiction services under section 5119.33 of the Revised Code, and any institution, hospital, or other place established, controlled, or supervised by the department under Chapter 5119. of the Revised Code.

(G) "Public hospital" means a facility that is tax-supported and under the jurisdiction of the department of mental health and addiction services.

(H) "Community mental health services provider" means an agency, association, corporation, individual, or program that provides community mental health services that are certified by the director of mental health and addiction services under section 5119.36 of the Revised Code.

(I) "Licensed clinical psychologist" means a person who holds a current, valid psychologist license issued under section 4732.12 of the Revised Code, and in addition, meets the educational requirements set forth in division (B) of section 4732.10 of the Revised Code and has a minimum of two years'

full-time professional experience, or the equivalent as determined by rule of the state board of psychology, at least one year of which shall be a predoctoral internship, in clinical psychological work in a public or private hospital or clinic or in private practice, diagnosing and treating problems of mental illness or intellectual disability under the supervision of a psychologist who is licensed or who holds a diploma issued by the American board of professional psychology, or whose qualifications are substantially similar to those required for licensure by the state board of psychology when the supervision has occurred prior to enactment of laws governing the practice of psychology.

(J) "Health officer" means any public health physician; public health nurse; or other person authorized or designated by a city or general health district or a board of alcohol, drug addiction, and mental health services to perform the duties of a health officer under this chapter.

(K) "Chief clinical officer" means the medical director of a hospital, community mental health services provider, or board of alcohol, drug addiction, and mental health services, or, if there is no medical director, the licensed physician responsible for the treatment provided by a hospital or community mental health services provider. The chief clinical officer may delegate to the attending physician responsible for a patient's care the duties imposed on the chief clinical officer by this chapter. In the case of a community mental health services provider, the chief clinical officer shall be designated by the governing body of the services provider and shall be a licensed physician or licensed clinical psychologist who supervises diagnostic and treatment services. A licensed physician or licensed clinical psychologist designated by the chief clinical

officer may perform the duties and accept the responsibilities of the chief clinical officer in the chief clinical officer's absence.

(L) "Working day" or "court day" means Monday, Tuesday, Wednesday, Thursday, and Friday, except when such day is a holiday.

(M) "Indigent" means unable without deprivation of satisfaction of basic needs to provide for the payment of an attorney and other necessary expenses of legal representation, including expert testimony.

(N) "Respondent" means the person whose detention, commitment, hospitalization, continued hospitalization or commitment, or discharge is being sought in any proceeding under this chapter.

(O) "Ohio protection and advocacy system" has the same meaning as in section 5123.60 of the Revised Code.

(P) "Independent expert evaluation" means an evaluation conducted by a licensed clinical psychologist, psychiatrist, or licensed physician who has been selected by the respondent or the respondent's counsel and who consents to conducting the evaluation.

(Q) "Court" means the probate division of the court of common pleas.

(R) "Expunge" means:

(1) The removal and destruction of court files and records, originals and copies, and the deletion of all index references;

(2) The reporting to the person of the nature and extent

of any information about the person transmitted to any other person by the court;

(3) Otherwise insuring that any examination of court files and records in question shall show no record whatever with respect to the person;

(4) That all rights and privileges are restored, and that the person, the court, and any other person may properly reply that no such record exists, as to any matter expunged.

(S) "Residence" means a person's physical presence in a county with intent to remain there, except that:

(1) If a person is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which the person maintained the person's primary place of residence at the time the person entered the facility;

(2) If a person is committed pursuant to section 2945.38, 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code, residence means the county where the criminal charges were filed.

When the residence of a person is disputed, the matter of residence shall be referred to the department of mental health and addiction services for investigation and determination. Residence shall not be a basis for a board of alcohol, drug addiction, and mental health services to deny services to any person present in the board's service district, and the board shall provide services for a person whose residence is in dispute while residence is being determined and for a person in an emergency situation.

(T) "Admission" to a hospital or other place means that a

patient is accepted for and stays at least one night at the hospital or other place.

(U) "Prosecutor" means the prosecuting attorney, village solicitor, city director of law, or similar chief legal officer who prosecuted a criminal case in which a person was found not guilty by reason of insanity, who would have had the authority to prosecute a criminal case against a person if the person had not been found incompetent to stand trial, or who prosecuted a case in which a person was found guilty.

(V)(1) "Treatment plan" means a written statement of reasonable objectives and goals for an individual established by the treatment team, with specific criteria to evaluate progress towards achieving those objectives.

(2) The active participation of the patient in establishing the objectives and goals shall be documented. The treatment plan shall be based on patient needs and include services to be provided to the patient while the patient is hospitalized, after the patient is discharged, or in an outpatient setting. The treatment plan shall address services to be provided. In the establishment of the treatment plan, consideration should be given to the availability of services, which may include but are not limited to all of the following:

(a) Community psychiatric supportive treatment;

(b) Assertive community treatment;

(c) Medications;

(d) Individual or group therapy;

(e) Peer support services;

(f) Financial services;

(g) Housing or supervised living services;

(h) Alcohol or substance abuse treatment;

(i) Any other services prescribed to treat the patient's mental illness and to either assist the patient in living and functioning in the community or to help prevent a relapse or a deterioration of the patient's current condition.

(3) If the person subject to the treatment plan has executed an advance directive for mental health treatment, the treatment team shall consider any directions included in such advance directive in developing the treatment plan.

(W) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.

(X) "Post-release control sanction" has the same meaning as in section 2967.01 of the Revised Code.

(Y) "Local correctional facility" has the same meaning as in section 2903.13 of the Revised Code.

(Z) "~~Clinical~~ Licensed 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:

(1) A clinical nurse specialist~~" and "~~ certified as a psychiatric-mental health CNS by the American nurses credentialing center;

(2) A certified nurse practitioner~~" have the same meanings as in section 4723.01 of the Revised Code~~ certified as a psychiatric-mental health NP by the American nurses credentialing center.

Sec. 5122.10. (A)(1) Any of the following who has reason to believe that a person is a mentally ill person subject to court order and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination may take the person into custody and may immediately transport the person to a hospital or, notwithstanding section 5119.33 of the Revised Code, to a general hospital not licensed by the department of mental health and addiction services where the person may be held for the period prescribed in this section:

(a) A psychiatrist;

(b) A licensed physician;

(c) A licensed clinical psychologist;

(d) A ~~clinical nurse specialist who is certified as a psychiatric-mental health CNS by the American nurses credentialing center;~~

~~(e) A certified nurse practitioner who is certified as a psychiatric-mental health NP by the American nurses credentialing center~~licensed psychiatric-mental health advanced practice registered nurse;

~~(f)~~ (e) A health officer;

~~(g)~~ (f) A parole officer;

~~(h)~~ (g) A police officer;

~~(i)~~ (h) A sheriff.

(2) If the chief of the adult parole authority or a parole or probation officer with the approval of the chief of the authority has reason to believe that a parolee, an offender

under a community control sanction or post-release control sanction, or an offender under transitional control is a mentally ill person subject to court order and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination, the chief or officer may take the parolee or offender into custody and may immediately transport the parolee or offender to a hospital or, notwithstanding section 5119.33 of the Revised Code, to a general hospital not licensed by the department of mental health and addiction services where the parolee or offender may be held for the period prescribed in this section.

(B) A written statement shall be given to the hospital by the individual authorized under division (A)(1) or (2) of this section to transport the person. The statement shall specify the circumstances under which such person was taken into custody and the reasons for the belief that the person is a mentally ill person subject to court order and represents a substantial risk of physical harm to self or others if allowed to remain at liberty pending examination. This statement shall be made available to the respondent or the respondent's attorney upon request of either.

(C) Every reasonable and appropriate effort shall be made to take persons into custody in the least conspicuous manner possible. A person taking the respondent into custody pursuant to this section shall explain to the respondent: the name and professional designation and affiliation of the person taking the respondent into custody; that the custody-taking is not a criminal arrest; and that the person is being taken for examination by mental health professionals at a specified mental health facility identified by name.

(D) If a person taken into custody under this section is transported to a general hospital, the general hospital may admit the person, or provide care and treatment for the person, or both, notwithstanding section 5119.33 of the Revised Code, but by the end of twenty-four hours after arrival at the general hospital, the person shall be transferred to a hospital as defined in section 5122.01 of the Revised Code.

(E) A person transported or transferred to a hospital or community mental health services provider under this section shall be examined by the staff of the hospital or services provider within twenty-four hours after arrival at the hospital or services provider. If to conduct the examination requires that the person remain overnight, the hospital or services provider shall admit the person in an unclassified status until making a disposition under this section. After the examination, if the chief clinical officer of the hospital or services provider believes that the person is not a mentally ill person subject to court order, the chief clinical officer shall release or discharge the person immediately unless a court has issued a temporary order of detention applicable to the person under section 5122.11 of the Revised Code. After the examination, if the chief clinical officer believes that the person is a mentally ill person subject to court order, the chief clinical officer may detain the person for not more than three court days following the day of the examination and during such period admit the person as a voluntary patient under section 5122.02 of the Revised Code or file an affidavit under section 5122.11 of the Revised Code. If neither action is taken and a court has not otherwise issued a temporary order of detention applicable to the person under section 5122.11 of the Revised Code, the chief clinical officer shall discharge the person at the end of the

three-day period unless the person has been sentenced to the department of rehabilitation and correction and has not been released from the person's sentence, in which case the person shall be returned to that department.

Sec. 5122.11. Proceedings for a mentally ill person subject to court order pursuant to sections 5122.11 to 5122.15 of the Revised Code shall be commenced by the filing of an affidavit in the manner prescribed by the department of mental health and addiction services and in a form prescribed in section 5122.111 of the Revised Code, by any person or persons with the probate court, either on reliable information or actual knowledge, whichever is determined to be proper by the court. This section does not apply to the hospitalization of a person pursuant to section 2945.39, 2945.40, 2945.401, or 2945.402 of the Revised Code.

The affidavit shall contain an allegation setting forth the specific category or categories under division (B) of section 5122.01 of the Revised Code upon which the jurisdiction of the court is based and a statement of alleged facts sufficient to indicate probable cause to believe that the person is a mentally ill person subject to court order. ~~The~~ In addition, the affidavit is subject to either of the following:

(A) The affidavit may be accompanied by, or the court may require that the affidavit be accompanied by, ~~by~~ a certificate ~~of a psychiatrist, or a certificate signed by a licensed clinical psychologist and a certificate signed by a licensed physician~~ stating that the person who issued the certificate has examined the person and is of the opinion that the person is a mentally ill person subject to court order~~, or~~. The examination may be conducted by any of the following and the certificate

shall be issued accordingly:

(1) A psychiatrist;

(2) A licensed psychiatric-mental health advanced practice registered nurse;

(3) A licensed clinical psychologist in conjunction with a licensed physician or licensed psychiatric-mental health advanced practice registered nurse, in which case the psychologist shall issue a certificate and the physician or nurse shall issue a certificate.

(B) The affidavit shall be accompanied by a written statement by the applicant, under oath, that the person has refused to submit to an examination by ~~a psychiatrist, or by a licensed clinical psychologist and licensed physician~~ any of the persons described in divisions (A)(1) to (3) of this section.

With regard to a defendant described in division (B)(1)(a)(v)(I) of section 2945.38 of the Revised Code for whom criminal charges were dismissed, the affidavit shall contain a space for the trial court or prosecutor filing the affidavit to indicate that the person named in the affidavit is such a defendant.

Upon receipt of the affidavit, if a judge of the court or a referee who is an attorney at law appointed by the court has probable cause to believe that the person named in the affidavit is a mentally ill person subject to court order, the judge or referee may issue a temporary order of detention ordering any health or police officer or sheriff to take into custody and transport the person to a hospital or other place designated in section 5122.17 of the Revised Code, or may set the matter for further hearing. If a temporary order of detention is issued and the person is transported to a hospital or other designated

place, the court that issued the order shall retain jurisdiction over the case as it relates to the person's outpatient treatment, notwithstanding that the hospital or other designated place to which the person is transported is outside the territorial jurisdiction of the court.

The person may be observed and treated until the hearing provided for in section 5122.141 of the Revised Code. If no such hearing is held, the person may be observed and treated until the hearing provided for in section 5122.15 of the Revised Code.

Sec. 5122.111. To initiate proceedings for court-ordered treatment of a person under section 5122.11 of the Revised Code, a person or persons shall file an affidavit with the probate court that is identical in form and content to the following:

AFFIDAVIT OF MENTAL ILLNESS

The State of Ohio

_____ County, ss.

_____ Court

_____

the undersigned, residing at

_____

says, that he/she has information to believe or has actual knowledge that

_____

(Please specify specific category(ies) below with an X.)

[ ] Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;

[ ] Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior or evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm or other evidence of present dangerousness;

[ ] Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence of being unable to provide for and of not providing for basic physical needs because of mental illness and that appropriate provision for such needs cannot be made immediately available in the community;

[ ] Would benefit from treatment for mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person; or

[ ] Would benefit from treatment as manifested by evidence of behavior that indicates all of the following:

(a) The person is unlikely to survive safely in the community without supervision, based on a clinical determination.

(b) The person has a history of lack of compliance with treatment for mental illness and one of the following applies:

(i) At least twice within the thirty-six months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance has been a significant factor in necessitating hospitalization in a hospital or receipt of services in a forensic or other mental health unit of a correctional facility, provided that the thirty-six-month period shall be extended by the length of any hospitalization or incarceration of the person

that occurred within the thirty-six-month period.

(ii) Within the forty-eight months prior to the filing of an affidavit seeking court-ordered treatment of the person under section 5122.111 of the Revised Code, the lack of compliance resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others, provided that the forty-eight-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period.

(c) The person, as a result of mental illness, is unlikely to voluntarily participate in necessary treatment.

(d) In view of the person's treatment history and current behavior, the person is in need of treatment in order to prevent a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others.

_____

(Name of the party filing the affidavit) further says that the facts supporting this belief are as follows:

_____

_____

_____

_____

_____

_____

These facts being sufficient to indicate probable cause that the above said person is a mentally ill person subject to court order.

The undersigned represents a trial court or a prosecutor who, as

described in division (B)(1)(a)(v)(I) of section 2945.38 of the Revised Code, is alleging that the above said person is a mentally ill person subject to court order: [ ] Yes [ ] No (please specify answer with an X). If Yes, please specify the name and address of the trial court or prosecutor:

_____

_____

Name of Patient's Last Physician, Licensed Psychiatric-Mental Health Advanced Practice Registered Nurse, or Licensed Clinical Psychologist

_____

Address of Patient's Last Physician, Licensed Psychiatric-Mental Health Advanced Practice Registered Nurse, or Licensed Clinical Psychologist

_____

_____

The name and address of respondent's legal guardian, spouse, and adult next of kin are:

Name Kinship Address _____ Legal Guardian

_____ _____ _____ Spouse

_____ _____ _____ Adult Next of Kin

_____ _____ _____ Adult Next of Kin

_____ _____

The following constitutes additional information that may be necessary for the purpose of determining residence:

_____

_____

_____

_____

_____

Dated this _____ day of _____, 20___

_____

Signature of the party filing the affidavit

Sworn to before me and signed in my presence on the day and year above dated.

_____

Signature of Probate Judge, Deputy Clerk, or Notary Public

WAIVER

I, the undersigned party filing the affidavit hereby waive the issuing and service of notice of the hearing on said affidavit, and voluntarily enter my appearance herein.

Dated this _____ day of _____, 20___

_____

Signature of the party filing the affidavit

Sec. 5122.14. (A)(1) Immediately after acceptance of an affidavit required under section 5122.11 of the Revised Code, the court may appoint a psychiatrist, a licensed psychiatric-mental health advanced practice registered nurse, or a licensed clinical psychologist ~~and~~ in conjunction with a licensed physician or licensed psychiatric-mental health advanced practice registered nurse to examine the respondent~~, and at~~. At

the first hearing held pursuant to section 5122.141 of the Revised Code, ~~such psychiatrist, or licensed clinical psychologist and licensed physician,~~ the one or more persons appointed to conduct the examination shall report to the court ~~his~~ the findings of the examination as to the mental condition of the respondent, and ~~his~~ the respondent's need for custody, care, or treatment in a mental hospital. ~~The~~

(2) In lieu of appointing persons under division (A)(1) of this section to examine the respondent, the court may accept as evidence ~~the~~ a written report ~~of a psychiatrist, or the written report of a licensed clinical psychologist and a licensed physician~~ that has been prepared by any of the following persons, designated by ~~the~~ a board of alcohol, drug addiction, and mental health services, as if that written report were the report and findings referred to in division (A)(1) of this section: a psychiatrist, a licensed psychiatric-mental health advanced practice registered nurse, or a licensed clinical psychologist in conjunction with a licensed physician or licensed psychiatric-mental health advanced practice registered nurse.

(B) The examination, if possible, shall be held at a hospital or other medical facility, at the home of the respondent, or at any other suitable place least likely to have a harmful effect on the respondent's health.

(C) The court shall prior to a hearing under section 5122.141 or 5122.15 of the Revised Code release a copy of the report to the respondent's counsel.

Sec. 5145.22. (A) ~~The chief~~ A physician, clinical nurse specialist, or certified nurse practitioner who is designated by the department of rehabilitation and correction shall keep a

correct record of vital statistics of the penitentiary, containing the name, nationality or race, weight, stature, former occupation, and family history of each prisoner, a statement of the condition of the heart, lungs, and other leading organs, rate of the pulse and respiration, measurement of the chest and abdomen, condition of the inguinal canal, and the arch of the foot, and any existing disease, deformity, or other disability, acquired or inherited. The ~~chief~~ physician or nurse designated by the department shall perform such other duties in the line of ~~his~~ the physician's or nurse's profession as the department ~~of rehabilitation and correction~~ requires.

(B) The ~~chief~~ physician or nurse designated under division (A) of this section shall keep a separate medical record of each prisoner as provided in division (C) of section 5120.21 of the Revised Code.

Sec. 5164.08. (A) As used in this section, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) The medicaid program shall cover both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The medicaid program's coverage of screening ~~mammography~~ mammographies pursuant to division (B)(1) of this section shall be provided in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D) The medicaid program's coverage of screening mammographies pursuant to division (B)(1) of this section shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(E) The medicaid program's coverage of cytologic screenings pursuant to division (B)(2) of this section shall be

provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 5502.522. (A) There is hereby created the statewide emergency alert program to aid in the identification and location of any individual who has a mental impairment or is sixty-five years of age or older, who is or is believed to be a temporary or permanent resident of this state, is at a location that cannot be determined by an individual familiar with the missing individual, and is incapable of returning to the missing individual's residence without assistance, and whose disappearance, as determined by a law enforcement agency, poses a credible threat of immediate danger of serious bodily harm or death to the missing individual. The program shall be a coordinated effort among the governor's office, the department of public safety, the attorney general, law enforcement agencies, the state's public and commercial television and radio broadcasters, and others as determined necessary by the governor. No name shall be given to the program created under this division that conflicts with any alert code standards that are required by federal law and that govern the naming of emergency alert programs.

(B) The statewide emergency alert program shall not be implemented unless all of the following activation criteria are met:

(1) The local investigating law enforcement agency confirms that the individual is missing.

(2) The individual is sixty-five years of age or older or has a mental impairment.

(3) The disappearance of the individual poses a credible threat of immediate danger of serious bodily harm or death to the individual.

(4) There is sufficient descriptive information about the individual and the circumstances surrounding the individual's disappearance to indicate that activation of the alert will help locate the individual.

(C) Nothing in division (B) of this section prevents the activation of a local or regional emergency alert program that may impose different criteria for the activation of a local or regional plan.

(D) Any radio broadcast station, television broadcast station, or cable system participating in the statewide emergency alert program or in any local or regional emergency alert program, and any director, officer, employee, or agent of any station or system participating in either type of alert program, shall not be liable to any person for damages for any loss allegedly caused by or resulting from the station's or system's broadcast or cablecast of, or failure to broadcast or cablecast, any information pursuant to the statewide emergency alert program or the local or regional emergency alert program.

(E) A local investigating law enforcement agency shall not be required to notify the statewide emergency alert program that the law enforcement agency has received information that meets the activation criteria set forth in division (B) of this section during the first twenty-four hours after the law enforcement agency receives the information.

(F) Nothing in this section shall be construed to authorize the use of the federal emergency alert system unless

otherwise authorized by federal law.

(G) As used in this section:

(1) "Cable system" has the same meaning as in section 2913.04 of the Revised Code.

(2) "Law enforcement agency" includes, but is not limited to, a county sheriff's office, the office of a village marshal, a police department of a municipal corporation, a police force of a regional transit authority, a police force of a metropolitan housing authority, the state highway patrol, a state university law enforcement agency, the office of a township police constable, and the police department of a township or joint police district.

(3) "Mental impairment" means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, or ability to live independently or provide self-care as certified by one of the following: a licensed physician, including a physician who is a psychiatrist~~,~~; a clinical nurse specialist or certified nurse practitioner who is certified as a psychiatric-mental health CNS or psychiatric-mental health NP by the American nurses credentialing center; or a licensed psychologist.

Sec. 5739.01. As used in this chapter:

(A) "Person" includes individuals, receivers, assignees, trustees in bankruptcy, estates, firms, partnerships, associations, joint-stock companies, joint ventures, clubs, societies, corporations, the state and its political subdivisions, and combinations of individuals of any form.

(B) "Sale" and "selling" include all of the following transactions for a consideration in any manner, whether

absolutely or conditionally, whether for a price or rental, in money or by exchange, and by any means whatsoever:

(1) All transactions by which title or possession, or both, of tangible personal property, is or is to be transferred, or a license to use or consume tangible personal property is or is to be granted;

(2) All transactions by which lodging by a hotel is or is to be furnished to transient guests;

(3) All transactions by which:

(a) An item of tangible personal property is or is to be repaired, except property, the purchase of which would not be subject to the tax imposed by section 5739.02 of the Revised Code;

(b) An item of tangible personal property is or is to be installed, except property, the purchase of which would not be subject to the tax imposed by section 5739.02 of the Revised Code or property that is or is to be incorporated into and will become a part of a production, transmission, transportation, or distribution system for the delivery of a public utility service;

(c) The service of washing, cleaning, waxing, polishing, or painting a motor vehicle is or is to be furnished;

(d) Laundry and dry cleaning services are or are to be provided;

(e) Automatic data processing, computer services, or electronic information services are or are to be provided for use in business when the true object of the transaction is the receipt by the consumer of automatic data processing, computer

services, or electronic information services rather than the receipt of personal or professional services to which automatic data processing, computer services, or electronic information services are incidental or supplemental. Notwithstanding any other provision of this chapter, such transactions that occur between members of an affiliated group are not sales. An "affiliated group" means two or more persons related in such a way that one person owns or controls the business operation of another member of the group. In the case of corporations with stock, one corporation owns or controls another if it owns more than fifty per cent of the other corporation's common stock with voting rights.

(f) Telecommunications service, including prepaid calling service, prepaid wireless calling service, or ancillary service, is or is to be provided, but not including coin-operated telephone service;

(g) Landscaping and lawn care service is or is to be provided;

(h) Private investigation and security service is or is to be provided;

(i) Information services or tangible personal property is provided or ordered by means of a nine hundred telephone call;

(j) Building maintenance and janitorial service is or is to be provided;

(k) Exterminating service is or is to be provided;

(l) Physical fitness facility service is or is to be provided;

(m) Recreation and sports club service is or is to be

provided;

(n) Satellite broadcasting service is or is to be provided;

(o) Personal care service is or is to be provided to an individual. As used in this division, "personal care service" includes skin care, the application of cosmetics, manicuring, pedicuring, hair removal, tattooing, body piercing, tanning, massage, and other similar services. "Personal care service" does not include a service provided by or on the order of a licensed physician ~~or licensed~~, certified nurse-midwife, clinical nurse specialist, certified nurse practitioner, or chiropractor, or the cutting, coloring, or styling of an individual's hair.

(p) The transportation of persons by motor vehicle or aircraft is or is to be provided, when the transportation is entirely within this state, except for transportation provided by an ambulance service, by a transit bus, as defined in section 5735.01 of the Revised Code, and transportation provided by a citizen of the United States holding a certificate of public convenience and necessity issued under 49 U.S.C. 41102;

(q) Motor vehicle towing service is or is to be provided. As used in this division, "motor vehicle towing service" means the towing or conveyance of a wrecked, disabled, or illegally parked motor vehicle.

(r) Snow removal service is or is to be provided. As used in this division, "snow removal service" means the removal of snow by any mechanized means, but does not include the providing of such service by a person that has less than five thousand dollars in sales of such service during the calendar year.

(s) Electronic publishing service is or is to be provided to a consumer for use in business, except that such transactions occurring between members of an affiliated group, as defined in division (B)(3)(e) of this section, are not sales.

(4) All transactions by which printed, imprinted, overprinted, lithographic, multilithic, blueprinted, photostatic, or other productions or reproductions of written or graphic matter are or are to be furnished or transferred;

(5) The production or fabrication of tangible personal property for a consideration for consumers who furnish either directly or indirectly the materials used in the production of fabrication work; and include the furnishing, preparing, or serving for a consideration of any tangible personal property consumed on the premises of the person furnishing, preparing, or serving such tangible personal property. Except as provided in section 5739.03 of the Revised Code, a construction contract pursuant to which tangible personal property is or is to be incorporated into a structure or improvement on and becoming a part of real property is not a sale of such tangible personal property. The construction contractor is the consumer of such tangible personal property, provided that the sale and installation of carpeting, the sale and installation of agricultural land tile, the sale and erection or installation of portable grain bins, or the provision of landscaping and lawn care service and the transfer of property as part of such service is never a construction contract.

As used in division (B)(5) of this section:

(a) "Agricultural land tile" means fired clay or concrete tile, or flexible or rigid perforated plastic pipe or tubing, incorporated or to be incorporated into a subsurface drainage

system appurtenant to land used or to be used primarily in production by farming, agriculture, horticulture, or floriculture. The term does not include such materials when they are or are to be incorporated into a drainage system appurtenant to a building or structure even if the building or structure is used or to be used in such production.

(b) "Portable grain bin" means a structure that is used or to be used by a person engaged in farming or agriculture to shelter the person's grain and that is designed to be disassembled without significant damage to its component parts.

(6) All transactions in which all of the shares of stock of a closely held corporation are transferred, or an ownership interest in a pass-through entity, as defined in section 5733.04 of the Revised Code, is transferred, if the corporation or pass-through entity is not engaging in business and its entire assets consist of boats, planes, motor vehicles, or other tangible personal property operated primarily for the use and enjoyment of the shareholders or owners;

(7) All transactions in which a warranty, maintenance or service contract, or similar agreement by which the vendor of the warranty, contract, or agreement agrees to repair or maintain the tangible personal property of the consumer is or is to be provided;

(8) The transfer of copyrighted motion picture films used solely for advertising purposes, except that the transfer of such films for exhibition purposes is not a sale;

(9) All transactions by which tangible personal property is or is to be stored, except such property that the consumer of the storage holds for sale in the regular course of business;

(10) All transactions in which "guaranteed auto protection" is provided whereby a person promises to pay to the consumer the difference between the amount the consumer receives from motor vehicle insurance and the amount the consumer owes to a person holding title to or a lien on the consumer's motor vehicle in the event the consumer's motor vehicle suffers a total loss under the terms of the motor vehicle insurance policy or is stolen and not recovered, if the protection and its price are included in the purchase or lease agreement;

(11)(a) Except as provided in division (B)(11)(b) of this section, all transactions by which health care services are paid for, reimbursed, provided, delivered, arranged for, or otherwise made available by a medicaid health insuring corporation pursuant to the corporation's contract with the state.

(b) If the centers for medicare and medicaid services of the United States department of health and human services determines that the taxation of transactions described in division (B)(11)(a) of this section constitutes an impermissible health care-related tax under the "Social Security Act," section 1903(w), 42 U.S.C. 1396b(w), and regulations adopted thereunder, the medicaid director shall notify the tax commissioner of that determination. Beginning with the first day of the month following that notification, the transactions described in division (B)(11)(a) of this section are not sales for the purposes of this chapter or Chapter 5741. of the Revised Code. The tax commissioner shall order that the collection of taxes under sections 5739.02, 5739.021, 5739.023, 5739.026, 5741.02, 5741.021, 5741.022, and 5741.023 of the Revised Code shall cease for transactions occurring on or after that date.

(12) All transactions by which a specified digital product

is provided for permanent use or less than permanent use, regardless of whether continued payment is required.

Except as provided in this section, "sale" and "selling" do not include transfers of interest in leased property where the original lessee and the terms of the original lease agreement remain unchanged, or professional, insurance, or personal service transactions that involve the transfer of tangible personal property as an inconsequential element, for which no separate charges are made.

(C) "Vendor" means the person providing the service or by whom the transfer effected or license given by a sale is or is to be made or given and, for sales described in division (B)(3)(i) of this section, the telecommunications service vendor that provides the nine hundred telephone service; if two or more persons are engaged in business at the same place of business under a single trade name in which all collections on account of sales by each are made, such persons shall constitute a single vendor.

Physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, dentists, hospitals, and veterinarians who are engaged in selling tangible personal property as received from others, such as eyeglasses, mouthwashes, dentifrices, or similar articles, are vendors. Veterinarians who are engaged in transferring to others for a consideration drugs, the dispensing of which does not require an order of a licensed veterinarian ~~or~~, physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner under federal law, are vendors.

The operator of any peer-to-peer car sharing program shall be considered to be the vendor.

(D)(1) "Consumer" means the person for whom the service is provided, to whom the transfer effected or license given by a sale is or is to be made or given, to whom the service described in division (B)(3)(f) or (i) of this section is charged, or to whom the admission is granted.

(2) Physicians, certified nurse-midwives, clinical nurse specialists, certified nurse practitioners, dentists, hospitals, and blood banks operated by nonprofit institutions and persons licensed to practice veterinary medicine, surgery, and dentistry are consumers of all tangible personal property and services purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service, or the practice of veterinary medicine, surgery, and dentistry. In addition to being consumers of drugs administered by them or by their assistants according to their direction, veterinarians also are consumers of drugs that under federal law may be dispensed only by or upon the order of a licensed veterinarian ~~or~~, physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner, when transferred by them to others for a consideration to provide treatment to animals as directed by the veterinarian.

(3) A person who performs a facility management, or similar service contract for a contractee is a consumer of all tangible personal property and services purchased for use in connection with the performance of such contract, regardless of whether title to any such property vests in the contractee. The purchase of such property and services is not subject to the exception for resale under division (E) of this section.

(4)(a) In the case of a person who purchases printed matter for the purpose of distributing it or having it

distributed to the public or to a designated segment of the public, free of charge, that person is the consumer of that printed matter, and the purchase of that printed matter for that purpose is a sale.

(b) In the case of a person who produces, rather than purchases, printed matter for the purpose of distributing it or having it distributed to the public or to a designated segment of the public, free of charge, that person is the consumer of all tangible personal property and services purchased for use or consumption in the production of that printed matter. That person is not entitled to claim exemption under division (B)(42)(f) of section 5739.02 of the Revised Code for any material incorporated into the printed matter or any equipment, supplies, or services primarily used to produce the printed matter.

(c) The distribution of printed matter to the public or to a designated segment of the public, free of charge, is not a sale to the members of the public to whom the printed matter is distributed or to any persons who purchase space in the printed matter for advertising or other purposes.

(5) A person who makes sales of any of the services listed in division (B)(3) of this section is the consumer of any tangible personal property used in performing the service. The purchase of that property is not subject to the resale exception under division (E) of this section.

(6) A person who engages in highway transportation for hire is the consumer of all packaging materials purchased by that person and used in performing the service, except for packaging materials sold by such person in a transaction separate from the service.

(7) In the case of a transaction for health care services under division (B)(11) of this section, a medicaid health insuring corporation is the consumer of such services. The purchase of such services by a medicaid health insuring corporation is not subject to the exception for resale under division (E) of this section or to the exemptions provided under divisions (B)(12), (18), (19), and (22) of section 5739.02 of the Revised Code.

(E) "Retail sale" and "sales at retail" include all sales, except those in which the purpose of the consumer is to resell the thing transferred or benefit of the service provided, by a person engaging in business, in the form in which the same is, or is to be, received by the person.

(F) "Business" includes any activity engaged in by any person with the object of gain, benefit, or advantage, either direct or indirect. "Business" does not include the activity of a person in managing and investing the person's own funds.

(G) "Engaging in business" means commencing, conducting, or continuing in business, and liquidating a business when the liquidator thereof holds itself out to the public as conducting such business. Making a casual sale is not engaging in business.

(H)(1)(a) "Price," except as provided in divisions (H)(2), (3), and (4) of this section, means the total amount of consideration, including cash, credit, property, and services, for which tangible personal property or services are sold, leased, or rented, valued in money, whether received in money or otherwise, without any deduction for any of the following:

(i) The vendor's cost of the property sold;

(ii) The cost of materials used, labor or service costs,

interest, losses, all costs of transportation to the vendor, all taxes imposed on the vendor, including the tax imposed under Chapter 5751. of the Revised Code, and any other expense of the vendor;

(iii) Charges by the vendor for any services necessary to complete the sale;

(iv) Delivery charges. As used in this division, "delivery charges" means charges by the vendor for preparation and delivery to a location designated by the consumer of tangible personal property or a service, including transportation, shipping, postage, handling, crating, and packing.

(v) Installation charges;

(vi) Credit for any trade-in.

(b) "Price" includes consideration received by the vendor from a third party, if the vendor actually receives the consideration from a party other than the consumer, and the consideration is directly related to a price reduction or discount on the sale; the vendor has an obligation to pass the price reduction or discount through to the consumer; the amount of the consideration attributable to the sale is fixed and determinable by the vendor at the time of the sale of the item to the consumer; and one of the following criteria is met:

(i) The consumer presents a coupon, certificate, or other document to the vendor to claim a price reduction or discount where the coupon, certificate, or document is authorized, distributed, or granted by a third party with the understanding that the third party will reimburse any vendor to whom the coupon, certificate, or document is presented;

(ii) The consumer identifies the consumer's self to the

seller as a member of a group or organization entitled to a price reduction or discount. A preferred customer card that is available to any patron does not constitute membership in such a group or organization.

(iii) The price reduction or discount is identified as a third party price reduction or discount on the invoice received by the consumer, or on a coupon, certificate, or other document presented by the consumer.

(c) "Price" does not include any of the following:

(i) Discounts, including cash, term, or coupons that are not reimbursed by a third party that are allowed by a vendor and taken by a consumer on a sale;

(ii) Interest, financing, and carrying charges from credit extended on the sale of tangible personal property or services, if the amount is separately stated on the invoice, bill of sale, or similar document given to the purchaser;

(iii) Any taxes legally imposed directly on the consumer that are separately stated on the invoice, bill of sale, or similar document given to the consumer. For the purpose of this division, the tax imposed under Chapter 5751. of the Revised Code is not a tax directly on the consumer, even if the tax or a portion thereof is separately stated.

(iv) Notwithstanding divisions (H)(1)(b)(i) to (iii) of this section, any discount allowed by an automobile manufacturer to its employee, or to the employee of a supplier, on the purchase of a new motor vehicle from a new motor vehicle dealer in this state.

(v) The dollar value of a gift card that is not sold by a vendor or purchased by a consumer and that is redeemed by the

consumer in purchasing tangible personal property or services if the vendor is not reimbursed and does not receive compensation from a third party to cover all or part of the gift card value. For the purposes of this division, a gift card is not sold by a vendor or purchased by a consumer if it is distributed pursuant to an awards, loyalty, or promotional program. Past and present purchases of tangible personal property or services by the consumer shall not be treated as consideration exchanged for a gift card.

(2) In the case of a sale of any new motor vehicle by a new motor vehicle dealer, as defined in section 4517.01 of the Revised Code, in which another motor vehicle is accepted by the dealer as part of the consideration received, "price" has the same meaning as in division (H)(1) of this section, reduced by the credit afforded the consumer by the dealer for the motor vehicle received in trade.

(3) In the case of a sale of any watercraft or outboard motor by a watercraft dealer licensed in accordance with section 1547.543 of the Revised Code, in which another watercraft, watercraft and trailer, or outboard motor is accepted by the dealer as part of the consideration received, "price" has the same meaning as in division (H)(1) of this section, reduced by the credit afforded the consumer by the dealer for the watercraft, watercraft and trailer, or outboard motor received in trade. As used in this division, "watercraft" includes an outdrive unit attached to the watercraft.

(4) In the case of transactions for health care services under division (B)(11) of this section, "price" means the amount of managed care premiums received each month by a medicaid health insuring corporation.

(I) "Receipts" means the total amount of the prices of the sales of vendors, provided that the dollar value of gift cards distributed pursuant to an awards, loyalty, or promotional program, and cash discounts allowed and taken on sales at the time they are consummated are not included, minus any amount deducted as a bad debt pursuant to section 5739.121 of the Revised Code. "Receipts" does not include the sale price of property returned or services rejected by consumers when the full sale price and tax are refunded either in cash or by credit.

(J) "Place of business" means any location at which a person engages in business.

(K) "Premises" includes any real property or portion thereof upon which any person engages in selling tangible personal property at retail or making retail sales and also includes any real property or portion thereof designated for, or devoted to, use in conjunction with the business engaged in by such person.

(L) "Casual sale" means a sale of an item of tangible personal property that was obtained by the person making the sale, through purchase or otherwise, for the person's own use and was previously subject to any state's taxing jurisdiction on its sale or use, and includes such items acquired for the seller's use that are sold by an auctioneer employed directly by the person for such purpose, provided the location of such sales is not the auctioneer's permanent place of business. As used in this division, "permanent place of business" includes any location where such auctioneer has conducted more than two auctions during the year.

(M) "Hotel" means every establishment kept, used,

maintained, advertised, or held out to the public to be a place where sleeping accommodations are offered to guests, in which five or more rooms are used for the accommodation of such guests, whether the rooms are in one or several structures, except as otherwise provided in section 5739.091 of the Revised Code.

(N) "Transient guests" means persons occupying a room or rooms for sleeping accommodations for less than thirty consecutive days.

(O) "Making retail sales" means the effecting of transactions wherein one party is obligated to pay the price and the other party is obligated to provide a service or to transfer title to or possession of the item sold. "Making retail sales" does not include the preliminary acts of promoting or soliciting the retail sales, other than the distribution of printed matter which displays or describes and prices the item offered for sale, nor does it include delivery of a predetermined quantity of tangible personal property or transportation of property or personnel to or from a place where a service is performed.

(P) "Used directly in the rendition of a public utility service" means that property that is to be incorporated into and will become a part of the consumer's production, transmission, transportation, or distribution system and that retains its classification as tangible personal property after such incorporation; fuel or power used in the production, transmission, transportation, or distribution system; and tangible personal property used in the repair and maintenance of the production, transmission, transportation, or distribution system, including only such motor vehicles as are specially designed and equipped for such use. Tangible personal property

and services used primarily in providing highway transportation for hire are not used directly in the rendition of a public utility service. In this definition, "public utility" includes a citizen of the United States holding, and required to hold, a certificate of public convenience and necessity issued under 49 U.S.C. 41102.

(Q) "Refining" means removing or separating a desirable product from raw or contaminated materials by distillation or physical, mechanical, or chemical processes.

(R) "Assembly" and "assembling" mean attaching or fitting together parts to form a product, but do not include packaging a product.

(S) "Manufacturing operation" means a process in which materials are changed, converted, or transformed into a different state or form from which they previously existed and includes refining materials, assembling parts, and preparing raw materials and parts by mixing, measuring, blending, or otherwise committing such materials or parts to the manufacturing process. "Manufacturing operation" does not include packaging.

(T) "Fiscal officer" means, with respect to a regional transit authority, the secretary-treasurer thereof, and with respect to a county that is a transit authority, the fiscal officer of the county transit board if one is appointed pursuant to section 306.03 of the Revised Code or the county auditor if the board of county commissioners operates the county transit system.

(U) "Transit authority" means a regional transit authority created pursuant to section 306.31 of the Revised Code or a county in which a county transit system is created pursuant to

section 306.01 of the Revised Code. For the purposes of this chapter, a transit authority must extend to at least the entire area of a single county. A transit authority that includes territory in more than one county must include all the area of the most populous county that is a part of such transit authority. County population shall be measured by the most recent census taken by the United States census bureau.

(V) "Legislative authority" means, with respect to a regional transit authority, the board of trustees thereof, and with respect to a county that is a transit authority, the board of county commissioners.

(W) "Territory of the transit authority" means all of the area included within the territorial boundaries of a transit authority as they from time to time exist. Such territorial boundaries must at all times include all the area of a single county or all the area of the most populous county that is a part of such transit authority. County population shall be measured by the most recent census taken by the United States census bureau.

(X) "Providing a service" means providing or furnishing anything described in division (B)(3) of this section for consideration.

(Y)(1)(a) "Automatic data processing" means processing of others' data, including keypunching or similar data entry services together with verification thereof, or providing access to computer equipment for the purpose of processing data.

(b) "Computer services" means providing services consisting of specifying computer hardware configurations and evaluating technical processing characteristics, computer

programming, and training of computer programmers and operators, provided in conjunction with and to support the sale, lease, or operation of taxable computer equipment or systems.

(c) "Electronic information services" means providing access to computer equipment by means of telecommunications equipment for the purpose of either of the following:

(i) Examining or acquiring data stored in or accessible to the computer equipment;

(ii) Placing data into the computer equipment to be retrieved by designated recipients with access to the computer equipment.

"Electronic information services" does not include electronic publishing.

(d) "Automatic data processing, computer services, or electronic information services" shall not include personal or professional services.

(2) As used in divisions (B)(3)(e) and (Y)(1) of this section, "personal and professional services" means all services other than automatic data processing, computer services, or electronic information services, including but not limited to:

(a) Accounting and legal services such as advice on tax matters, asset management, budgetary matters, quality control, information security, and auditing and any other situation where the service provider receives data or information and studies, alters, analyzes, interprets, or adjusts such material;

(b) Analyzing business policies and procedures;

(c) Identifying management information needs;

(d) Feasibility studies, including economic and technical analysis of existing or potential computer hardware or software needs and alternatives;

(e) Designing policies, procedures, and custom software for collecting business information, and determining how data should be summarized, sequenced, formatted, processed, controlled, and reported so that it will be meaningful to management;

(f) Developing policies and procedures that document how business events and transactions are to be authorized, executed, and controlled;

(g) Testing of business procedures;

(h) Training personnel in business procedure applications;

(i) Providing credit information to users of such information by a consumer reporting agency, as defined in the "Fair Credit Reporting Act," 84 Stat. 1114, 1129 (1970), 15 U.S.C. 1681a(f), or as hereafter amended, including but not limited to gathering, organizing, analyzing, recording, and furnishing such information by any oral, written, graphic, or electronic medium;

(j) Providing debt collection services by any oral, written, graphic, or electronic means;

(k) Providing digital advertising services.

The services listed in divisions (Y)(2)(a) to (k) of this section are not automatic data processing or computer services.

(Z) "Highway transportation for hire" means the transportation of personal property belonging to others for consideration by any of the following:

(1) The holder of a permit or certificate issued by this state or the United States authorizing the holder to engage in transportation of personal property belonging to others for consideration over or on highways, roadways, streets, or any similar public thoroughfare;

(2) A person who engages in the transportation of personal property belonging to others for consideration over or on highways, roadways, streets, or any similar public thoroughfare but who could not have engaged in such transportation on December 11, 1985, unless the person was the holder of a permit or certificate of the types described in division (Z)(1) of this section;

(3) A person who leases a motor vehicle to and operates it for a person described by division (Z)(1) or (2) of this section.

(AA)(1) "Telecommunications service" means the electronic transmission, conveyance, or routing of voice, data, audio, video, or any other information or signals to a point, or between or among points. "Telecommunications service" includes such transmission, conveyance, or routing in which computer processing applications are used to act on the form, code, or protocol of the content for purposes of transmission, conveyance, or routing without regard to whether the service is referred to as voice-over internet protocol service or is classified by the federal communications commission as enhanced or value-added. "Telecommunications service" does not include any of the following:

(a) Data processing and information services that allow data to be generated, acquired, stored, processed, or retrieved and delivered by an electronic transmission to a consumer where

the consumer's primary purpose for the underlying transaction is the processed data or information;

(b) Installation or maintenance of wiring or equipment on a customer's premises;

(c) Tangible personal property;

(d) Advertising, including directory advertising;

(e) Billing and collection services provided to third parties;

(f) Internet access service;

(g) Radio and television audio and video programming services, regardless of the medium, including the furnishing of transmission, conveyance, and routing of such services by the programming service provider. Radio and television audio and video programming services include, but are not limited to, cable service, as defined in 47 U.S.C. 522(6), and audio and video programming services delivered by commercial mobile radio service providers, as defined in 47 C.F.R. 20.3;

(h) Ancillary service;

(i) Digital products delivered electronically, including software, music, video, reading materials, or ring tones.

(2) "Ancillary service" means a service that is associated with or incidental to the provision of telecommunications service, including conference bridging service, detailed telecommunications billing service, directory assistance, vertical service, and voice mail service. As used in this division:

(a) "Conference bridging service" means an ancillary

service that links two or more participants of an audio or video conference call, including providing a telephone number. "Conference bridging service" does not include telecommunications services used to reach the conference bridge.

(b) "Detailed telecommunications billing service" means an ancillary service of separately stating information pertaining to individual calls on a customer's billing statement.

(c) "Directory assistance" means an ancillary service of providing telephone number or address information.

(d) "Vertical service" means an ancillary service that is offered in connection with one or more telecommunications services, which offers advanced calling features that allow customers to identify callers and manage multiple calls and call connections, including conference bridging service.

(e) "Voice mail service" means an ancillary service that enables the customer to store, send, or receive recorded messages. "Voice mail service" does not include any vertical services that the customer may be required to have in order to utilize the voice mail service.

(3) "900 service" means an inbound toll telecommunications service purchased by a subscriber that allows the subscriber's customers to call in to the subscriber's prerecorded announcement or live service, and which is typically marketed under the name "900 service" and any subsequent numbers designated by the federal communications commission. "900 service" does not include the charge for collection services provided by the seller of the telecommunications service to the subscriber, or services or products sold by the subscriber to the subscriber's customer.

(4) "Prepaid calling service" means the right to access exclusively telecommunications services, which must be paid for in advance and which enables the origination of calls using an access number or authorization code, whether manually or electronically dialed, and that is sold in predetermined units or dollars of which the number declines with use in a known amount.

(5) "Prepaid wireless calling service" means a telecommunications service that provides the right to utilize mobile telecommunications service as well as other non-telecommunications services, including the download of digital products delivered electronically, and content and ancillary services, that must be paid for in advance and that is sold in predetermined units or dollars of which the number declines with use in a known amount.

(6) "Value-added non-voice data service" means a telecommunications service in which computer processing applications are used to act on the form, content, code, or protocol of the information or data primarily for a purpose other than transmission, conveyance, or routing.

(7) "Coin-operated telephone service" means a telecommunications service paid for by inserting money into a telephone accepting direct deposits of money to operate.

(8) "Customer" has the same meaning as in section 5739.034 of the Revised Code.

(BB) "Laundry and dry cleaning services" means removing soil or dirt from towels, linens, articles of clothing, or other fabric items that belong to others and supplying towels, linens, articles of clothing, or other fabric items. "Laundry and dry

cleaning services" does not include the provision of self-service facilities for use by consumers to remove soil or dirt from towels, linens, articles of clothing, or other fabric items.

(CC) "Magazines distributed as controlled circulation publications" means magazines containing at least twenty-four pages, at least twenty-five per cent editorial content, issued at regular intervals four or more times a year, and circulated without charge to the recipient, provided that such magazines are not owned or controlled by individuals or business concerns which conduct such publications as an auxiliary to, and essentially for the advancement of the main business or calling of, those who own or control them.

(DD) "Landscaping and lawn care service" means the services of planting, seeding, sodding, removing, cutting, trimming, pruning, mulching, aerating, applying chemicals, watering, fertilizing, and providing similar services to establish, promote, or control the growth of trees, shrubs, flowers, grass, ground cover, and other flora, or otherwise maintaining a lawn or landscape grown or maintained by the owner for ornamentation or other nonagricultural purpose. However, "landscaping and lawn care service" does not include the providing of such services by a person who has less than five thousand dollars in sales of such services during the calendar year.

(EE) "Private investigation and security service" means the performance of any activity for which the provider of such service is required to be licensed pursuant to Chapter 4749. of the Revised Code, or would be required to be so licensed in performing such services in this state, and also includes the

services of conducting polygraph examinations and of monitoring or overseeing the activities on or in, or the condition of, the consumer's home, business, or other facility by means of electronic or similar monitoring devices. "Private investigation and security service" does not include special duty services provided by off-duty police officers, deputy sheriffs, and other peace officers regularly employed by the state or a political subdivision.

(FF) "Information services" means providing conversation, giving consultation or advice, playing or making a voice or other recording, making or keeping a record of the number of callers, and any other service provided to a consumer by means of a nine hundred telephone call, except when the nine hundred telephone call is the means by which the consumer makes a contribution to a recognized charity.

(GG) "Research and development" means designing, creating, or formulating new or enhanced products, equipment, or manufacturing processes, and also means conducting scientific or technological inquiry and experimentation in the physical sciences with the goal of increasing scientific knowledge which may reveal the bases for new or enhanced products, equipment, or manufacturing processes.

(HH) "Qualified research and development equipment" means capitalized tangible personal property, and leased personal property that would be capitalized if purchased, used by a person primarily to perform research and development. Tangible personal property primarily used in testing, as defined in division (A)(4) of section 5739.011 of the Revised Code, or used for recording or storing test results, is not qualified research and development equipment unless such property is primarily used

by the consumer in testing the product, equipment, or manufacturing process being created, designed, or formulated by the consumer in the research and development activity or in recording or storing such test results.

(II) "Building maintenance and janitorial service" means cleaning the interior or exterior of a building and any tangible personal property located therein or thereon, including any services incidental to such cleaning for which no separate charge is made. However, "building maintenance and janitorial service" does not include the providing of such service by a person who has less than five thousand dollars in sales of such service during the calendar year. As used in this division, "cleaning" does not include sanitation services necessary for an establishment described in 21 U.S.C. 608 to comply with rules and regulations adopted pursuant to that section.

(JJ) "Exterminating service" means eradicating or attempting to eradicate vermin infestations from a building or structure, or the area surrounding a building or structure, and includes activities to inspect, detect, or prevent vermin infestation of a building or structure.

(KK) "Physical fitness facility service" means all transactions by which a membership is granted, maintained, or renewed, including initiation fees, membership dues, renewal fees, monthly minimum fees, and other similar fees and dues, by a physical fitness facility such as an athletic club, health spa, or gymnasium, which entitles the member to use the facility for physical exercise.

(LL) "Recreation and sports club service" means all transactions by which a membership is granted, maintained, or renewed, including initiation fees, membership dues, renewal

fees, monthly minimum fees, and other similar fees and dues, by a recreation and sports club, which entitles the member to use the facilities of the organization. "Recreation and sports club" means an organization that has ownership of, or controls or leases on a continuing, long-term basis, the facilities used by its members and includes an aviation club, gun or shooting club, yacht club, card club, swimming club, tennis club, golf club, country club, riding club, amateur sports club, or similar organization.

(MM) "Livestock" means farm animals commonly raised for food, food production, or other agricultural purposes, including, but not limited to, cattle, sheep, goats, swine, poultry, and captive deer. "Livestock" does not include invertebrates, amphibians, reptiles, domestic pets, animals for use in laboratories or for exhibition, or other animals not commonly raised for food or food production.

(NN) "Livestock structure" means a building or structure used exclusively for the housing, raising, feeding, or sheltering of livestock, and includes feed storage or handling structures and structures for livestock waste handling.

(OO) "Horticulture" means the growing, cultivation, and production of flowers, fruits, herbs, vegetables, sod, mushrooms, and nursery stock. As used in this division, "nursery stock" has the same meaning as in section 927.51 of the Revised Code.

(PP) "Horticulture structure" means a building or structure used exclusively for the commercial growing, raising, or overwintering of horticultural products, and includes the area used for stocking, storing, and packing horticultural products when done in conjunction with the production of those

products.

(QQ) "Newspaper" means an unbound publication bearing a title or name that is regularly published, at least as frequently as biweekly, and distributed from a fixed place of business to the public in a specific geographic area, and that contains a substantial amount of news matter of international, national, or local events of interest to the general public.

(RR)(1) "Feminine hygiene products" means tampons, panty liners, menstrual cups, sanitary napkins, and other similar tangible personal property designed for feminine hygiene in connection with the human menstrual cycle, but does not include grooming and hygiene products.

(2) "Grooming and hygiene products" means soaps and cleaning solutions, shampoo, toothpaste, mouthwash, antiperspirants, and sun tan lotions and screens, regardless of whether any of these products are over-the-counter drugs.

(3) "Over-the-counter drugs" means a drug that contains a label that identifies the product as a drug as required by 21 C.F.R. 201.66, which label includes a drug facts panel or a statement of the active ingredients with a list of those ingredients contained in the compound, substance, or preparation.

(SS)(1) "Lease" or "rental" means any transfer of the possession or control of tangible personal property for a fixed or indefinite term, for consideration. "Lease" or "rental" includes future options to purchase or extend, and agreements described in 26 U.S.C. 7701(h)(1) covering motor vehicles and trailers where the amount of consideration may be increased or decreased by reference to the amount realized upon the sale or

disposition of the property. "Lease" or "rental" does not include:

(a) A transfer of possession or control of tangible personal property under a security agreement or a deferred payment plan that requires the transfer of title upon completion of the required payments;

(b) A transfer of possession or control of tangible personal property under an agreement that requires the transfer of title upon completion of required payments and payment of an option price that does not exceed the greater of one hundred dollars or one per cent of the total required payments;

(c) Providing tangible personal property along with an operator for a fixed or indefinite period of time, if the operator is necessary for the property to perform as designed. For purposes of this division, the operator must do more than maintain, inspect, or set up the tangible personal property.

(2) "Lease" and "rental," as defined in division (SS) of this section, shall not apply to leases or rentals that exist before June 26, 2003.

(3) "Lease" and "rental" have the same meaning as in division (SS)(1) of this section regardless of whether a transaction is characterized as a lease or rental under generally accepted accounting principles, the Internal Revenue Code, Title XIII of the Revised Code, or other federal, state, or local laws.

(TT) "Mobile telecommunications service" has the same meaning as in the "Mobile Telecommunications Sourcing Act," Pub. L. No. 106-252, 114 Stat. 631 (2000), 4 U.S.C.A. 124(7), as amended, and, on and after August 1, 2003, includes related fees

and ancillary services, including universal service fees, detailed billing service, directory assistance, service initiation, voice mail service, and vertical services, such as caller ID and three-way calling.

(UU) "Certified service provider" has the same meaning as in section 5740.01 of the Revised Code.

(VV) "Satellite broadcasting service" means the distribution or broadcasting of programming or services by satellite directly to the subscriber's receiving equipment without the use of ground receiving or distribution equipment, except the subscriber's receiving equipment or equipment used in the uplink process to the satellite, and includes all service and rental charges, premium channels or other special services, installation and repair service charges, and any other charges having any connection with the provision of the satellite broadcasting service.

(WW) "Tangible personal property" means personal property that can be seen, weighed, measured, felt, or touched, or that is in any other manner perceptible to the senses. For purposes of this chapter and Chapter 5741. of the Revised Code, "tangible personal property" includes motor vehicles, electricity, water, gas, steam, and prewritten computer software.

(XX) "Municipal gas utility" means a municipal corporation that owns or operates a system for the distribution of natural gas.

(YY) "Computer" means an electronic device that accepts information in digital or similar form and manipulates it for a result based on a sequence of instructions.

(ZZ) "Computer software" means a set of coded instructions

designed to cause a computer or automatic data processing equipment to perform a task.

(AAA) "Delivered electronically" means delivery of computer software from the seller to the purchaser by means other than tangible storage media.

(BBB) "Prewritten computer software" means computer software, including prewritten upgrades, that is not designed and developed by the author or other creator to the specifications of a specific purchaser. The combining of two or more prewritten computer software programs or prewritten portions thereof does not cause the combination to be other than prewritten computer software. "Prewritten computer software" includes software designed and developed by the author or other creator to the specifications of a specific purchaser when it is sold to a person other than the purchaser. If a person modifies or enhances computer software of which the person is not the author or creator, the person shall be deemed to be the author or creator only of such person's modifications or enhancements. Prewritten computer software or a prewritten portion thereof that is modified or enhanced to any degree, where such modification or enhancement is designed and developed to the specifications of a specific purchaser, remains prewritten computer software; provided, however, that where there is a reasonable, separately stated charge or an invoice or other statement of the price given to the purchaser for the modification or enhancement, the modification or enhancement shall not constitute prewritten computer software.

(CCC)(1) "Food" means substances, whether in liquid, concentrated, solid, frozen, dried, or dehydrated form, that are sold for ingestion or chewing by humans and are consumed for

their taste or nutritional value. "Food" does not include alcoholic beverages, dietary supplements, soft drinks, or tobacco.

(2) As used in division (CCC)(1) of this section:

(a) "Alcoholic beverages" means beverages that are suitable for human consumption and contain one-half of one per cent or more of alcohol by volume.

(b) "Dietary supplements" means any product, other than tobacco, that is intended to supplement the diet and that is intended for ingestion in tablet, capsule, powder, softgel, gelcap, or liquid form, or, if not intended for ingestion in such a form, is not represented as conventional food for use as a sole item of a meal or of the diet; that is required to be labeled as a dietary supplement, identifiable by the "supplement facts" box found on the label, as required by 21 C.F.R. 101.36; and that contains one or more of the following dietary ingredients:

(i) A vitamin;

(ii) A mineral;

(iii) An herb or other botanical;

(iv) An amino acid;

(v) A dietary substance for use by humans to supplement the diet by increasing the total dietary intake;

(vi) A concentrate, metabolite, constituent, extract, or combination of any ingredient described in divisions (CCC)(2)(b)(i) to (v) of this section.

(c) "Soft drinks" means nonalcoholic beverages that

contain natural or artificial sweeteners. "Soft drinks" does not include beverages that contain milk or milk products, soy, rice, or similar milk substitutes, or that contains greater than fifty per cent vegetable or fruit juice by volume.

(d) "Tobacco" means cigarettes, cigars, chewing or pipe tobacco, or any other item that contains tobacco.

(DDD) "Drug" means a compound, substance, or preparation, and any component of a compound, substance, or preparation, other than food, dietary supplements, or alcoholic beverages that is recognized in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States, or official national formulary, and supplements to them; is intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease; or is intended to affect the structure or any function of the body.

(EEE) "Prescription" means an order, formula, or recipe issued in any form of oral, written, electronic, or other means of transmission by a duly licensed practitioner authorized by the laws of this state to issue a prescription.

(FFF) "Durable medical equipment" means equipment, including repair and replacement parts for such equipment, that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is not worn in or on the body. "Durable medical equipment" does not include mobility enhancing equipment.

(GGG) "Mobility enhancing equipment" means equipment, including repair and replacement parts for such equipment, that is primarily and customarily used to provide or increase the

ability to move from one place to another and is appropriate for use either in a home or a motor vehicle, that is not generally used by persons with normal mobility, and that does not include any motor vehicle or equipment on a motor vehicle normally provided by a motor vehicle manufacturer. "Mobility enhancing equipment" does not include durable medical equipment.

(HHH) "Prosthetic device" means a replacement, corrective, or supportive device, including repair and replacement parts for the device, worn on or in the human body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body. As used in this division, before July 1, 2019, "prosthetic device" does not include corrective eyeglasses, contact lenses, or dental prosthesis. On or after July 1, 2019, "prosthetic device" does not include dental prosthesis but does include corrective eyeglasses or contact lenses.

(III)(1) "Fractional aircraft ownership program" means a program in which persons within an affiliated group sell and manage fractional ownership program aircraft, provided that at least one hundred airworthy aircraft are operated in the program and the program meets all of the following criteria:

(a) Management services are provided by at least one program manager within an affiliated group on behalf of the fractional owners.

(b) Each program aircraft is owned or possessed by at least one fractional owner.

(c) Each fractional owner owns or possesses at least a one-sixteenth interest in at least one fixed-wing program aircraft.

(d) A dry-lease aircraft interchange arrangement is in effect among all of the fractional owners.

(e) Multi-year program agreements are in effect regarding the fractional ownership, management services, and dry-lease aircraft interchange arrangement aspects of the program.

(2) As used in division (III)(1) of this section:

(a) "Affiliated group" has the same meaning as in division (B)(3)(e) of this section.

(b) "Fractional owner" means a person that owns or possesses at least a one-sixteenth interest in a program aircraft and has entered into the agreements described in division (III)(1)(e) of this section.

(c) "Fractional ownership program aircraft" or "program aircraft" means a turbojet aircraft that is owned or possessed by a fractional owner and that has been included in a dry-lease aircraft interchange arrangement and agreement under divisions (III)(1)(d) and (e) of this section, or an aircraft a program manager owns or possesses primarily for use in a fractional aircraft ownership program.

(d) "Management services" means administrative and aviation support services furnished under a fractional aircraft ownership program in accordance with a management services agreement under division (III)(1)(e) of this section, and offered by the program manager to the fractional owners, including, at a minimum, the establishment and implementation of safety guidelines; the coordination of the scheduling of the program aircraft and crews; program aircraft maintenance; program aircraft insurance; crew training for crews employed, furnished, or contracted by the program manager or the

fractional owner; the satisfaction of record-keeping requirements; and the development and use of an operations manual and a maintenance manual for the fractional aircraft ownership program.

(e) "Program manager" means the person that offers management services to fractional owners pursuant to a management services agreement under division (III)(1)(e) of this section.

(JJJ) "Electronic publishing" means providing access to one or more of the following primarily for business customers, including the federal government or a state government or a political subdivision thereof, to conduct research: news; business, financial, legal, consumer, or credit materials; editorials, columns, reader commentary, or features; photos or images; archival or research material; legal notices, identity verification, or public records; scientific, educational, instructional, technical, professional, trade, or other literary materials; or other similar information which has been gathered and made available by the provider to the consumer in an electronic format. Providing electronic publishing includes the functions necessary for the acquisition, formatting, editing, storage, and dissemination of data or information that is the subject of a sale.

(KKK) "Medicaid health insuring corporation" means a health insuring corporation that holds a certificate of authority under Chapter 1751. of the Revised Code and is under contract with the department of medicaid pursuant to section 5167.10 of the Revised Code.

(LLL) "Managed care premium" means any premium, capitation, or other payment a medicaid health insuring

corporation receives for providing or arranging for the provision of health care services to its members or enrollees residing in this state.

(MMM) "Captive deer" means deer and other cervidae that have been legally acquired, or their offspring, that are privately owned for agricultural or farming purposes.

(NNN) "Gift card" means a document, card, certificate, or other record, whether tangible or intangible, that may be redeemed by a consumer for a dollar value when making a purchase of tangible personal property or services.

(OOO) "Specified digital product" means an electronically transferred digital audiovisual work, digital audio work, or digital book.

As used in division (OOO) of this section:

(1) "Digital audiovisual work" means a series of related images that, when shown in succession, impart an impression of motion, together with accompanying sounds, if any.

(2) "Digital audio work" means a work that results from the fixation of a series of musical, spoken, or other sounds, including digitized sound files that are downloaded onto a device and that may be used to alert the customer with respect to a communication.

(3) "Digital book" means a work that is generally recognized in the ordinary and usual sense as a book.

(4) "Electronically transferred" means obtained by the purchaser by means other than tangible storage media.

(PPP) "Digital advertising services" means providing access, by means of telecommunications equipment, to computer

equipment that is used to enter, upload, download, review, manipulate, store, add, or delete data for the purpose of electronically displaying, delivering, placing, or transferring promotional advertisements to potential customers about products or services or about industry or business brands.

(QQQ) "Peer-to-peer car sharing program" has the same meaning as in section 4516.01 of the Revised Code.

Sec. 5901.28. Upon the death of an inmate of any home for indigent parents, spouses, or surviving spouses of veterans, the manager of the home may, upon a certificate signed by the attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner of the home, certify as to the death of the inmate to the board of county commissioners of the county from which the parent, spouse, or surviving spouse was admitted to the home, and the board shall proceed as provided in section 5901.32 of the Revised Code.

Section 2. That existing sections 1.64, 109.921, 124.38, 124.82, 173.501, 173.521, 173.542, 305.03, 313.12, 313.121, 323.153, 339.01, 339.73, 339.76, 339.78, 339.81, 339.82, 503.241, 742.38, 940.09, 955.41, 1337.29, 1347.08, 1561.12, 1571.012, 1731.01, 1751.62, 1751.74, 1753.21, 2105.35, 2108.16, 2108.40, 2111.031, 2111.49, 2133.25, 2135.01, 2151.33, 2151.3515, 2151.421, 2305.235, 2313.14, 2317.47, 2317.54, 2945.38, 2967.05, 3101.05, 3105.091, 3111.12, 3111.90, 3111.93, 3111.94, 3111.96, 3119.05, 3119.54, 3301.0711, 3304.23, 3309.22, 3309.41, 3309.45, 3313.64, 3313.671, 3313.71, 3313.712, 3313.716, 3313.72, 3313.73, 3319.141, 3319.143, 3321.04, 3354.21, 3501.382, 3701.01, 3701.031, 3701.046, 3701.144, 3701.146, 3701.162, 3701.243, 3701.245, 3701.262, 3701.47, 3701.48, 3701.50, 3701.505, 3701.5010, 3701.59, 3701.60,

3701.74, 3701.76, 3705.01, 3705.15, 3705.16, 3705.17, 3705.22, 3705.29, 3705.30, 3705.33, 3705.35, 3707.08, 3707.10, 3707.72, 3709.11, 3709.13, 3709.241, 3710.07, 3715.02, 3715.872, 3721.01, 3721.011, 3721.041, 3721.21, 3727.09, 3727.19, 3742.03, 3742.04, 3742.07, 3742.32, 3901.56, 3916.01, 3916.07, 3916.16, 3923.25, 3923.52, 3923.53, 3923.54, 3923.55, 3923.56, 3923.84, 3929.62, 3929.63, 3929.64, 3929.67, 4113.23, 4123.511, 4123.512, 4123.54, 4123.56, 4123.57, 4123.651, 4123.71, 4123.84, 4123.85, 4303.21, 4503.066, 4506.07, 4507.06, 4507.08, 4507.081, 4507.141, 4507.30, 4511.81, 4723.36, 4725.14, 4729.284, 4729.41, 4729.44, 4729.45, 4729.47, 5119.93, 5119.94, 5120.17, 5120.21, 5122.01, 5122.10, 5122.11, 5122.111, 5122.14, 5145.22, 5164.08, 5502.522, 5739.01, and 5901.28 of the Revised Code are hereby repealed.

Section 3. That the versions of sections 3701.5010, 3705.30, and 3929.67 of the Revised Code that are scheduled to take effect September 30, 2024, be amended to read as follows:

Sec. 3701.5010. (A) As used in this section:

(1) "Critical congenital heart defects screening" means the identification of a newborn that may have a critical congenital heart defect, through the use of a physiologic test.

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

(3) "Hospital," "maternity unit," "newborn," and "physician" have the same meanings as in section 3701.503 of the Revised Code.

(4) "Pulse oximetry" means a noninvasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

(B) Except as provided in division (C) of this section,

each hospital and each freestanding birthing center shall conduct a critical congenital heart defects screening on each newborn born in the hospital or center, unless the newborn is being transferred to another hospital. The screening shall be performed before discharge. If the newborn is transferred to another hospital, that hospital shall conduct the screening when determined to be medically appropriate. The hospital or center shall promptly notify the newborn's parent, guardian, or custodian and attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner of the screening results.

(C) A hospital or freestanding birthing center shall not conduct a critical congenital heart defects screening if the newborn's parent objects on the grounds that the screening conflicts with the parent's religious tenets and practices.

(D)(1) The director of health shall adopt rules in accordance with Chapter 119. of the Revised Code establishing standards and procedures for the screening required by this section, including all of the following:

(a) Designating the person or persons responsible for causing the screening to be performed;

(b) Specifying screening equipment and methods;

(c) Identifying when the screening should be performed;

(d) Providing notice of the required screening to the newborn's parent, guardian, or custodian;

(e) Communicating screening results to the newborn's parent, guardian, or custodian and attending physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner;

(f) Reporting screening results to the department of health;

(g) Referring newborns that receive abnormal screening results to providers of follow-up services.

(2) In adopting rules under division (D)(1)(b) of this section, the director shall specify screening equipment and methods that include the use of pulse oximetry or other screening equipment and methods that detect critical congenital heart defects at least as accurately as pulse oximetry. The screening equipment and methods specified shall be consistent with recommendations issued by nationally recognized organizations that advocate on behalf of medical professionals or individuals with cardiovascular conditions.

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

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

(2) "Hospital" has the same meaning as in section 3722.01 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) 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. 3929.67. (A) A medical liability insurance policy that insures a physician ~~or~~, podiatrist, certified nurse-midwife, clinical nurse specialist, or certified nurse

practitioner, 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.

Section 4. That the existing versions of sections 3701.5010, 3705.30, and 3929.67 of the Revised Code that are scheduled to take effect September 30, 2024, are hereby repealed.

Section 5. Sections 3 and 4 of this act take effect September 30, 2024.

Section 6. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the following sections, presented in this act as composites of the sections as amended by the acts indicated, are the resulting versions of the sections in effect prior to the effective date of the sections as presented in this act:

Section 2151.421 of the Revised Code as amended by both H.B. 92 and H.B. 110 of the 134th General Assembly.

Section 3701.74 of the Revised Code as amended by both H.B. 232 and H.B. 483 of the 130th General Assembly.