

CHAPTER 2024-15

Committee Substitute for Senate Bill No. 7016

An act relating to health care; amending s. 381.4019, F.S.; revising the purpose of the Dental Student Loan Repayment Program; defining the term “free clinic”; including dental hygienists in the program; revising eligibility requirements for the program; specifying limits on award amounts for and participation of dental hygienists under the program; revising requirements for the distribution of awards under the program; deleting the maximum number of new practitioners who may participate in the program each fiscal year; specifying that dentists and dental hygienists are not eligible to receive funds under the program unless they provide specified documentation; requiring practitioners who receive payments under the program to furnish certain information requested by the Department of Health; requiring the Agency for Health Care Administration to seek federal authority to use specified matching funds for the program; providing for future repeal of the program; transferring, renumbering, and amending s. 1009.65, F.S.; renaming the Medical Education Reimbursement and Loan Repayment Program as the Florida Reimbursement Assistance for Medical Education Program; revising the types of practitioners who are eligible to participate in the program; revising requirements for the distribution of funds under the program; making conforming and technical changes; requiring practitioners who receive payments under the program to furnish certain information requested by the department; requiring the agency to seek federal authority to use specified matching funds for the program; providing for future repeal of the program; creating s. 381.4021, F.S.; requiring the department to provide annual reports to the Governor and the Legislature on specified student loan repayment programs; providing requirements for the report; requiring the department to contract with an independent third party to develop and conduct a design study for evaluating the effectiveness of specified student loan repayment programs; specifying requirements for the design study; requiring the department to begin collecting data for the study and submit the study results to the Governor and the Legislature by specified dates; requiring the department to participate in a certain multistate collaborative for a specified purpose; providing for future repeal of the requirement; creating s. 381.9855, F.S.; requiring the department to implement the Dr. and Mrs. Alfonse and Kathleen Cinotti Health Care Screening and Services Grant Program for a specified purpose; specifying duties of the department; authorizing nonprofit entities to apply for grant funds to implement new health care screening or services programs or mobile clinics or units to expand the program’s delivery capabilities; specifying requirements for grant recipients; authorizing the department to adopt rules; requiring the department to create and maintain an Internet-based portal to provide specified information relating to available health care screenings and services and volunteer opportunities; authorizing the department to contract with a

third-party vendor to create and maintain the portal; specifying requirements for the portal; requiring the department to coordinate with county health departments for a specified purpose; requiring the department to include a clear and conspicuous link to the portal on the homepage of its website; requiring the department to publicize and encourage the use of the portal and enlist the aid of county health departments for such outreach; amending s. 383.2163, F.S.; expanding the telehealth minority maternity care program from a pilot program to a statewide program; authorizing the department to enlist, rather than requiring the department to direct, county health departments to assist in program implementation; authorizing the department to receive certain referrals from the Healthy Start program; requiring the department to submit annual reports to the Governor and the Legislature; providing requirements for the reports; amending s. 383.302, F.S.; defining the terms “advanced birth center” and “medical director”; revising the definition of the term “consultant”; creating s. 383.3081, F.S.; providing requirements for birth centers designated as advanced birth centers with respect to operating procedures, staffing, and equipment; requiring advanced birth centers to enter into a written agreement with a blood bank for emergency blood bank services; requiring that a patient who receives an emergency blood transfusion at an advanced birth center be immediately transferred to a hospital for further care; requiring the agency to establish by rule a process for birth centers to be designated as advanced birth centers; authorizing the agency to develop certain additional requirements or standards for advanced birth centers; amending s. 383.309, F.S.; providing minimum standards for advanced birth centers; amending s. 383.313, F.S.; making technical and conforming changes; creating s. 383.3131, F.S.; providing requirements for laboratory and surgical services at advanced birth centers; providing conditions for administration of anesthesia; authorizing the intrapartal use of chemical agents; amending s. 383.315, F.S.; requiring advanced birth centers to employ or maintain an agreement with an obstetrician for specified purposes; amending s. 383.316, F.S.; requiring advanced birth centers to provide for the transport of emergency patients to a hospital; requiring each advanced birth center to enter into a written transfer agreement with a local hospital or an obstetrician for such transfers; requiring birth centers and advanced birth centers to assess and document transportation services and transfer protocols annually; amending s. 383.318, F.S.; providing protocols for postpartum care of clients and infants at advanced birth centers; amending s. 394.455, F.S.; revising definitions; amending s. 394.457, F.S.; requiring the Department of Children and Families to adopt certain minimum standards for mobile crisis response services; amending s. 394.4598, F.S.; authorizing certain psychiatric nurses to provide opinions to the court for the appointment of guardian advocates; authorizing certain psychiatric nurses to consult with guardian advocates for purposes of obtaining consent for treatment; amending s. 394.4615, F.S.; authorizing psychiatric nurses to make certain determinations related to the release of clinical records; amending s. 394.4625, F.S.; requiring certain treating psychiatric nurses to document specified

information in a patient's clinical record within a specified timeframe of his or her voluntary admission for mental health treatment; requiring clinical psychologists who make determinations of involuntary placement at certain mental health facilities to have specified clinical experience; authorizing certain psychiatric nurses to order emergency treatment for certain patients; amending s. 394.463, F.S.; authorizing certain psychiatric nurses to order emergency treatment of certain patients; requiring a clinical psychologist to have specified clinical experience to approve the release of an involuntary patient at certain mental health facilities; amending s. 394.4655, F.S.; requiring clinical psychologists to have specified clinical experience in order to recommend involuntary outpatient services for mental health treatment; authorizing certain psychiatric nurses to recommend involuntary outpatient services for mental health treatment; providing an exception; authorizing psychiatric nurses to make certain clinical determinations that warrant bringing a patient to a receiving facility for an involuntary examination; making a conforming change; amending s. 394.467, F.S.; requiring clinical psychologists to have specified clinical experience in order to recommend involuntary inpatient services for mental health treatment; authorizing certain psychiatric nurses to recommend involuntary inpatient services for mental health treatment; providing an exception; amending s. 394.4781, F.S.; revising the definition of the term "psychotic or severely emotionally disturbed child"; amending s. 394.4785, F.S.; authorizing psychiatric nurses to admit individuals over a certain age into certain mental health units of a hospital under certain conditions; requiring the agency to seek federal approval for Medicaid coverage and reimbursement authority for mobile crisis response services; requiring the Department of Children and Families to coordinate with the agency to provide specified education to contracted mobile response team services providers; amending s. 394.875, F.S.; authorizing certain psychiatric nurses to prescribe medication to clients of crisis stabilization units; amending s. 395.1055, F.S.; requiring the agency to adopt rules ensuring that hospitals that accept certain payments give enrollment priority to certain medical students, regardless of such payments, and requiring certain hospitals to submit a non-emergent care access plan (NCAP) to the agency for approval before initial licensure or licensure renewal; requiring that, beginning on a specified date, such NCAPs be approved before a license may be issued or renewed; requiring such hospitals to submit specified data to the agency as part of the licensure renewal process and update their NCAPs as needed, or as directed by the agency, before each licensure renewal; specifying requirements for NCAPs; requiring the agency to establish a process for hospitals to share certain information with certain patients' managed care plans; providing construction; amending s. 408.051, F.S.; requiring certain hospitals to make available certain data to the agency's Florida Health Information Exchange program for a specified purpose; authorizing the agency to adopt rules; amending s. 409.909, F.S.; authorizing the agency to allocate specified funds under the Slots for Doctors Program for existing resident positions at hospitals and qualifying institutions if certain conditions are met; requiring hospitals and qualifying institutions that

receive certain state funds to report specified data to the agency annually; defining the term “sponsoring institution”; requiring such hospitals and qualifying institutions, beginning on a specified date, to produce certain financial records or submit to certain financial audits; providing applicability; providing that hospitals and qualifying institutions that fail to produce such financial records to the agency are no longer eligible to participate in the Statewide Medicaid Residency Program until a certain determination is made by the agency; requiring hospitals and qualifying institutions to request exit surveys of residents upon completion of their residency; providing requirements for the exit surveys; creating the Graduate Medical Education Committee within the agency; providing for membership and meetings of the committee; requiring the committee, beginning on a specified date, to submit an annual report to the Governor and the Legislature detailing specified information; requiring the agency to provide administrative support to assist the committee in the performance of its duties and to provide certain information to the committee; creating s. 409.91256, F.S.; creating the Training, Education, and Clinicals in Health (TEACH) Funding Program for a specified purpose; providing legislative intent; defining terms; requiring the agency to develop an application process and enter into certain agreements to implement the program; specifying requirements to qualify to receive reimbursements under the program; requiring the agency, in consultation with the Department of Health, to develop, or contract for the development of, specified training for, and to provide technical support to, preceptors; providing for reimbursement under the program; requiring the agency to submit an annual report to the Governor and the Legislature; providing requirements for the report; requiring the agency to contract with an independent third party to develop and conduct a design study for evaluating the impact of the program; specifying requirements for the design study; requiring the agency to begin collecting data for the study and submit the study results to the Governor and the Legislature by specified dates; authorizing the agency to adopt rules; requiring the agency to seek federal approval to use specified matching funds for the program; providing for future repeal of the program; amending s. 409.967, F.S.; requiring the agency to produce a specified annual report on patient encounter data under the statewide managed care program; providing requirements for the report; requiring the agency to submit the report to the Governor and the Legislature by a specified date; authorizing the agency to contract with a third-party vendor to produce the report; amending s. 409.973, F.S.; requiring Medicaid managed care plans to continue assisting certain enrollees in scheduling an initial appointment with a primary care provider and report certain information to the agency; requiring plans to seek to ensure that such enrollees have at least one primary care appointment annually; requiring such plans to coordinate with hospitals that contact them for a specified purpose; requiring the plans to coordinate with their members and members’ primary care providers for such purpose; requiring the agency to seek federal approval necessary to implement an acute hospital care at home program meeting specified criteria; amending s. 458.311, F.S.; revising an education and

training requirement for physician licensure; exempting foreign-trained applicants for physician licensure from the residency requirement if they meet specified criteria; providing that applicants who do not meet the specified criteria may be certified for restricted licensure under certain circumstances; providing certain employment requirements for such applicants; requiring such applicants to notify the Board of Medicine of any changes in employment within a specified timeframe; repealing s. 458.3124, F.S., relating to restricted licenses of certain experienced foreign-trained physicians; amending s. 458.314, F.S.; authorizing the board to exclude certain foreign medical schools from consideration as an institution that provides medical education that is reasonably comparable to similar accredited institutions in the United States; providing construction; deleting obsolete language; amending s. 458.3145, F.S.; revising criteria for medical faculty certificates; deleting a cap on the maximum number of extended medical faculty certificates that may be issued at specified institutions; amending ss. 458.315 and 459.0076, F.S.; authorizing that temporary certificates for practice in areas of critical need be issued to physician assistants, rather than only to physicians, who meet specified criteria; making conforming and technical changes; amending ss. 458.317 and 459.0075, F.S.; specifying who may be considered a graduate assistant physician; creating limited licenses for graduate assistant physicians; specifying criteria a person must meet to obtain such licensure; requiring the Board of Medicine and the Board of Osteopathic Medicine, respectively, to establish certain requirements by rule; providing for a one-time renewal of such licenses; providing that limited licensed graduate assistant physicians are not eligible to apply for another limited license; authorizing limited licensed graduate assistant physicians to provide health care services only under the direct supervision of a physician and pursuant to a written protocol; providing requirements for, and limitations on, such supervision and practice; providing requirements for the supervisory protocols; providing that supervising physicians are liable for any acts or omissions of such graduate assistant physicians acting under their supervision and control; authorizing third-party payors to provide reimbursement for covered services rendered by graduate assistant physicians; authorizing the Board of Medicine and the Board of Osteopathic Medicine, respectively, to adopt rules; creating s. 464.0121, F.S.; providing that temporary certificates for practice in areas of critical need may be issued to advanced practice registered nurses who meet specified criteria; providing restrictions on the issuance of temporary certificates; waiving licensure fees for such applicants under certain circumstances; amending s. 464.0123, F.S.; requiring certain certified nurse midwives, as a condition precedent to providing out-of-hospital intrapartum care, to maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services; requiring that such policy prescribe and require the use of an emergency plan-of-care form; providing requirements for the form; requiring such certified nurse midwives to document specified information on the form if a transfer of care is determined to be necessary; requiring certified nurse midwives to verbally provide the receiving provider with specified information and

make himself or herself immediately available for consultation; requiring certified nurse midwives to provide the patient's emergency plan-of-care form, as well as certain patient records, to the receiving provider upon the patient's transfer; requiring the Board of Nursing to adopt certain rules; amending s. 464.019, F.S.; deleting the sunset date of a certain annual report required of the Florida Center for Nursing; amending s. 766.1115, F.S.; revising the definition of the term "low-income" for purposes of certain government contracts for health care services; amending s. 1002.32, F.S.; requiring developmental research (laboratory) schools (lab schools) to develop programs for a specified purpose; requiring lab schools to offer technical assistance to any school district seeking to replicate the lab school's programs; requiring lab schools, beginning on a specified date, to annually report to the Legislature on the development of such programs and their results; amending s. 1009.8962, F.S.; revising the definition of the term "institution" for purposes of the Linking Industry to Nursing Education (LINE) Fund; amending ss. 381.4018 and 395.602, F.S.; conforming provisions to changes made by the act; creating s. 456.4501, F.S.; enacting the Interstate Medical Licensure Compact in this state; providing the purpose of the compact; providing that state medical boards of member states retain jurisdiction to impose adverse action against licenses issued under the compact; defining terms; specifying eligibility requirements for physicians seeking an expedited license under the compact; providing requirements for designation of a state of principal license for purposes of the compact; authorizing the Interstate Medical Licensure Compact Commission to develop certain rules; providing an application and verification process for expedited licensure under the compact; providing for expiration and termination of expedited licenses; authorizing the Interstate Commission to develop certain rules; providing requirements for renewal of expedited licenses; authorizing the Interstate Commission to develop certain rules; providing for the establishment of a database for coordinating licensure data amongst member states; requiring and authorizing member boards to report specified information to the database; providing for confidentiality of such information; providing construction; authorizing the Interstate Commission to develop certain rules; authorizing member states to conduct joint investigations and share certain materials; providing for disciplinary action of physicians licensed under the compact; creating the Interstate Medical Licensure Compact Commission; providing purpose and authority of the commission; providing for membership and meetings of the commission; providing public meeting and notice requirements; authorizing closed meetings under certain circumstances; providing public record requirements; requiring the commission to establish an executive committee; providing for membership, powers, and duties of the committee; authorizing the commission to establish other committees; specifying powers and duties of the commission; providing for financing of the commission; providing for organization and operation of the commission; providing limited immunity from liability for commissioners and other agents or employees of the commission; authorizing the commission to adopt rules; providing for rulemaking procedures, including public notice and meeting

requirements; providing for judicial review of adopted rules; providing for oversight and enforcement of the compact in member states; requiring courts in member states to take judicial notice of the compact and the commission rules for purposes of certain proceedings; providing that the commission is entitled to receive service of process and has standing in certain proceedings; rendering judgments or orders void as to the commission, the compact, or commission rules under certain circumstances; providing for enforcement of the compact; specifying venue and civil remedies in such proceedings; providing for attorney fees; providing construction; specifying default procedures for member states; providing for dispute resolution between member states; providing for eligibility and procedures for enactment of the compact; requiring that governors of nonmember states be invited to participate in the activities of the commission on a nonvoting basis before the compact is adopted in that state; providing for amendment to the compact; specifying procedures for withdrawal from and subsequent reinstatement of the compact; authorizing the Interstate Commission to develop certain rules; providing for dissolution of the compact; providing severability and construction; creating s. 456.4502, F.S.; providing that a formal hearing before the Division of Administrative Hearings must be held if there are any disputed issues of material fact when the licenses of certain physicians and osteopathic physicians are suspended or revoked by this state under the compact; requiring the Department of Health to notify the Division of Administrative Hearings of a petition for a formal hearing within a specified timeframe; requiring the administrative law judge to issue a recommended order; requiring the Board of Medicine or the Board of Osteopathic Medicine, as applicable, to determine and issue final orders in certain cases; providing the department with standing to seek judicial review of any final order of the boards; creating s. 456.4504, F.S.; authorizing the department to adopt rules to implement the compact; creating ss. 458.3129 and 459.074, F.S.; providing that an allopathic physician or an osteopathic physician, respectively, licensed under the compact is deemed to be licensed under ch. 458, F.S., or ch. 459, F.S., as applicable; amending s. 768.28, F.S.; designating the state commissioners of the Interstate Medical Licensure Compact Commission and other members or employees of the commission as state agents for the purpose of applying sovereign immunity and waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the commission to maintain insurance coverage to pay such claims or judgments; creating s. 468.1335, F.S.; creating the Audiology and Speech-Language Pathology Interstate Compact; providing the purpose and objectives of the compact; defining terms; specifying requirements for state participation in the compact and duties of member states; specifying that the compact does not affect an individual's ability to apply for, and a member state's ability to grant, a single-state license pursuant to the laws of that state; providing for recognition of compact privilege in member states; specifying criteria a licensee must meet for a compact privilege; providing for the expiration and renewal of the compact privilege; specifying that a licensee with a compact privilege in a remote state

must adhere to the laws and rules of that state; authorizing member states to act on a licensee's compact privilege under certain circumstances; specifying the consequences and parameters of practice for a licensee whose compact privilege has been acted on or whose home state license is encumbered; specifying that a licensee may hold a home state license in only one member state at a time; specifying requirements and procedures for changing a home state license designation; providing for the recognition of the practice of audiology and speech-language pathology through telehealth in member states; specifying that licensees must adhere to the laws and rules of the remote state where they provide audiology or speech-language pathology through telehealth; authorizing active duty military personnel and their spouses to keep their home state designation during active duty; specifying how such individuals may subsequently change their home state license designation; authorizing member states to take adverse actions against licensees and issue subpoenas for hearings and investigations under certain circumstances; providing requirements and procedures for such adverse action; authorizing member states to engage in joint investigations under certain circumstances; providing that a licensee's compact privilege must be deactivated in all member states for the duration of an encumbrance imposed by the licensee's home state; providing for notice to the data system and the licensee's home state of any adverse action taken against a licensee; establishing the Audiology and Speech-Language Pathology Interstate Compact Commission; providing for jurisdiction and venue for court proceedings; providing for membership and powers of the commission; specifying powers and duties of the commission's executive committee; providing for the financing of the commission; providing specified individuals immunity from civil liability under certain circumstances; providing exceptions; requiring the commission to defend the specified individuals in civil actions under certain circumstances; requiring the commission to indemnify and hold harmless specified individuals for any settlement or judgment obtained in such actions under certain circumstances; providing for the development of the data system, reporting procedures, and the exchange of specified information between member states; requiring the commission to notify member states of any adverse action taken against a licensee or applicant for licensure; authorizing member states to designate as confidential information provided to the data system; requiring the commission to remove information from the data system under certain circumstances; providing rulemaking procedures for the commission; providing procedures for the resolution of certain disputes; providing for commission enforcement of the compact; providing for remedies; providing for implementation of, withdrawal from, and amendment to the compact; providing construction and for severability; specifying that the compact, commission rules, and commission actions are binding on member states; amending s. 468.1135, F.S.; requiring the Board of Speech-Language Pathology and Audiology to appoint two of its board members to serve as the state's delegates on the compact commission; amending s. 468.1185, F.S.; exempting audiologists and speech-language pathologists from licensure requirements if they are practicing in this state pursuant to a

compact privilege under the compact; amending s. 468.1295, F.S.; authorizing the board to take adverse action against the compact privilege of audiologists and speech-language pathologists for specified prohibited acts; amending s. 768.28, F.S.; designating the state delegates and other members or employees of the compact commission as state agents for the purpose of applying sovereign immunity and waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the compact commission to maintain insurance coverage to pay such claims or judgments; creating s. 486.112, F.S.; creating the Physical Therapy Licensure Compact; providing a purpose and objectives of the compact; defining terms; specifying requirements for state participation in the compact; authorizing member states to obtain biometric-based information from and conduct criminal background checks on licensees applying for a compact privilege; requiring member states to grant the compact privilege to licensees if they meet specified criteria; specifying criteria licensees must meet to exercise the compact privilege under the compact; providing for the expiration of the compact privilege; requiring licensees practicing in a remote state under the compact privilege to comply with the laws and rules of that state; subjecting licensees to the regulatory authority of remote states where they practice under the compact privilege; providing for disciplinary action; specifying circumstances under which licensees are ineligible for a compact privilege; specifying conditions that a licensee must meet to regain his or her compact privilege after an adverse action; specifying locations active duty military personnel and their spouses may use to designate their home state for purposes of the compact; providing that only a home state may impose adverse action against a license issued by that state; authorizing home states to take adverse action based on investigative information of a remote state, subject to certain requirements; directing member states that use alternative programs in lieu of discipline to require the licensee to agree not to practice in other member states while participating in the program, unless authorized by the member state; authorizing member states to investigate violations by licensees in other member states; authorizing member states to take adverse action against compact privileges issued in their respective states; providing for joint investigations of licensees under the compact; establishing the Physical Therapy Compact Commission; providing for the venue and jurisdiction for court proceedings by or against the commission; providing construction; providing for commission membership, voting, and meetings; authorizing the commission to convene closed, nonpublic meetings under certain circumstances; specifying duties and powers of the commission; providing for membership and duties of the executive board of the commission; providing for financing of the commission; providing for qualified immunity, defense, and indemnification of the commission; requiring the commission to develop and maintain a coordinated database and reporting system for certain information about licensees under the compact; requiring member states to submit specified information to the system; requiring that information contained in the system be available only to member states; requiring the commission to promptly

notify all member states of reported adverse action taken against licensees or applicants for licensure; authorizing member states to designate reported information as exempt from public disclosure; providing for the removal of submitted information from the system under certain circumstances; providing for commission rulemaking; providing construction; providing for state enforcement of the compact; providing for the default and termination of compact membership; providing for appeals and costs; providing procedures for the resolution of certain disputes; providing for enforcement against a defaulting state; providing construction; providing for implementation and administration of the compact and associated rules; providing that compact states that join after initial adoption of the commission's rules are subject to such rules; specifying procedures for compact states to withdraw from the compact; providing construction; providing for amendment of the compact; providing construction and severability; amending s. 456.073, F.S.; requiring the Department of Health to report certain investigative information to the respective data systems of the Audiology and Speech-Language Pathology Interstate Compact and the Physical Therapy Licensure Compact; amending s. 456.076, F.S.; requiring monitoring contracts for certain impaired practitioners participating in treatment programs to contain specified terms; amending s. 486.023, F.S.; requiring the Board of Physical Therapy Practice to appoint an individual to serve as the state's delegate on the Physical Therapy Compact Commission; amending ss. 486.028, 486.031, 486.081, 486.102, and 486.107, F.S.; exempting physical therapists and physical therapist assistants from licensure requirements if they are practicing in this state pursuant to a compact privilege under the compact; amending s. 486.125, F.S.; authorizing the board to take adverse action against the compact privilege of physical therapists and physical therapist assistants for specified prohibited acts; amending s. 768.28, F.S.; designating the state delegate and other members or employees of the commission as state agents for the purpose of applying sovereign immunity and waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the commission to maintain insurance coverage to pay such claims or judgments; amending ss. 486.025, 486.0715, and 486.1065, F.S.; conforming cross-references; providing appropriations; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.4019, Florida Statutes, is amended to read:

381.4019 Dental Student Loan Repayment Program.—The Dental Student Loan Repayment Program is established to support the state Medicaid program and promote access to dental care by supporting qualified dentists and dental hygienists who treat medically underserved populations in dental health professional shortage areas or medically underserved areas.

(1) As used in this section, the term:

(a) “Dental health professional shortage area” means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(b) “Department” means the Department of Health.

(c) “Free clinic” means a provider that meets the description of a clinic specified in s. 766.1115(3)(d)14.

(d) “Loan program” means the Dental Student Loan Repayment Program.

(e)(d) “Medically underserved area” means a geographic area, an area having a special population, or a facility which is designated by department rule as a health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and other low-income patients.

(f)(e) “Public health program” means a county health department, the Children’s Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

(2) The department shall establish a dental student loan repayment program to benefit Florida-licensed dentists and dental hygienists who:

(a) Demonstrate, as required by department rule, active employment in a public health program or private practice that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or a medically underserved area; and

(b) Volunteer 25 hours per year providing dental services in a free clinic that is located in a dental health professional shortage area or a medically underserved area, through another volunteer program operated by the state pursuant to part IV of chapter 110, or through a pro bono program approved by the Board of Dentistry. In order to meet the requirements of this paragraph, the volunteer hours must be verifiable in a manner determined by the department.

(3) The department shall award funds from the loan program to repay the student loans of a dentist or dental hygienist who meets the requirements of subsection (2).

(a) An award shall be 20 percent of a dentist’s or dental hygienist’s principal loan amount at the time he or she applied for the program but may not exceed \$50,000 per year per eligible dentist or \$7,500 per year per eligible dental hygienist.

(b) Only loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses may be covered.

(c) All repayments are contingent upon continued proof of eligibility and must be made directly to the holder of the loan. The state bears no responsibility for the collection of any interest charges or other remaining balances.

~~(d) A dentist or dental hygienist may receive funds under the loan program for at least 1 year, up to a maximum of 5 awards pursuant to paragraph (a), one award for each year he or she maintains eligibility for the program for the entire year. Such awards are not required to be awarded in consecutive years, and, if a dentist or dental hygienist loses eligibility pursuant to subsection (4) for the current year, he or she may reapply for the program in a future year once he or she has regained eligibility.~~

~~(e) The department shall limit the number of new dentists participating in the loan program to not more than 10 per fiscal year.~~

(4) A dentist or dental hygienist is ~~not no longer~~ eligible to receive funds under the loan program if the dentist or dental hygienist:

(a) Is no longer employed by a public health program or private practice that meets the requirements of subsection (2) ~~or does not verify, in a manner determined by the department, that he or she has volunteered his or her dental services for the required number of hours.~~

(b) Ceases to participate in the Florida Medicaid program.

(c) Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of s. 466.028.

(5) A dentist or dental hygienist who receives payment under the program shall furnish information requested by the department for the purpose of the department's duties under s. 381.4021.

(6) The department shall adopt rules to administer the loan program.

~~(7)~~(6) Implementation of the loan program is subject to legislative appropriation.

(8) The Agency for Health Care Administration shall seek federal authority to use Title XIX matching funds for this program.

(9) This section is repealed on July 1, 2034.

Section 2. Section 1009.65, Florida Statutes, is transferred, renumbered as section 381.402, Florida Statutes, and amended to read:

381.402 1009.65 Florida Reimbursement Assistance for Medical Education Reimbursement and Loan Repayment Program.—

(1) To support the state Medicaid program and to encourage qualified medical professionals to practice in underserved locations where there are shortages of such personnel, there is established the Florida Reimbursement

Assistance for Medical Education Reimbursement and Loan Repayment Program. The function of the program is to make payments that offset loans and educational expenses incurred by students for studies leading to a medical or nursing degree, medical or nursing licensure, or advanced practice registered nurse licensure or physician assistant licensure.

(2) The following licensed or certified health care ~~practitioners~~ professionals are eligible to participate in the ~~this~~ program:

(a) Medical doctors with primary care specialties~~,~~

(b) Doctors of osteopathic medicine with primary care specialties.

(c) Advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123, ~~physician assistants, licensed practical nurses and registered nurses, and~~

(d) ~~Advanced practice registered nurses with primary care specialties such as certified nurse midwives.~~

(e) Physician assistants.

(f) Mental health professionals, including licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists.

(g) Licensed practical nurses and registered nurses.

Primary care medical specialties for physicians include obstetrics, gynecology, general and family practice, geriatrics, internal medicine, pediatrics, psychiatry, and other specialties which may be identified by the Department of Health.

(3) From the funds available, the Department of Health shall make payments as follows:

(a)1. For a 4-year period of continued proof of practice in an area specified in paragraph (b), up to \$150,000 for physicians, up to \$90,000 for advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123 and practicing autonomously, up to \$75,000 for advanced practice registered nurses and physician assistants, up to \$75,000 for mental health professionals, and up to \$45,000 \$4,000 per year for licensed practical nurses and registered nurses. Each practitioner is eligible to receive an award for only one 4-year period of continued proof of practice; however, the 4 years of practice are not required to be consecutive. At the end of each year that a practitioner participates in the program, the department shall award 25 percent of a practitioner's principal loan amount at the time he or she applied for the program, up to \$10,000 per year for advanced practice registered nurses and physician assistants, and up to \$20,000 per year for physicians. Penalties for noncompliance are shall be the same as those in the National Health Services Corps Loan Repayment Program.

Educational expenses include costs for tuition, matriculation, registration, books, laboratory and other fees, other educational costs, and reasonable living expenses as determined by the Department of Health.

(b)2. All payments are contingent on continued proof of:

1.a. Primary care practice in a rural hospital as an area defined in s. 395.602(2)(b), or an underserved area designated by the Department of Health, provided the practitioner accepts Medicaid reimbursement if eligible for such reimbursement; or

b. For practitioners other than physicians, practice in other settings, including, but not limited to, a nursing home facility as defined in s. 400.021, a home health agency as defined in s. 400.462, or an intermediate care facility for the developmentally disabled as defined in s. 400.960. Any such setting must be located in, or serve residents or patients in, an underserved area designated by the Department of Health and must provide services to Medicaid patients.

2. Providing 25 hours annually of volunteer primary care services in a free clinic as specified in s. 766.1115(3)(d)14. or through another volunteer program operated by the state pursuant to part IV of chapter 110. In order to meet the requirements of this subparagraph, the volunteer hours must be verifiable in a manner determined by the department.

(c) Correctional facilities, state hospitals, and other state institutions that employ medical personnel must shall be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

~~(b) Advanced practice registered nurses registered to engage in autonomous practice under s. 464.0123 and practicing in the primary care specialties of family medicine, general pediatrics, general internal medicine, or midwifery. From the funds available, the Department of Health shall make payments of up to \$15,000 per year to advanced practice registered nurses registered under s. 464.0123 who demonstrate, as required by department rule, active employment providing primary care services in a public health program, an independent practice, or a group practice that serves Medicaid recipients and other low-income patients and that is located in a primary care health professional shortage area. Only loans to pay the costs of tuition, books, medical equipment and supplies, uniforms, and living expenses may be covered. For the purposes of this paragraph:~~

~~1. "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the Federal Office of Rural Health Policy.~~

~~2. “Public health program” means a county health department, the Children’s Medical Services program, a federally funded community health center, a federally funded migrant health center, or any other publicly funded or nonprofit health care program designated by the department.~~

~~(4)(2) The Department of Health may use funds appropriated for the Medical Education Reimbursement and Loan Repayment program as matching funds for federal loan repayment programs such as the National Health Service Corps State Loan Repayment Program.~~

~~(5) A health care practitioner who receives payment under the program shall furnish information requested by the department for the purpose of the department’s duties under s. 381.4021.~~

~~(6)(3) The Department of Health may adopt any rules necessary for the administration of the Medical Education Reimbursement and Loan Repayment program. The department may also solicit technical advice regarding conduct of the program from the Department of Education and Florida universities and Florida College System institutions. The Department of Health shall submit a budget request for an amount sufficient to fund medical education reimbursement, loan repayments, and program administration.~~

~~(7) The Agency for Health Care Administration shall seek federal authority to use Title XIX matching funds for this program.~~

~~(8) This section is repealed on July 1, 2034.~~

Section 3. Section 381.4021, Florida Statutes, is created to read:

381.4021 Student loan repayment programs reporting.—

(1) For the student loan repayment programs established in ss. 381.4019 and 381.402, the department shall annually provide a report, beginning July 1, 2024, to the Governor, the President of the Senate, and the Speaker of the House of Representatives which, at a minimum, details all of the following:

- (a) The number of applicants for loan repayment.
- (b) The number of loan payments made under each program.
- (c) The amounts for each loan payment made.
- (d) The type of practitioner to whom each loan payment was made.
- (e) The number of loan payments each practitioner has received under either program.
- (f) The practice setting in which each practitioner who received a loan payment practices.

(2)(a) The department shall contract with an independent third party to develop and conduct a design study to evaluate the impact of the student loan repayment programs established in ss. 381.4019 and 381.402, including, but not limited to, the effectiveness of the programs in recruiting and retaining health care professionals in geographic and practice areas experiencing shortages. The department shall begin collecting data for the study by January 1, 2025, and shall submit the results of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2030.

(b) The department shall participate in a provider retention and information system management multistate collaborative that collects data to measure outcomes of education debt support-for-service programs.

(3) This section is repealed on July 1, 2034.

Section 4. Section 381.9855, Florida Statutes, is created to read:

381.9855 Dr. and Mrs. Alfonse and Kathleen Cinotti Health Care Screening and Services Grant Program; portal.—

(1)(a) The Department of Health shall implement the Dr. and Mrs. Alfonse and Kathleen Cinotti Health Care Screening and Services Grant Program. The purpose of the program is to expand access to no-cost health care screenings or services for the general public facilitated by nonprofit entities. The department shall do all of the following:

1. Publicize the availability of funds and enlist the aid of county health departments for outreach to potential applicants at the local level.

2. Establish an application process for submitting a grant proposal and criteria an applicant must meet to be eligible.

3. Develop guidelines a grant recipient must follow for the expenditure of grant funds and uniform data reporting requirements for the purpose of evaluating the performance of grant recipients. The guidelines must require grant funds to be spent on screenings, including referrals for treatment, if appropriate, or related services for one or more of the following:

a. Hearing.

b. Vision.

c. Dental.

d. Cancer.

e. Diabetes.

f. Renal disease.

g. Chronic obstructive pulmonary disease.

h. Hypertension.

i. Heart disease.

j. Stroke.

k. Scoliosis.

(b) A nonprofit entity may apply for grant funds in order to implement new health care screening or services programs that the entity has not previously implemented.

(c) A nonprofit entity that has previously implemented a specific health care screening or services program at one or more specific locations may apply for grant funds in order to provide the same or similar screenings or services at new locations or through a mobile health clinic or mobile unit in order to expand the program's delivery capabilities.

(d) An entity that receives a grant under this section must:

1. Follow Department of Health guidelines for reporting on expenditure of grant funds and measures to evaluate the effectiveness of the entity's health care screening or services program.

2. Publicize to the general public and encourage the use of the health care screening portal created under subsection (2).

(e) The Department of Health may adopt rules for the implementation of this subsection.

(2)(a) The Department of Health shall create and maintain an Internet-based portal to direct the general public to events, organizations, and venues in this state from which health screenings or services may be obtained at no cost or at a reduced cost and for the purpose of directing licensed health care practitioners to opportunities for volunteering their services to conduct, administer, or facilitate such health screenings or services. The department may contract with a third-party vendor for the creation or maintenance of the portal.

(b) The portal must be easily accessible by the public, not require a sign-up or login, and include the ability for a member of the public to enter his or her address and obtain localized and current data on opportunities for screenings and services and volunteer opportunities for health care practitioners. The portal must include, but need not be limited to, all statutorily created screening programs, other than newborn screenings established under chapter 383, which are funded and operational under the department's authority. The department shall coordinate with county health departments so that the portal includes information on such health screenings and services provided by county health departments or by nonprofit entities in partnership with county health departments.

(c) The department shall include a clear and conspicuous link to the portal on the homepage of its website. The department shall publicize the portal to, and encourage the use of the portal by, the general public and shall enlist the aid of county health departments for such outreach.

Section 5. Section 383.2163, Florida Statutes, is amended to read:

383.2163 Telehealth minority maternity care program ~~pilot programs~~. ~~By July 1, 2022, The department shall establish a statewide telehealth minority maternity care pilot program that in Duval County and Orange County which~~ uses telehealth to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations. The department may enlist shall direct and assist the county health departments in Duval County and Orange County to assist with program implementation ~~implement the programs~~.

(1) DEFINITIONS.—As used in this section, the term:

(a) “Department” means the Department of Health.

(b) “Eligible pregnant woman” means a pregnant woman who is receiving, or is eligible to receive, maternal or infant care services from the department under chapter 381 or this chapter.

(c) “Health care practitioner” has the same meaning as in s. 456.001.

(d) “Health professional shortage area” means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(e) “Indigenous population” means any Indian tribe, band, or nation or other organized group or community of Indians recognized as eligible for services provided to Indians by the United States Secretary of the Interior because of their status as Indians, including any Alaskan native village as defined in 43 U.S.C. s. 1602(c), the Alaska Native Claims Settlement Act, as that definition existed on the effective date of this act.

(f) “Maternal mortality” means a death occurring during pregnancy or the postpartum period which is caused by pregnancy or childbirth complications.

(g) “Medically underserved population” means the population of an urban or rural area designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health care services or a population group designated by the United States Secretary of Health and Human Services as having a shortage of such services.

(h) “Perinatal professionals” means doulas, personnel from Healthy Start and home visiting programs, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and

dietitians, social workers, and other licensed and nonlicensed professionals who assist women through their prenatal or postpartum periods.

(i) “Postpartum” means the 1-year period beginning on the last day of a woman’s pregnancy.

(j) “Severe maternal morbidity” means an unexpected outcome caused by a woman’s labor and delivery which results in significant short-term or long-term consequences to the woman’s health.

(k) “Technology-enabled collaborative learning and capacity building model” means a distance health care education model that connects health care professionals, particularly specialists, with other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

(2) PURPOSE.—The purpose of the program ~~pilot programs~~ is to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.
2. Health professional shortage areas.
3. Areas with significant racial and ethnic disparities in maternal health outcomes and high rates of adverse maternal health outcomes, including, but not limited to, maternal mortality and severe maternal morbidity.
4. Medically underserved populations.
5. Indigenous populations.

(b) Provide for the adoption of and use of telehealth services that allow for screening and treatment of common pregnancy-related complications, including, but not limited to, anxiety, depression, substance use disorder, hemorrhage, infection, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders relating to pregnancy, diabetes, cerebrovascular accidents, cardiomyopathy, and other cardiovascular conditions.

(3) TELEHEALTH SERVICES AND EDUCATION.—The program ~~pilot programs~~ shall adopt the use of telehealth or coordinate with prenatal home visiting programs, or both, to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Referrals to Healthy Start’s coordinated intake and referral program to offer families prenatal home visiting services. The program may also

accept referrals from the Healthy Start program of eligible pregnant women seeking services offered under the program.

(b) Services and education addressing social determinants of health, including, but not limited to, all of the following:

1. Housing placement options.
2. Transportation services or information on how to access such services.
3. Nutrition counseling.
4. Access to healthy foods.
5. Lactation support.
6. Lead abatement and other efforts to improve air and water quality.
7. Child care options.
8. Car seat installation and training.
9. Wellness and stress management programs.
10. Coordination across safety net and social support services and programs.

(c) Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods.

(d) For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers.

(e) Tools for prenatal women to conduct key components of maternal wellness checks, including, but not limited to, all of the following:

1. A device to measure body weight, such as a scale.
2. A device to measure blood pressure which has a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.
3. A device to measure blood sugar levels with a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.
4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary.

(4) TRAINING.—The ~~program pilot programs~~ shall provide training to participating health care practitioners and other perinatal professionals on all of the following:

(a) Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers to accessing adequate and competent maternity care.

(b) The use of remote patient monitoring tools for pregnancy-related complications.

(c) How to screen for social determinants of health risks in the prenatal and postpartum periods, such as inadequate housing, lack of access to nutritional foods, environmental risks, transportation barriers, and lack of continuity of care.

(d) Best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders.

(e) Information collection, recording, and evaluation activities to:

1. Study the impact of the ~~pilot~~ program;
2. Ensure access to and the quality of care;
3. Evaluate patient outcomes as a result of the ~~pilot~~ program;
4. Measure patient experience; and
5. Identify best practices for the future expansion of the ~~pilot~~ program.

(5) REPORTS.—By October 31, 2025, and each October 31 thereafter, the department shall submit a program report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes, at a minimum, all of the following for the previous fiscal year:

(a) The total number of clients served and the demographic information for the population served, including ethnicity and race, age, education levels, and geographic location.

(b) The total number of screenings performed, by type.

(c) The number of participants identified as having experienced pregnancy-related complications, the number of participants who received treatments for such complications, and the final outcome of the pregnancy for such participants.

(d) The number of referrals made to the Healthy Start program or other prenatal home visiting programs and the number of participants who subsequently received services from such programs.

(e) The number of referrals made to doulas and other perinatal professionals and the number of participants who subsequently received services from doulas and other perinatal professionals.

(f) The number and types of devices given to participants to conduct maternal wellness checks.

(g) The average length of participation by program participants.

(h) Composite results of a participant survey that measures the participants' experience with the program.

(i) The total number of health care practitioners trained, by provider type and specialty.

(j) The results of a survey of the health care practitioners trained under the program. The survey must address the quality and impact of the training provided, the health care practitioners' experiences using remote patient monitoring tools, the best practices provided in the training, and any suggestions for improvements.

(k) Aggregate data on the maternal and infant health outcomes of program participants.

(l) For the initial report, all available quantifiable data related to the telehealth minority maternity care pilot programs.

~~(6) FUNDING.—The pilot programs shall be funded using funds appropriated by the Legislature for the Closing the Gap grant program. The department's Division of Community Health Promotion and Office of Minority Health and Health Equity shall also work in partnership to apply for federal funds that are available to assist the department in accomplishing the program's purpose and successfully implementing the program pilot programs.~~

~~(7)(6) RULES.—The department may adopt rules to implement this section.~~

Section 6. Present subsections (1) through (8), (9), and (10) of section 383.302, Florida Statutes, are redesignated as subsections (2) through (9), (11), and (12), respectively, new subsections (1) and (10) are added to that section, and present subsection (4) of that section is amended, to read:

383.302 Definitions of terms used in ss. 383.30-383.332.—As used in ss. 383.30-383.332, the term:

(1) "Advanced birth center" means a licensed birth center designated as an advanced birth center which may perform trial of labor after cesarean deliveries for screened patients who qualify; planned low-risk cesarean deliveries; and anticipated vaginal deliveries for laboring patients from the

beginning of the 37th week of gestation through the end of the 41st week of gestation.

(5)(4) “Consultant” means a physician licensed pursuant to chapter 458 or chapter 459 who agrees to provide advice and services to a birth center and who either:

(a) Is certified or eligible for certification by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology; or

(b) Has hospital obstetrical privileges.

(10) “Medical director” means a person who holds an active unrestricted license as a physician under chapter 458 or chapter 459.

Section 7. Section 383.3081, Florida Statutes, is created to read:

383.3081 Advanced birth center designation.—

(1) To be designated as an advanced birth center, a birth center must, in addition to maintaining compliance with all of the requirements under ss. 383.30-383.332 applicable to birth centers and advanced birth centers, meet all of the following criteria:

(a) Be operated and staffed 24 hours per day, 7 days per week.

(b) Employ two medical directors to oversee the activities of the center, one of whom must be a board-certified obstetrician and one of whom must be a board-certified anesthesiologist.

(c) Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.

(d) Employ at least one registered nurse and ensure that at least one registered nurse is present in the center at all times and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.

(e) Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage which include provisions for emergency blood transfusions. If a patient admitted to an advanced birth center receives an emergency blood transfusion at the center, the patient must immediately thereafter be transferred to a hospital for further care.

(f) Meet all standards adopted by rule for birth centers, unless specified otherwise, and advanced birth centers pursuant to s. 383.309.

(g) Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.

(h) Qualify for, enter into, and maintain a Medicaid provider agreement with the agency pursuant to s. 409.907 and provide services to Medicaid recipients according to the terms of the provider agreement.

(2) The agency shall establish by rule a process for designating a birth center that meets the requirements of this section as an advanced birth center. The agency may develop any requirements or standards it deems necessary for patient safety which advanced birth centers must meet as a condition of the designation.

Section 8. Section 383.309, Florida Statutes, is amended to read:

383.309 Minimum standards for birth centers and advanced birth centers; rules and enforcement.—

(1) The agency shall adopt and enforce rules to administer ss. 383.30-383.332 and part II of chapter 408, which rules shall include, but are not limited to, reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented.

(c) Licensed facilities are established, organized, and operated consistent with established programmatic standards.

(2) The standards adopted by rule for designating a birth center as an advanced birth center must, at a minimum, be equivalent to the minimum standards adopted for ambulatory surgical centers pursuant to s. 395.1055 and must include standards for quality of care, blood transfusions, and sanitary conditions for food handling and food service.

(3) The agency may not establish any rule governing the design, construction, erection, alteration, modification, repair, or demolition of birth centers. It is the intent of the Legislature to preempt that function to the Florida Building Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. However, the agency shall provide technical assistance to the commission and the State Fire Marshal in updating the construction standards of the Florida Building Code and the Florida Fire Prevention Code which govern birth centers. In addition, the agency may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code which apply to birth centers in conducting any inspection authorized under this chapter or part II of chapter 408.

Section 9. Section 383.313, Florida Statutes, is amended to read:

383.313 Birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—A birth center may collect specimens for those tests that are requested under protocol. A birth center must obtain and continuously maintain certification by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder in order to perform laboratory tests specified by rule of the agency, and which are appropriate to meet the needs of the patient.

(2) SURGICAL SERVICES.—~~Except for advanced birth centers authorized to provide surgical services under s. 383.3131, only those surgical procedures that are shall be limited to those normally performed during uncomplicated childbirths, such as episiotomies and repairs, may be performed at a birth center. and shall not include Operative obstetrics or cesarean caesarean sections may not be performed at a birth center.~~

(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIA.—General and conduction anesthesia may not be administered at a birth center. Systemic analgesia may be administered, and local anesthesia for pudendal block and episiotomy repair may be performed if procedures are outlined by the clinical staff and performed by personnel who have the ~~with~~ statutory authority to do so.

(4) INTRAPARTAL USE OF CHEMICAL AGENTS.—Labor may not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor unless prescribed by personnel who have the ~~with~~ statutory authority to do so and unless in connection with and before ~~prior to~~ emergency transport.

Section 10. Section 383.3131, Florida Statutes, is created to read:

383.3131 Advanced birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.—

(1) LABORATORY SERVICES.—An advanced birth center shall have a clinical laboratory on site. The clinical laboratory must, at a minimum, be capable of providing laboratory testing for hematology, metabolic screening, liver function, and coagulation studies. An advanced birth center may collect specimens for those tests that are requested under protocol. An advanced birth center may perform laboratory tests as defined by rule of the agency. Laboratories located in advanced birth centers must be appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

(2) SURGICAL SERVICES.—In addition to surgical procedures authorized under s. 383.313(2), surgical procedures for low-risk cesarean deliveries and surgical management of immediate complications may also be

performed at an advanced birth center. Postpartum sterilization may be performed before discharge of the patient who has given birth during that admission. Circumcisions may be performed before discharge of the newborn infant.

(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIA.—General, conduction, and local anesthesia may be administered at an advanced birth center if administered by personnel who have the statutory authority to do so. All general anesthesia must be administered by an anesthesiologist or a certified registered nurse anesthetist in accordance with s. 464.012. When general anesthesia is administered, a physician or a certified registered nurse anesthetist must be present in the advanced birth center during the anesthesia and postanesthesia recovery period until the patient is fully alert. Each advanced birth center shall comply with s. 395.0191(2)(b).

(4) INTRAPARTAL USE OF CHEMICAL AGENTS.—Labor may be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor at an advanced birth center if prescribed by personnel who have the statutory authority to do so. Labor may be electively induced beginning at the 39th week of gestation for a patient with a documented Bishop score of 8 or greater.

Section 11. Subsection (3) is added to section 383.315, Florida Statutes, to read:

383.315 Agreements with consultants for advice or services; maintenance.—

(3) An advanced birth center shall employ or maintain an agreement with an obstetrician who must be on call at all times during which a patient is in active labor in the center to attend deliveries, available to respond to emergencies, and, when necessary, available to perform cesarean deliveries.

Section 12. Section 383.316, Florida Statutes, is amended to read:

383.316 Transfer and transport of clients to hospitals.—

(1) If unforeseen complications arise during labor, delivery, or postpartum recovery, the client must shall be transferred to a hospital.

(2) Each birth center licensed facility shall make arrangements with a local ambulance service licensed under chapter 401 for the transport of emergency patients to a hospital. Such arrangements must shall be documented in the center's policy and procedures manual ~~of the facility~~ if the birth center does not own or operate a licensed ambulance. The policy and procedures manual shall also must contain specific protocols for the transfer of any patient to a licensed hospital.

(3) Each advanced birth center shall enter into a written transfer agreement with a local hospital licensed under chapter 395 for the transfer and admission of emergency patients to the hospital or a written agreement

with an obstetrician who has hospital privileges to provide coverage at all times and who has agreed to accept the transfer of the advanced birth center's patients.

(4) A birth center licensed facility shall identify neonatal-specific transportation services, including ground and air ambulances; list their particular qualifications; and have the telephone numbers for access to these services clearly listed and immediately available.

(5)(4) The birth center shall assess and document Annual assessments of the transportation services and transfer protocols annually shall be made and documented.

Section 13. Present subsections (2) and (3) of section 383.318, Florida Statutes, are redesignated as subsections (3) and (4), respectively, a new subsection (2) is added to that section, and subsection (1) of that section is amended, to read:

383.318 Postpartum care for birth center clients and infants.—

(1) Except at advanced birth centers that must adhere to the requirements of subsection (2), a mother and her infant must shall be dismissed from a the birth center within 24 hours after the birth of the infant, except in unusual circumstances as defined by rule of the agency. If a mother or her infant is retained at the birth center for more than 24 hours after the birth, a report must shall be filed with the agency within 48 hours after of the birth and must describe describing the circumstances and the reasons for the decision.

(2)(a) A mother and her infant must be dismissed from an advanced birth center within 48 hours after a vaginal delivery of the infant or within 72 hours after a delivery by cesarean section, except in unusual circumstances as defined by rule of the agency.

(b) If a mother or her infant is retained at the advanced birth center for more than the timeframes set forth in paragraph (a), a report must be filed with the agency within 48 hours after the scheduled discharge time and must describe the circumstances and the reasons for the decision.

Section 14. Subsections (5), (31), and (36) of section 394.455, Florida Statutes, are amended to read:

394.455 Definitions.—As used in this part, the term:

(5) “Clinical psychologist” means a person licensed to practice psychology under chapter 490 a psychologist as defined in s. 490.003(7) with 3 years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility under this part.

(31) “Mobile crisis response service” or “mobile response team” means a nonresidential behavioral health crisis service available 24 hours per day, 7 days per week which provides immediate intensive assessments and interventions, including screening for admission into a mental health receiving facility, an addictions receiving facility, or a detoxification facility, for the purpose of identifying appropriate treatment services.

(36) “Psychiatric nurse” means an advanced practice registered nurse licensed under s. 464.012 who has a master’s or doctoral degree in psychiatric nursing and, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 1 year 2 years of post-master’s clinical experience under the supervision of a physician.

Section 15. Paragraph (c) of subsection (5) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.—

(5) RULES.—

(c) The department shall adopt rules establishing minimum standards for services provided by a mental health overlay program or a mobile crisis response service. Minimum standards for a mobile crisis response service must:

1. Include the requirements of the child, adolescent, and young adult mobile response teams established under s. 394.495(7) and ensure coverage of all counties by these specified teams; and

2. Create a structure for general mobile response teams which focuses on crisis diversion and the reduction of involuntary commitment under this chapter. The structure must require, but need not be limited to, the following:

a. Triage and rapid crisis intervention within 60 minutes;

b. Provision of and referral to evidence-based services that are responsive to the needs of the individual and the individual’s family;

c. Screening, assessment, early identification, and care coordination; and

d. Confirmation that the individual who received the mobile crisis response was connected to a service provider and prescribed medications, if needed.

Section 16. Subsections (1) and (3) of section 394.4598, Florida Statutes, are amended to read:

394.4598 Guardian advocate.—

(1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and had a guardian with the authority to consent to mental health treatment appointed, the court must ~~it shall~~ appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court must ~~shall~~ appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding must ~~shall~~ be recorded, either electronically or stenographically, and testimony must ~~shall~~ be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in s. 394.4655 or s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the patient under this part, a departmental employee, a facility administrator, or member of the Florida local advocacy council may ~~shall~~ not be appointed. A person ~~who~~ is appointed as a guardian advocate must agree to the appointment.

(3) A facility requesting appointment of a guardian advocate must, before ~~prior to~~ the appointment, provide the prospective guardian advocate with information about the duties and responsibilities of guardian advocates, including the information about the ethics of medical decisionmaking. Before asking a guardian advocate to give consent to treatment for a patient, the facility shall provide to the guardian advocate sufficient information so that the guardian advocate can decide whether to give express and informed consent to the treatment, including information that the treatment is essential to the care of the patient, and that the treatment does not present an unreasonable risk of serious, hazardous, or irreversible side effects. Before giving consent to treatment, the guardian advocate must meet and talk with the patient and the patient's physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist in person, if at all possible, and by telephone, if not. The decision of the guardian advocate may be reviewed by the court, upon petition of the patient's attorney, the patient's family, or the facility administrator.

Section 17. Subsection (11) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(11) Patients must ~~shall~~ have reasonable access to their clinical records, unless such access is determined by the patient's physician or the patient's psychiatric nurse to be harmful to the patient. If the patient's right to inspect his or her clinical record is restricted by the facility, written notice of such restriction must ~~shall~~ be given to the patient and the patient's guardian,

guardian advocate, attorney, and representative. In addition, the restriction must shall be recorded in the clinical record, together with the reasons for it. The restriction of a patient's right to inspect his or her clinical record expires shall expire after 7 days but may be renewed, after review, for subsequent 7-day periods.

Section 18. Paragraph (f) of subsection (1) and subsection (5) of section 394.4625, Florida Statutes, are amended to read:

394.4625 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(f) Within 24 hours after admission of a voluntary patient, the treating admitting physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist shall document in the patient's clinical record that the patient is able to give express and informed consent for admission. If the patient is not able to give express and informed consent for admission, the facility must shall either discharge the patient or transfer the patient to involuntary status pursuant to subsection (5).

(5) TRANSFER TO INVOLUNTARY STATUS.—When a voluntary patient, or an authorized person on the patient's behalf, makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, a clinical psychologist with at least 3 years of clinical experience, or a psychiatrist as quickly as possible, but not later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient must shall be discharged. Pending the filing of the petition, the patient may be held and emergency treatment rendered in the least restrictive manner, upon the written order of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, if it is determined that such treatment is necessary for the safety of the patient or others.

Section 19. Paragraph (f) of subsection (2) of section 394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(f) A patient must shall be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist if the physician or psychiatric nurse determines

that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist with at least 3 years of clinical experience or, if the receiving facility is owned or operated by a hospital, health system, or nationally accredited community mental health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist. The release may be approved through telehealth.

Section 20. Paragraphs (a) and (b) of subsection (3), paragraph (b) of subsection (7), and paragraph (a) of subsection (8) of section 394.4655, Florida Statutes, are amended to read:

394.4655 Involuntary outpatient services.—

(3) INVOLUNTARY OUTPATIENT SERVICES.—

(a)1. A patient who is being recommended for involuntary outpatient services by the administrator of the facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or another psychiatrist,~~ or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or a clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, a clinical psychologist with less than 3 years of clinical experience, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate that authorizes the facility to retain the patient pending completion of a hearing. The certificate must be made a part of the patient's clinical record.

2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while awaiting the hearing for involuntary outpatient services. Before filing a petition for involuntary outpatient

services, the administrator of the facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.

3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services. If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.

(b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient services, the administrator of the facility may, before the expiration of the period during which the facility is authorized to retain the patient, recommend involuntary outpatient services. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or another psychiatrist, or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist,~~ both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or a clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, a clinical psychologist with less than 3 years of clinical experience, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by

electronic means. Such recommendation must be entered on an involuntary outpatient services certificate, and the certificate must be made a part of the patient's clinical record.

(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES.—

(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court must ~~shall~~ issue an order for involuntary outpatient services. The court order must ~~shall~~ be for a period of up to 90 days. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient services when the order expires or any time the patient no longer meets the criteria for involuntary placement. Upon discharge, the service provider shall send a certificate of discharge to the court.

2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court. The order may be submitted electronically through existing data systems. After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).

3. If, in the clinical judgment of a physician or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician or psychiatric nurse, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the facility. The involuntary outpatient services order must ~~shall~~ remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which

the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).

(8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT SERVICES.—

(a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider must shall, at least 10 days before the expiration of the period during which the treatment is ordered for the person, file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.

2. The existing involuntary outpatient services order remains in effect until disposition on the petition for continued involuntary outpatient services.

3. A certificate must shall be attached to the petition which includes a statement from the person's physician or a clinical psychologist with at least 3 years of clinical experience justifying the request, a brief description of the patient's treatment during the time he or she was receiving involuntary services, and an individualized plan of continued treatment.

4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.

Section 21. Subsection (2) of section 394.467, Florida Statutes, is amended to read:

394.467 Involuntary inpatient placement.—

(2) ADMISSION TO A TREATMENT FACILITY.—A patient may be retained by a facility or involuntarily placed in a treatment facility upon the recommendation of the administrator of the facility where the patient has been examined and after adherence to the notice and hearing procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist with at least 3 years of clinical experience, ~~or~~ another psychiatrist, ~~or a psychiatric nurse practicing within the framework of an established protocol with a psychiatrist~~, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary inpatient

placement are met. However, if the administrator certifies that a psychiatrist or a clinical psychologist with at least 3 years of clinical experience is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a clinical psychologist with less than 3 years of clinical experience, or ~~by~~ a psychiatric nurse. Any opinion authorized in this subsection may be conducted through a face-to-face examination, in person, or by electronic means. Such recommendation ~~must~~ shall be entered on a petition for involuntary inpatient placement certificate that authorizes the facility to retain the patient pending transfer to a treatment facility or completion of a hearing.

Section 22. Subsection (1) of section 394.4781, Florida Statutes, is amended to read:

394.4781 Residential care for psychotic and emotionally disturbed children.—

(1) DEFINITIONS.—As used in this section, the term:

(b)(a) “Psychotic or severely emotionally disturbed child” means a child so diagnosed by a psychiatrist or a clinical psychologist with at least 3 years of clinical experience, each of whom must have ~~who has~~ specialty training and experience with children. Such a severely emotionally disturbed child or psychotic child shall be considered by this diagnosis to benefit by and require residential care as contemplated by this section.

(a)(b) “Department” means the Department of Children and Families.

Section 23. Subsection (2) of section 394.4785, Florida Statutes, is amended to read:

394.4785 Children and adolescents; admission and placement in mental facilities.—

(2) A person under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 may not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. However, a person 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician or psychiatric nurse documents in the case record that such placement is medically indicated or for reasons of safety. Such placement ~~must~~ shall be reviewed by the attending physician or a designee or on-call physician each day and documented in the case record.

Section 24. Effective upon this act becoming a law, the Agency for Health Care Administration shall seek federal approval for coverage and reimbursement authority for mobile crisis response services pursuant to 42 U.S.C. s. 1396w-6. The Department of Children and Families must coordinate with the Agency for Health Care Administration to educate contracted providers of child, adolescent, and young adult mobile response

team services on the process to enroll as a Medicaid provider; encourage and incentivize enrollment as a Medicaid provider; and reduce barriers to maximizing federal reimbursement for community-based mobile crisis response services.

Section 25. Paragraph (a) of subsection (1) of section 394.875, Florida Statutes, is amended to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)(a) The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs. Crisis stabilization units may screen, assess, and admit for stabilization persons who present themselves to the unit and persons who are brought to the unit under s. 394.463. Clients may be provided 24-hour observation, medication prescribed by a physician, ~~or psychiatrist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist,~~ and other appropriate services. Crisis stabilization units shall provide services regardless of the client's ability to pay and shall be limited in size to a maximum of 30 beds.

Section 26. Paragraphs (i) and (j) are added to subsection (1) of section 395.1055, Florida Statutes, to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(i) A hospital that accepts payment from any medical school in exchange for, or directly or indirectly related to, allowing students from the medical school to obtain clinical hours or instruction at that hospital gives priority to medical students enrolled in a medical school listed in s. 458.3145(1)(i), regardless of such payments.

(j) All hospitals with an emergency department, including hospital-based off-campus emergency departments, submit to the agency for approval a nonemergent care access plan (NCAP) for assisting patients to gain access to appropriate care settings when they either present at the emergency department with nonemergent health care needs or indicate, when receiving a medical screening examination, triage, or treatment at the hospital, that they lack regular access to primary care. Effective July 1, 2025, such NCAP must be approved by the agency before the hospital may receive initial licensure or licensure renewal occurring after that date. A hospital with an approved NCAP must submit data to the agency demonstrating the implementation and results of its plan as part of the licensure renewal

process and must update the plan as necessary, or as directed by the agency, before each licensure renewal. An NCAP must include:

1. Procedures that ensure the plan does not conflict or interfere with the hospital's duties and responsibilities under s. 395.1041 or 42 U.S.C. s. 1395dd;

2. Procedures to educate such patients about care that would be best provided in a primary care setting and the importance of receiving regular primary care; and

3. At least one of the following:

a. A collaborative partnership with one or more nearby federally qualified health centers or other primary care settings. The goals of such partnership must include, but need not be limited to, identifying patients who have presented at the emergency department for nonemergent care, care that would best be provided in a primary care setting, or emergency care that could potentially have been avoided through the regular provision of primary care, and, if such a patient indicates that he or she lacks regular access to primary care, proactively seeking to establish a relationship between the patient and the federally qualified health center or other primary care setting so that the patient develops a medical home at such setting for nonemergent and preventive health care services. A hospital that establishes one or more collaborative partnerships under this sub-subparagraph may not enter into an arrangement relating to such partnership which would prevent a federally qualified health center or other primary care setting from establishing collaborative partnerships with other hospitals.

b. The establishment, construction, and operation of a hospital-owned urgent care center colocated within or adjacent to the hospital emergency department location. After the hospital conducts a medical screening examination, and if appropriate for the patient's needs, the hospital may seek to divert to the urgent care center a patient who presents at the emergency department needing nonemergent health care services. An NCAP with procedures for diverting a patient from the emergency department in this manner must include procedures for assisting such patient in identifying appropriate primary care settings, providing a current list, with contact information, of such settings within 20 miles of the hospital location, and subsequently assisting the patient in arranging for a follow-up examination in a primary care setting, as appropriate for the patient.

For such patients who are enrolled in the Medicaid program and are members of a Medicaid managed care plan, the hospital's NCAP must include outreach to the patient's Medicaid managed care plan and coordination with the managed care plan for establishing a relationship between the patient and a primary care setting as appropriate for the patient, which may include a federally qualified health center or other primary care setting with which the hospital has a collaborative

partnership. For such a Medicaid enrollee, the agency shall establish a process for the hospital to share updated contact information for the patient, if such information is in the hospital's possession, with the patient's managed care plan. This paragraph may not be construed to preclude a hospital from complying with s. 395.1041 or 42 U.S.C. s. 1395dd.

Section 27. Present subsections (5) and (6) of section 408.051, Florida Statutes, are redesignated as subsections (6) and (7), respectively, and a new subsection (5) is added to that section, to read:

408.051 Florida Electronic Health Records Exchange Act.—

(5) HOSPITAL DATA.—A hospital as defined in s. 395.002(12) which maintains certified electronic health record technology must make available admit, transfer, and discharge data to the agency's Florida Health Information Exchange program for the purpose of supporting public health data registries and patient care coordination. The agency may adopt rules to implement this subsection.

Section 28. Present subsection (8) of section 409.909, Florida Statutes, is redesignated as subsection (10), a new subsection (8) and subsection (9) are added to that section, and paragraph (a) of subsection (6) of that section is amended, to read:

409.909 Statewide Medicaid Residency Program.—

(6) The Slots for Doctors Program is established to address the physician workforce shortage by increasing the supply of highly trained physicians through the creation of new resident positions, which will increase access to care and improve health outcomes for Medicaid recipients.

(a)1. Notwithstanding subsection (4), the agency shall annually allocate \$100,000 to hospitals and qualifying institutions for each newly created resident position that is first filled on or after June 1, 2023, and filled thereafter, and that is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit.

2. Notwithstanding the requirement that a new resident position be created to receive funding under this subsection, the agency may allocate \$100,000 to hospitals and qualifying institutions, pursuant to subparagraph 1., for up to 200 resident positions that existed before July 1, 2023, if such resident position:

a. Is in a physician specialty or subspecialty experiencing a statewide supply-and-demand deficit;

b. Has been unfilled for a period of 3 or more years;

c. Is subsequently filled on or after June 1, 2024, and remains filled thereafter; and

d. Is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program.

3. If applications for resident positions under this paragraph exceed the number of authorized resident positions or the available funding allocated, the agency shall prioritize applications for resident positions that are in a primary care specialty as specified in paragraph (2)(a).

(8) If a hospital or qualifying institution receives state funds, including, but not limited to, intergovernmental transfers, under any of the programs established under this chapter, that hospital or qualifying institution must annually report to the agency data on each resident position funded.

(a) Specific to funds allocated under this section, other than funds allocated pursuant to subsection (5), the data required to be reported under this subsection must include, but is not limited to, all of the following:

1. The sponsoring institution for the resident position. As used in this section, the term “sponsoring institution” means an organization that oversees, supports, and administers one or more resident positions.

2. The year the position was created and the current program year of the resident who is filling the position.

3. Whether the position is currently filled and whether there has been any period of time when it was not filled.

4. The specialty or subspecialty for which the position is accredited and whether the position is a fellowship position.

5. Each state funding source that was used to create the position or is being used to maintain the position, and the general purpose for which the funds were used.

(b) Specific to funds allocated pursuant to subsection (5) on or after July 1, 2021, the data must include, but is not limited to, all of the following:

1. The date on which the hospital or qualifying institution applied for funds under the program.

2. The date on which the position funded by the program became accredited.

3. The date on which the position was first filled and whether it has remained filled.

4. The specialty of the position created.

(c) Beginning on July 1, 2025, each hospital or qualifying institution shall annually produce detailed financial records no later than 30 days after the end of its fiscal year, detailing the manner in which state funds allocated under this section were expended. This requirement does not apply to funds allocated before July 1, 2025. The agency may also require that any hospital or qualifying institution submit to an audit of its financial records related to funds allocated under this section after July 1, 2025.

(d) If a hospital or qualifying institution fails to produce records as required by this section, such hospital or qualifying institution is no longer eligible to participate in any program established under this section until the hospital or qualifying institution has met the agency's requirements for producing the required records.

(e) Upon completion of a residency, each hospital or qualifying institution must request that the resident fill out an exit survey on a form developed by the agency. The completed exit surveys must be provided to the agency annually. The exit survey must include, but need not be limited to, questions on all of the following:

1. Whether the exiting resident has procured employment.
2. Whether the exiting resident plans to leave the state and, if so, for which reasons.
3. Where and in which specialty the exiting resident intends to practice.
4. Whether the exiting resident envisions himself or herself working in the medical field as a long-term career.

(9) The Graduate Medical Education Committee is created within the agency.

(a) The committee shall be composed of the following members:

1. Three deans, or their designees, from medical schools in this state, appointed by the chair of the Council of Florida Medical School Deans.
2. Four members appointed by the Governor, one of whom is a representative of the Florida Medical Association or the Florida Osteopathic Medical Association who has supervised or is currently supervising residents, one of whom is a member of the Florida Hospital Association, one of whom is a member of the Safety Net Hospital Alliance, and one of whom is a physician licensed under chapter 458 or chapter 459 practicing at a qualifying institution.
3. Two members appointed by the Secretary of Health Care Administration, one of whom represents a statutory teaching hospital as defined in s. 408.07(46) and one of whom is a physician who has supervised or is currently supervising residents.

4. Two members appointed by the State Surgeon General, one of whom must represent a teaching hospital as defined in s. 408.07 and one of whom is a physician who has supervised or is currently supervising residents or interns.

5. Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of the Representatives.

(b)1. The members of the committee appointed under subparagraph (a)1. shall serve 4-year terms. When such members' terms expire, the chair of the Council of Florida Medical School Deans shall appoint new members as detailed in paragraph (a)1. from different medical schools on a rotating basis and may not reappoint a dean from a medical school that has been represented on the committee until all medical schools in the state have had an opportunity to be represented on the committee.

2. The members of the committee appointed under subparagraphs (a)2., 3., and 4. shall serve 4-year terms, with the initial term being 3 years for members appointed under subparagraph (a)4. and 2 years for members appointed under subparagraph (a)3. The committee shall elect a chair to serve for a 1-year term.

(c) Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

(d) The committee shall convene its first meeting by July 1, 2024, and shall meet as often as necessary to conduct its business, but at least twice annually, at the call of the chair. The committee may conduct its meetings through teleconference or other electronic means. A majority of the members of the committee constitutes a quorum, and a meeting may not be held with less than a quorum present. The affirmative vote of a majority of the members of the committee present is necessary for any official action by the committee.

(e) Beginning on July 1, 2025, the committee shall submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must, at a minimum, detail all of the following:

1. The role of residents and medical faculty in the provision of health care.

2. The relationship of graduate medical education to the state's physician workforce.

3. The typical workload for residents and the role such workload plays in retaining physicians in the long-term workforce.

4. The costs of training medical residents for hospitals and qualifying institutions.

5. The availability and adequacy of all sources of revenue available to support graduate medical education.

6. The use of state funds, including, but not limited to, intergovernmental transfers, for graduate medical education for each hospital or qualifying institution receiving such funds.

(f) The agency shall provide reasonable and necessary support staff and materials to assist the committee in the performance of its duties. The agency shall also provide the information obtained pursuant to subsection (8) to the committee and assist the committee, as requested, in obtaining any other information deemed necessary by the committee to produce its report.

Section 29. Section 409.91256, Florida Statutes, is created to read:

409.91256 Training, Education, and Clinicals in Health (TEACH) Funding Program.—

(1) PURPOSE AND INTENT.—The Training, Education, and Clinicals in Health (TEACH) Funding Program is created to provide a high-quality educational experience while supporting participating federally qualified health centers, community mental health centers, rural health clinics, and certified community behavioral health clinics by offsetting administrative costs and loss of revenue associated with training residents and students to become licensed health care practitioners. Further, it is the intent of the Legislature to use the program to support the state Medicaid program and underserved populations by expanding the available health care workforce.

(2) DEFINITIONS.—As used in this section, the term:

(a) “Agency” means the Agency for Health Care Administration.

(b) “Preceptor” means a Florida-licensed health care practitioner who directs, teaches, supervises, and evaluates the learning experience of a resident or student during a clinical rotation.

(c) “Primary care specialty” means general internal medicine, family medicine, obstetrics and gynecology, general pediatrics, psychiatry, geriatric medicine, or any other specialty the agency identifies as primary care.

(d) “Qualified facility” means a federally qualified health center, a community mental health center, rural health clinic, or a certified community behavioral health clinic.

(3) APPLICATION FOR REIMBURSEMENT; AGREEMENTS; PARTICIPATION REQUIREMENTS.—The agency shall develop an application process for qualified facilities to apply for funds to offset the administrative costs and loss of revenue associated with establishing, maintaining, or expanding a clinical training program. Upon approving an application, the agency shall enter into an agreement with the qualified facility which, at minimum, must require the qualified facility to do all of the following:

(a) Agree to provide appropriate supervision or precepting for one or more of the following categories of residents or students:

1. Allopathic or osteopathic residents pursuing a primary care specialty.
2. Dental residents.
3. Advanced practice registered nursing students pursuing a primary care specialty.
4. Nursing students.
5. Allopathic or osteopathic medical students.
6. Dental students.
7. Dental hygiene students.
8. Physician assistant students.
9. Behavioral health students, including students studying psychology, clinical social work, marriage and family therapy, or mental health counseling.

(b) Meet and maintain all requirements to operate an accredited residency program if the qualified facility operates a residency program.

(c) Obtain and maintain accreditation from an accreditation body approved by the agency if the qualified facility provides clinical rotations.

(d) Ensure that clinical preceptors meet agency standards for precepting students, including the completion of any training required by the agency.

(e) Submit quarterly reports to the agency by the first day of the second month following the end of a quarter to obtain reimbursement. At a minimum, the report must include all of the following:

1. The type of residency or clinical rotation offered by the qualified facility, the number of residents or students participating in each type of clinical rotation or residency, and the number of hours worked by each resident or student each month.
2. Evaluations by the residents and student participants of the clinical experience on an evaluation form developed by the agency.
3. An itemized list of administrative costs associated with the operation of the clinical training program, including accreditation costs and other costs relating to the creation, implementation, and maintenance of the program.
4. A calculation of lost revenue associated with operating the clinical training program.

(4) TRAINING.—The agency, in consultation with the Department of Health, shall develop, or contract for the development of, training for preceptors and make such training available in either a live or electronic format. The agency shall also provide technical support for preceptors.

(5) REIMBURSEMENT.—Qualified facilities may be reimbursed under this section only to offset the administrative costs or lost revenue associated with training students, allopathic residents, osteopathic residents, or dental residents who are enrolled in an accredited educational or residency program based in this state.

(a) Subject to an appropriation, the agency may reimburse a qualified facility based on the number of clinical training hours reported under subparagraph (3)(e)1. The allowed reimbursement per student is as follows:

1. A medical or dental resident at a rate of \$50 per hour.
2. A first-year medical student at a rate of \$27 per hour.
3. A second-year medical student at a rate of \$27 per hour.
4. A third-year medical student at a rate of \$29 per hour.
5. A fourth-year medical student at a rate of \$29 per hour.
6. A dental student at a rate of \$22 per hour.
7. An advanced practice registered nursing student at a rate of \$22 per hour.
8. A physician assistant student at a rate of \$22 per hour.
9. A behavioral health student at a rate of \$15 per hour.
10. A dental hygiene student at a rate of \$15 per hour.

(b) A qualified facility may not be reimbursed more than \$75,000 per fiscal year; however, if it operates a residency program, it may be reimbursed up to \$100,000 each fiscal year.

(6) DATA.—A qualified facility that receives payment under the program shall furnish information requested by the agency for the purpose of the agency's duties under subsections (7) and (8).

(7) REPORTS.—By December 1, 2025, and each December 1 thereafter, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report detailing the effects of the program for the prior fiscal year, including, but not limited to, all of the following:

(a) The number of students trained in the program, by school, area of study, and clinical hours earned.

(b) The number of students trained and the amount of program funds received by each participating qualified facility.

(c) The number of program participants found to be employed by a participating qualified facility or in a federally designated health professional shortage area upon completion of their education and training.

(d) Any other data the agency deems useful for determining the effectiveness of the program.

(8) EVALUATION.—The agency shall contract with an independent third party to develop and conduct a design study to evaluate the impact of the TEACH funding program, including, but not limited to, the program's effectiveness in both of the following areas:

(a) Enabling qualified facilities to provide clinical rotations and residency opportunities to students and medical school graduates, as applicable.

(b) Enabling the recruitment and retention of health care professionals in geographic and practice areas experiencing shortages.

The agency shall begin collecting data for the study by January 1, 2025, and shall submit the results of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2030.

(9) RULES.—The agency may adopt rules to implement this section.

(10) FEDERAL FUNDING.—The agency shall seek federal approval to use Title XIX matching funds for the program.

(11) SUNSET.—This section is repealed on July 1, 2034.

Section 30. Paragraph (e) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(e) *Encounter data.*—The agency shall maintain and operate a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans.

1. Each prepaid plan must comply with the agency's reporting requirements for the Medicaid Encounter Data System. Prepaid plans must submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act provisions for electronic claims and in accordance with deadlines established by the agency. Prepaid plans must certify that the data reported is accurate and complete.

2. The agency is responsible for validating the data submitted by the plans. The agency shall develop methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of prepaid plan enrollees to allow comparison of service utilization among plans and against expected levels of use. The analysis shall be used to identify possible cases of systemic underutilization or denials of claims and inappropriate service utilization such as higher-than-expected emergency department encounters. The analysis shall provide periodic feedback to the plans and enable the agency to establish corrective action plans when necessary. One of the focus areas for the analysis shall be the use of prescription drugs.

3. The agency shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

4. The agency shall annually produce a report entitled “Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees.” The report must include, but need not be limited to, an analysis of the potentially preventable hospital emergency department visits, hospital admissions, and hospital readmissions that occurred during the previous state fiscal year which may have been prevented with better access to primary care, improved medication management, or better coordination of care, reported by age, eligibility group, managed care plan, and region, including conditions contributing to each potentially preventable event or category of potentially preventable events. The agency may include any other data or analysis parameters to augment the report which it deems pertinent to the analysis. The report must demonstrate trends using applicable historical data. The agency shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2024, and each October 1 thereafter. The agency may contract with a third-party vendor to produce the report required under this subparagraph.

Section 31. Subsection (4) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(a) Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider.

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an initial appointment with the primary care provider. If possible, such enrollee's initial the appointment should be made within 30 days after enrollment in the plan. If an initial appointment is not made within such 30-day period, the plan must continue assisting the enrollee to schedule an initial appointment and must report the delay and the reason for the delay to the agency. The plan shall seek to ensure that such an enrollee has at least one appointment annually with his or her primary care provider.

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

(f) Coordinate with a hospital that contacts the plan under the requirements of s. 395.1055(1)(j) for the purpose of establishing the appropriate delivery of primary care services for the plan's members who present at the hospital's emergency department for nonemergent care or emergency care that could potentially have been avoided through the regular provision of primary care. The plan shall coordinate with such member and the member's primary care provider for such purpose.

Section 32. The Agency for Health Care Administration shall seek federal approval necessary to implement an acute hospital care at home program in the state Medicaid program which is substantially consistent with the parameters specified in 42 U.S.C. s. 1395cc-7(a)(2) and (3).

Section 33. Paragraph (f) of subsection (1) and subsections (3) and (8) of section 458.311, Florida Statutes, are amended to read:

458.311 Licensure by examination; requirements; fees.—

(1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the department on forms furnished by the department. The department shall license each applicant who the board certifies:

(f) Meets one of the following medical education and postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education or is a graduate of an allopathic medical school or allopathic college within a territorial jurisdiction of the United States

recognized by the accrediting agency of the governmental body of that jurisdiction;

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

2.a. Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of the Educational Commission for Foreign Medical Graduates English proficiency certificate or by a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

3.a. Is a graduate of an allopathic foreign medical school which has not been certified pursuant to s. 458.314 and has not been excluded from consideration under s. 458.314(8);

b. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination utilized by that commission; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency or fellowship of at least 2 years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties.

(3) Notwithstanding ~~the provisions of~~ subparagraph (1)(f)3., a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8) need not present the certificate issued by the Educational Commission for Foreign Medical Graduates or pass the examination utilized by that commission if the graduate:

(a) Has received a bachelor's degree from an accredited United States college or university.

(b) Has studied at a medical school which is recognized by the World Health Organization.

(c) Has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and has passed part I of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(d) Has completed an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion has passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(8) When the board determines that any applicant for licensure has failed to meet, to the board's satisfaction, each of the appropriate requirements set forth in this section, it may enter an order requiring one or more of the following terms:

(a) Refusal to certify to the department an application for licensure, certification, or registration;

(b) Certification to the department of an application for licensure, certification, or registration with restrictions on the scope of practice of the licensee; or

(c) Certification to the department of an application for licensure, certification, or registration with placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another physician;

(d) Certification to the department of a person desiring to be licensed as a physician under this section who has held an active medical faculty certificate under s. 458.3145 for at least 3 years and has held a full-time faculty appointment for at least 3 consecutive years to teach in a program of medicine listed under s. 458.3145(1)(i); or

(e) Certification to the department of an application for licensure submitted by a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8) if the graduate has not completed an approved residency under sub-subparagraphs (1)(f)2.c. or 3.c. but meets the following criteria:

1. Has an active, unencumbered license to practice medicine in a foreign country;

2. Has actively practiced medicine during the entire 4-year period preceding the date of the submission of a licensure application;

3. Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction which is substantially similar to a residency program accredited by the Accreditation Council for Graduate Medical Education, as determined by the board;

4. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination used by that commission; and

5. Has an offer for full-time employment as a physician from a health care provider that operates in this state. For the purposes of this paragraph, the term “health care provider” means a health care professional, health care facility, or entity licensed or certified to provide health services in this state as recognized by the board.

An applicant who is not certified for unrestricted licensure under this paragraph may be certified by the board under paragraph (b) or paragraph (c), as applicable. A physician licensed after receiving certification under this paragraph must maintain his or her employment with the original employer or with another health care provider that operates in this state, at a location within this state, for at least 2 consecutive years after licensure, in accordance with rules adopted by the board. Such physician must notify the board within 5 business days after any change of employer.

Section 34. Section 458.3124, Florida Statutes, is repealed.

Section 35. Subsection (8) of section 458.314, Florida Statutes, is amended to read:

458.314 Certification of foreign educational institutions.—

(8) If a foreign medical school does not seek certification under this section, the board may, at its discretion, exclude the foreign medical school from consideration as an institution that provides medical education that is reasonably comparable to that of similar accredited institutions in the United States and that adequately prepares its students for the practice of medicine in this state. However, a license or medical faculty certificate issued to a physician under this chapter before July 1, 2024, is not affected by this subsection ~~Each institution which has been surveyed before October 1, 1986, by the Commission to Evaluate Foreign Medical Schools or the Commission on Foreign Medical Education of the Federation of State Medical Boards, Inc., and whose survey and supporting documentation demonstrates that it provides an educational program, including curriculum, reasonably comparable to that of similar accredited institutions in the United States shall be considered fully certified, for purposes of chapter 86-245, Laws of Florida.~~

Section 36. Subsections (1) and (4) of section 458.3145, Florida Statutes, are amended to read:

458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who meets all of the following criteria:

(a) Is a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization which has not been excluded from consideration under s. 458.314(8);

(b) Holds a valid, current license to practice medicine in another jurisdiction;

(c) Has completed the application form and remitted a nonrefundable application fee not to exceed \$500;

(d) Has completed an approved residency or fellowship of at least 1 year or has received training that ~~which~~ has been determined by the board to be equivalent to the 1-year residency requirement;

(e) Is at least 21 years of age;

(f) Is of good moral character;

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331;

(h) For any applicant who has graduated from medical school after October 1, 1992, has completed, before entering medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which must include, at a minimum, courses in such fields as anatomy, biology, and chemistry; ~~and~~

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at any of the following institutions:

1. The University of Florida;
2. The University of Miami;
3. The University of South Florida;
4. The Florida State University;
5. The Florida International University;
6. The University of Central Florida;

7. The Mayo Clinic College of Medicine and Science in Jacksonville, Florida.;
8. The Florida Atlantic University.;
9. The Johns Hopkins All Children's Hospital in St. Petersburg, Florida.;
10. Nova Southeastern University.;
11. Lake Erie College of Osteopathic Medicine.
12. Burrell College of Osteopathic Medicine in Melbourne, Florida.

~~(4) In any year, the maximum number of extended medical faculty certificateholders as provided in subsection (2) may not exceed 30 persons at each institution named in subparagraphs (1)(i)1., 6., 8., and 9. and at the facility named in s. 1004.43 and may not exceed 10 persons at the institution named in subparagraph (1)(i)7.~~

Section 37. Section 458.315, Florida Statutes, is amended to read:

458.315 Temporary certificate for practice in areas of critical need.—

(1) A physician or physician assistant who is licensed to practice in any jurisdiction of the United States and, whose license is currently valid, ~~and who pays an application fee of \$300~~ may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of \$300.

(2) A temporary certificate may be issued under this section to a physician or physician assistant who will:

(a) ~~Will~~ Practice in an area of critical need;

(b) ~~Will~~ Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care services to meet the needs of underserved populations in this state; or

(c) ~~Will~~ Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

(3) The board of ~~Medicine~~ may issue a this temporary certificate under this section ~~subject to~~ with the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied, as applicable.

(b) The board may administer an abbreviated oral examination to determine the physician's or physician assistant's competency, but a written regular examination is not required. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the 3-year period immediately preceding the application ~~prior 3 years~~ and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate having reasonable restrictions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The board of ~~Medicine~~ shall review each temporary certificateholder at least not less than annually to ascertain that the certificateholder is complying with the minimum requirements of the Medical Practice Act and its adopted rules, as applicable to the certificateholder are being complied with. If it is determined that the certificateholder is not meeting such minimum requirements ~~are not being met~~, the board must ~~shall~~ revoke such certificate or ~~shall~~ impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any physician or physician assistant who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this chapter until such time as the investigation is complete, at which time ~~the provisions of s. 458.331~~ applies apply.

(4) The application fee and all licensure fees, including neurological injury compensation assessments, ~~are~~ shall be waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the physician or physician assistant will not receive any compensation for any health care services provided by the applicant service involving the practice of medicine.

Section 38. Section 458.317, Florida Statutes, is amended to read:

458.317 Limited licenses.—

(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS.

(a) Any person desiring to obtain a limited license under this subsection shall submit to the board an application and fee not to exceed \$300 and demonstrate that he or she has been licensed to practice medicine in any jurisdiction in the United States for at least 10 years and intends to practice only pursuant to the restrictions of a limited license granted pursuant to this subsection ~~section~~. However, a physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license shall pay such fees if the person receives compensation for the practice of medicine.

(b) If it has been more than 3 years since active practice was conducted by the applicant, the full-time director of the county health department or a licensed physician, approved by the board, must ~~shall~~ supervise the applicant for a period of 6 months after he or she is granted a limited license under this subsection ~~for practice~~, unless the board determines that a shorter period of supervision will be sufficient to ensure that the applicant is qualified for licensure. Procedures for such supervision must ~~shall~~ be established by the board.

(c) The recipient of a limited license under this subsection may practice only in the employ of public agencies or institutions or nonprofit agencies or institutions meeting the requirements of s. 501(c)(3) of the Internal Revenue Code, which agencies or institutions are located in the areas of critical medical need as determined by the board. Determination of medically underserved areas shall be made by the board after consultation with the ~~department of Health~~ and statewide medical organizations; however, such determination shall include, but not be limited to, health professional shortage areas designated by the United States Department of Health and Human Services. A recipient of a limited license under this subsection may use the license to work for any approved employer in any area of critical need approved by the board.

(d) The recipient of a limited license shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied.

~~(e) This subsection does not limit~~ ~~Nothing herein limits in any way~~ any policy by the board, otherwise authorized by law, to grant licenses to physicians duly licensed in other states under conditions less restrictive than the requirements of this ~~subsection~~ ~~section~~. Notwithstanding the other provisions of this ~~subsection~~ ~~section~~, the board may refuse to authorize a physician otherwise qualified to practice in the employ of any agency or institution otherwise qualified if the agency or institution has caused or permitted violations of the provisions of this chapter which it knew or should have known were occurring.

~~(f)(2)~~ The board shall notify the director of the full-time local county health department of any county in which a licensee intends to practice under the provisions of this ~~subsection~~ ~~aet.~~ The director of the full-time county health department shall assist in the supervision of any licensee within the county and shall notify the board ~~which issued the licensee his or her license~~ if he or she becomes aware of any actions by the licensee which would be grounds for revocation of the limited license. The board shall establish procedures for such supervision.

~~(g)(3)~~ The board shall review the practice of each licensee biennially to verify compliance with the restrictions prescribed in this ~~subsection~~ ~~section~~ and other applicable provisions of this chapter.

~~(h)(4)~~ Any person holding an active license to practice medicine in this state may convert that license to a limited license under this subsection for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine. The application fee and all licensure fees, including neurological injury compensation assessments, are shall be waived for such applicant.

(2) GRADUATE ASSISTANT PHYSICIANS.—A graduate assistant physician is a medical school graduate who meets the requirements of this subsection and has obtained a limited license from the board for the purpose of practicing temporarily under the direct supervision of a physician who has a full, active, and unencumbered license issued under this chapter, pending the graduate's entrance into a residency under the National Resident Match Program.

(a) Any person desiring to obtain a limited license as a graduate assistant physician must submit to the board an application and demonstrate that he or she meets all of the following criteria:

1. Is a graduate of an allopathic medical school or allopathic college approved by an accrediting agency recognized by the United States Department of Education.

2. Has successfully passed all parts of the United States Medical Licensing Examination.

3. Has not received and accepted a residency match from the National Resident Match Program within the first year following graduation from medical school.

(b) The board shall issue a graduate assistant physician limited license for a duration of 2 years to an applicant who meets the requirements of paragraph (a) and all of the following criteria:

1. Is at least 21 years of age.

2. Is of good moral character.

3. Submits documentation that the applicant has agreed to enter into a written protocol drafted by a physician with a full, active, and unencumbered license issued under this chapter upon the board's issuance of a limited license to the applicant and submits a copy of the protocol. The board shall establish by rule specific provisions that must be included in a physician-drafted protocol.

4. Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331.

5. Has submitted to the department a set of fingerprints on a form and under procedures specified by the department.

6. The board may not certify to the department for limited licensure under this subsection any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter or chapter 456 until such investigation is completed. Upon completion of the investigation, s. 458.331 applies. Furthermore, the department may not issue a limited license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 458.331. If the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 458.331, the board may enter an order imposing one of the following terms:

a. Refusal to certify to the department an application for a graduate assistant physician limited license; or

b. Certification to the department of an application for a graduate assistant physician limited license with restrictions on the scope of practice of the licensee.

(c) A graduate assistant physician limited licensee may apply for a one-time renewal of his or her limited license by submitting a board-approved application, documentation of actual practice under the required protocol during the initial limited licensure period, and documentation of applications he or she has submitted for accredited graduate medical education training programs. The one-time renewal terminates after 1 year. A graduate assistant physician who has received a limited license under this subsection is not eligible to apply for another limited license, regardless of whether he or she received a one-time renewal under this paragraph.

(d) A limited licensed graduate assistant physician may provide health care services only under the direct supervision of a physician with a full, active, and unencumbered license issued under this chapter.

(e) A physician must be approved by the board to supervise a limited licensed graduate assistant physician.

(f) A physician may supervise no more than two graduate assistant physicians with limited licenses.

(g) Supervision of limited licensed graduate assistant physicians requires the physical presence of the supervising physician at the location where the services are rendered.

(h) A physician-drafted protocol must specify the duties and responsibilities of the limited licensed graduate assistant physician according to criteria adopted by board rule.

(i) Each protocol that applies to a limited licensed graduate assistant physician and his or her supervising physician must ensure that:

1. There is a process for the evaluation of the limited licensed graduate assistant physicians' performance; and

2. The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the graduate assistant physician's level of competency.

(j) A limited licensed graduate assistant physician's prescriptive authority is governed by the physician-drafted protocol and criteria adopted by the board and may not exceed that of his or her supervising physician. Any prescriptions and orders issued by the graduate assistant physician must identify both the graduate assistant physician and the supervising physician.

(k) A physician who supervises a graduate assistant physician is liable for any acts or omissions of the graduate assistant physician acting under the physician's supervision and control. Third-party payors may reimburse employers of graduate assistant physicians for covered services rendered by graduate assistant physicians.

(3) RULES.—The board may adopt rules to implement this section.

Section 39. Section 459.0075, Florida Statutes, is amended to read:

459.0075 Limited licenses.—

(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS.

(a) Any person desiring to obtain a limited license under this subsection must shall:

1.(a) Submit to the board a licensure application and fee required by this chapter. However, an osteopathic physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing agency or institution stating that she or he will not receive monetary compensation for any service involving the practice of osteopathic medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license must shall pay such fees if the person receives compensation for the practice of osteopathic medicine.

2.(b) Submit proof that such osteopathic physician has been licensed to practice osteopathic medicine in any jurisdiction in the United States in good standing and pursuant to law for at least 10 years.

3.(e) Complete an amount of continuing education established by the board.

(b)(2) If it has been more than 3 years since active practice was conducted by the applicant, the full-time director of the local county health department must shall supervise the applicant for a period of 6 months after the applicant is granted a limited license under this subsection to practice, unless the board determines that a shorter period of supervision will be sufficient to ensure that the applicant is qualified for licensure under this subsection pursuant to this section. Procedures for such supervision must shall be established by the board.

(c)(3) The recipient of a limited license under this subsection may practice only in the employ of public agencies or institutions or nonprofit agencies or institutions meeting the requirements of s. 501(c)(3) of the Internal Revenue Code, which agencies or institutions are located in areas of critical medical need or in medically underserved areas as determined pursuant to 42 U.S.C. s. 300e-1(7).

(d)(4) The board shall notify the director of the full-time local county health department of any county in which a licensee intends to practice under the provisions of this subsection section. The director of the full-time county health department shall assist in the supervision of any licensee within the her or his county and shall notify the board if she or he becomes aware of any action by the licensee which would be a ground for revocation of

the limited license. The board shall establish procedures for such supervision.

~~(e)(5)~~ The State board of Osteopathic Medicine shall review the practice of each licensee under this subsection ~~section~~ biennially to verify compliance with the restrictions prescribed in this subsection ~~section~~ and other provisions of this chapter.

~~(f)(6)~~ Any person holding an active license to practice osteopathic medicine in this ~~the~~ state may convert that license to a limited license under this subsection for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that she or he or she will not receive compensation for any service involving the practice of osteopathic medicine. The application fee and all licensure fees, including neurological injury compensation assessments, are shall be waived for such applicant.

(2) GRADUATE ASSISTANT PHYSICIANS.—A graduate assistant physician is a medical school graduate who meets the requirements of this subsection and has obtained a limited license from the board for the purpose of practicing temporarily under the direct supervision of a physician who has a full, active, and unencumbered license issued under this chapter, pending the graduate's entrance into a residency under the National Resident Match Program.

(a) Any person desiring to obtain a limited license as a graduate assistant physician must submit to the board an application and demonstrate that she or he meets all of the following criteria:

1. Is a graduate of a school or college of osteopathic medicine approved by an accrediting agency recognized by the United States Department of Education.

2. Has successfully passed all parts of the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the board.

3. Has not received and accepted a residency match from the National Residency Match Program within the first year following graduation from medical school.

(b) The board shall issue a graduate assistant physician limited license for a duration of 2 years to an applicant who meets the requirements of paragraph (a) and all of the following criteria:

1. Is at least 21 years of age.

2. Is of good moral character.

3. Submits documentation that the applicant has agreed to enter into a written protocol drafted by a physician with a full, active, and

unencumbered license issued under this chapter upon the board's issuance of a limited license to the applicant, and submits a copy of the protocol. The board shall establish by rule specific provisions that must be included in a physician-drafted protocol.

4. Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 459.015.

5. Has submitted to the department a set of fingerprints on a form and under procedures specified by the department.

6. The board may not certify to the department for limited licensure under this subsection any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter or chapter 456 until such investigation is completed. Upon completion of the investigation, s. 459.015 applies. Furthermore, the department may not issue a limited license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 459.015. If the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under s. 459.015, the board may enter an order imposing one of the following terms:

a. Refusal to certify to the department an application for a graduate assistant physician limited license; or

b. Certification to the department of an application for a graduate assistant physician limited license with restrictions on the scope of practice of the licensee.

(c) A graduate assistant physician limited licensee may apply for a one-time renewal of his or her limited licensed by submitting a board-approved application, documentation of actual practice under the required protocol during the initial limited licensure period, and documentation of applications he or she has submitted for accredited graduate medical education training programs. The one-time renewal terminates after 1 year. A graduate assistant physician who has received a limited license under this subsection is not eligible to apply for another limited license, regardless of whether he or she received a one-time renewal under this paragraph.

(d) A limited licensed graduate assistant physician may provide health care services only under the direct supervision of a physician with a full, active, and unencumbered license issued under this chapter.

(e) A physician must be approved by the board to supervise a limited licensed graduate assistant physician.

(f) A physician may supervise no more than two graduate assistant physicians with limited licenses.

(g) Supervision of limited licensed graduate assistant physicians requires the physical presence of the supervising physician at the location where the services are rendered.

(h) A physician-drafted protocol must specify the duties and responsibilities of the limited licensed graduate assistant physician according to criteria adopted by board rule.

(i) Each protocol that applies to a limited licensed graduate assistant physician and his or her supervising physician must ensure that:

1. There is a process for the evaluation of the limited licensed graduate assistant physicians' performance; and

2. The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the graduate assistant physician's level of competency.

(j) A limited licensed graduate assistant physician's prescriptive authority is governed by the physician-drafted protocol and criteria adopted by the board and may not exceed that of his or her supervising physician. Any prescriptions and orders issued by the graduate assistant physician must identify both the graduate assistant physician and the supervising physician.

(k) A physician who supervises a graduate assistant physician is liable for any acts or omissions of the graduate assistant physician acting under the physician's supervision and control. Third-party payors may reimburse employers of graduate assistant physicians for covered services rendered by graduate assistant physicians.

(3) RULES.—The board may adopt rules to implement this section.

Section 40. Section 459.0076, Florida Statutes, is amended to read:

459.0076 Temporary certificate for practice in areas of critical need.—

(1) A physician or physician assistant who holds a valid license is licensed to practice in any jurisdiction of the United States, whose license is currently valid, and who pays an application fee of \$300 may be issued a temporary certificate for practice in areas of critical need. A physician seeking such certificate must pay an application fee of \$300.

(2) A temporary certificate may be issued under this section to a physician or physician assistant who will:

(a) Will Practice in an area of critical need;

(b) Will Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public

Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state; or

(c) Will Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

(3) The board of ~~Osteopathic Medicine~~ may issue this temporary certificate subject to ~~with~~ the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied, as applicable.

(b) The board may administer an abbreviated oral examination to determine the physician's or physician assistant's competency, but a written regular examination is not required. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the 3-year period immediately preceding the application ~~prior 3 years~~ and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate having reasonable restrictions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The board of ~~Osteopathic Medicine~~ shall

review each temporary certificateholder at least ~~not less than~~ annually to ascertain that the certificateholder is complying with the minimum requirements of the Osteopathic Medical Practice Act and its adopted rules, as applicable to the certificateholder are being complied with. If it is determined that the certificateholder is not meeting such minimum requirements ~~are not being met~~, the board must ~~shall~~ revoke such certificate or ~~shall~~ impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any physician or physician assistant who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this chapter until such time as the investigation is complete, at which time ~~the provisions of s. 459.015~~ applies apply.

(4) The application fee and all licensure fees, including neurological injury compensation assessments, are ~~shall be~~ waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the physician or physician assistant will not receive any compensation for any health care services that he or she provides service involving the practice of medicine.

Section 41. Section 464.0121, Florida Statutes, is created to read:

464.0121 Temporary certificate for practice in areas of critical need.—

(1) An advanced practice registered nurse who is licensed to practice in any jurisdiction of the United States, whose license is currently valid, and who meets educational and training requirements established by the board may be issued a temporary certificate for practice in areas of critical need.

(2) A temporary certificate may be issued under this section to an advanced practice registered nurse who will:

(a) Practice in an area of critical need;

(b) Be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or another agency or institution that is approved by the State Surgeon General and that provides health care services to meet the needs of underserved populations in this state; or

(c) Practice for a limited time to address critical health care specialty, demographic, or geographic needs relating to this state's accessibility of health care services as determined by the State Surgeon General.

(3) The board may issue a temporary certificate under this section subject to the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices as part of his or her employment.

(b) The board may administer an abbreviated oral examination to determine the advanced practice registered nurse's competency, but may not require a written regular examination. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the 3-year period immediately preceding the application and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate imposing reasonable restrictions that may include, but are not limited to, a requirement that the applicant practice under the supervision of a physician approved by the board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board, which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General maintains the determination that the critical need that supported the issuance of the temporary certificate remains a critical need to the state. The board shall review each temporary certificateholder at least annually to ascertain that the certificateholder is complying with the minimum requirements of the Nurse Practice Act and its adopted rules, as applicable to the certificateholder. If it is determined that the certificateholder is not meeting such minimum requirements, the board must revoke such certificate or impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any advanced practice registered nurse who is under

investigation in any jurisdiction in the United States for an act that would constitute a violation of this part until such time as the investigation is complete, at which time s. 464.018 applies.

(4) All licensure fees, including neurological injury compensation assessments, are waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the advanced practice registered nurse will not receive any compensation for any health care services that he or she provides.

Section 42. Paragraph (b) of subsection (3) of section 464.0123, Florida Statutes, is amended to read:

464.0123 Autonomous practice by an advanced practice registered nurse.—

(3) PRACTICE REQUIREMENTS.—

(b)1. In order to provide out-of-hospital intrapartum care, a certified nurse midwife engaged in the autonomous practice of nurse midwifery must maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services. The policy must prescribe and require the use of an emergency plan-of-care form, which must be signed by the patient before admission to intrapartum care. At a minimum, the form must include all of the following:

a. The name and address of the closest hospital that provides maternity and newborn services.

b. Reasons for which transfer of care would be necessary, including the transfer-of-care conditions prescribed by board rule.

c. Ambulances or other emergency medical services that would be used to transport the patient in the event of an emergency.

2. If transfer of care is determined necessary by the certified nurse midwife or under the terms of the written policy, the certified nurse midwife must document all of the following information on the patient's emergency plan-of-care form:

a. The name, date of birth, and condition of the patient.

b. The gravidity and parity of the patient and the gestational age and condition of the fetus or newborn infant.

c. The reasons that necessitated the transfer of care.

d. A description of the situation, relevant clinical background, assessment, and recommendations.

- e. The planned mode of transporting the patient to the receiving facility.
- f. The expected time of arrival at the receiving facility.

3. Before transferring the patient, or as soon as possible during or after an emergency transfer, the certified nurse midwife shall provide the receiving provider with a verbal summary of the information specified in subparagraph 2. and make himself or herself immediately available for consultation. Upon transfer of the patient to the receiving facility, the certified nurse midwife must provide the receiving provider with the patient's emergency plan-of-care form as soon as practicable.

4. The certified nurse midwife shall provide the receiving provider, as soon as practicable, with the patient's prenatal records, including patient history, prenatal laboratory results, sonograms, prenatal care flow sheets, maternal fetal medical reports, and labor flow charting and current notations.

5. The board shall adopt rules to prescribe transfer-of-care conditions, monitor for excessive transfers, conduct reviews of adverse maternal and neonatal outcomes, and monitor the licensure of certified nurse midwives engaged in autonomous practice must have a written patient transfer agreement with a hospital and a written referral agreement with a physician licensed under chapter 458 or chapter 459 to engage in nurse midwifery.

Section 43. Subsection (10) of section 464.019, Florida Statutes, is amended to read:

464.019 Approval of nursing education programs.—

(10) IMPLEMENTATION STUDY.—The Florida Center for Nursing shall study the administration of this section and submit reports to the Governor, the President of the Senate, and the Speaker of the House of Representatives annually by January 30, ~~through January 30, 2025~~. The annual reports shall address the previous academic year; provide data on the measures specified in paragraphs (a) and (b), as such data becomes available; and include an evaluation of such data for purposes of determining whether this section is increasing the availability of nursing education programs and the production of quality nurses. The department and each approved program or accredited program shall comply with requests for data from the Florida Center for Nursing.

(a) The Florida Center for Nursing shall evaluate program-specific data for each approved program and accredited program conducted in the state, including, but not limited to:

- 1. The number of programs and student slots available.
- 2. The number of student applications submitted, the number of qualified applicants, and the number of students accepted.

- 3. The number of program graduates.
- 4. Program retention rates of students tracked from program entry to graduation.
- 5. Graduate passage rates on the National Council of State Boards of Nursing Licensing Examination.
- 6. The number of graduates who become employed as practical or professional nurses in the state.

(b) The Florida Center for Nursing shall evaluate the board’s implementation of the:

- 1. Program application approval process, including, but not limited to, the number of program applications submitted under subsection (1), the number of program applications approved and denied by the board under subsection (2), the number of denials of program applications reviewed under chapter 120, and a description of the outcomes of those reviews.
- 2. Accountability processes, including, but not limited to, the number of programs on probationary status, the number of approved programs for which the program director is required to appear before the board under subsection (5), the number of approved programs terminated by the board, the number of terminations reviewed under chapter 120, and a description of the outcomes of those reviews.

(c) The Florida Center for Nursing shall complete an annual assessment of compliance by programs with the accreditation requirements of subsection (11), include in the assessment a determination of the accreditation process status for each program, and submit the assessment as part of the reports required by this subsection.

Section 44. Paragraph (e) of subsection (3) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

(3) DEFINITIONS.—As used in this section, the term:

(e) “Low-income” means:

- 1. A person who is Medicaid-eligible under Florida law;
- 2. A person who is without health insurance and whose family income does not exceed 300 ~~200~~ percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or
- 3. Any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

Section 45. Paragraph (f) is added to subsection (3) of section 1002.32, Florida Statutes, to read:

1002.32 Developmental research (laboratory) schools.—

(3) MISSION.—The mission of a lab school shall be the provision of a vehicle for the conduct of research, demonstration, and evaluation regarding management, teaching, and learning. Programs to achieve the mission of a lab school shall embody the goals and standards established pursuant to ss. 1000.03(5) and 1001.23(1) and shall ensure an appropriate education for its students.

(f) Each lab school shall develop programs that accelerate the entry of enrolled lab school students into articulated health care programs at its affiliated university or at any public or private postsecondary institution, with the approval of the university president. Each lab school shall offer technical assistance to any Florida school district seeking to replicate the lab school's programs and must annually, beginning December 1, 2025, report to the President of the Senate and the Speaker of the House of Representatives on the development of such programs and their results.

Section 46. Paragraph (b) of subsection (3) of section 1009.8962, Florida Statutes, is amended to read:

1009.8962 Linking Industry to Nursing Education (LINE) Fund.—

(3) As used in this section, the term:

(b) “Institution” means a school district career center under s. 1001.44; a charter technical career center under s. 1002.34; a Florida College System institution; a state university; ~~or an independent nonprofit college or university located and chartered in this state and accredited by an agency or association that is recognized by the database created and maintained by the United States Department of Education to grant baccalaureate degrees; or an independent school, college, or university with an accredited program as defined in s. 464.003 which is located in this state and licensed by the Commission for Independent Education pursuant to s. 1005.31,~~ which has a nursing education program that meets or exceeds the following:

1. For a certified nursing assistant program, a completion rate of at least 70 percent for the prior year.

2. For a licensed practical nurse, associate of science in nursing, and bachelor of science in nursing program, a first-time passage rate on the National Council of State Boards of Nursing Licensing Examination of at least ~~75~~ 70 percent for the prior year based on a minimum of 10 testing participants.

Section 47. Paragraph (f) of subsection (3) of section 381.4018, Florida Statutes, is amended to read:

381.4018 Physician workforce assessment and development.—

(3) GENERAL FUNCTIONS.—The department shall maximize the use of existing programs under the jurisdiction of the department and other state agencies and coordinate governmental and nongovernmental stakeholders and resources in order to develop a state strategic plan and assess the implementation of such strategic plan. In developing the state strategic plan, the department shall:

(f) Develop strategies to maximize federal and state programs that provide for the use of incentives to attract physicians to this state or retain physicians within the state. Such strategies should explore and maximize federal-state partnerships that provide incentives for physicians to practice in federally designated shortage areas, in otherwise medically underserved areas, or in rural areas. Strategies shall also consider the use of state programs, such as the Medical Education Reimbursement and Loan Repayment Program pursuant to s. 381.402 ~~s. 1009.65~~, which provide for education loan repayment or loan forgiveness and provide monetary incentives for physicians to relocate to underserved areas of the state.

The department may adopt rules to implement this subsection, including rules that establish guidelines to implement the federal Conrad 30 Waiver Program created under s. 214(l) of the Immigration and Nationality Act.

Section 48. Subsection (3) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(3) USE OF FUNDS.—It is the intent of the Legislature that funds as appropriated shall be utilized by the department for the purpose of increasing the number of primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses in rural areas, either through the Medical Education Reimbursement and Loan Repayment Program as defined by s. 381.402 ~~s. 1009.65~~ or through a federal loan repayment program which requires state matching funds. The department may use funds appropriated for the Medical Education Reimbursement and Loan Repayment Program as matching funds for federal loan repayment programs for health care personnel, such as that authorized in Pub. L. No. 100-177, s. 203. If the department receives federal matching funds, the department shall only implement the federal program. Reimbursement through either program shall be limited to:

(a) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural hospitals, as defined in this act; and

(b) Primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses employed by or affiliated with rural

area health education centers, as defined in this section. These personnel shall practice:

1. In a county with a population density of no greater than 100 persons per square mile; or
2. Within the boundaries of a hospital tax district which encompasses a population of no greater than 100 persons per square mile.

If the department administers a federal loan repayment program, priority shall be given to obligating state and federal matching funds pursuant to paragraphs (a) and (b). The department may use federal matching funds in other health workforce shortage areas and medically underserved areas in the state for loan repayment programs for primary care physicians, physician assistants, certified nurse midwives, nurse practitioners, and nurses who are employed by publicly financed health care programs that serve medically indigent persons.

Section 49. Section 456.4501, Florida Statutes, is created to read:

456.4501 Interstate Medical Licensure Compact.—The Interstate Medical Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

SECTION 1

PURPOSE

In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards and provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing medical practice act. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the compact.

SECTION 2DEFINITIONS

As used in the compact, the term:

(1) “Bylaws” means those bylaws established by the Interstate Commission pursuant to Section 11 for its governance or for directing and controlling its actions and conduct.

(2) “Commissioner” means the voting representative appointed by each member board pursuant to Section 11.

(3) “Conviction” means a finding by a court that an individual is guilty of a criminal offense, through adjudication or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

(4) “Expedited license” means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.

(5) “Interstate Commission” means the Interstate Medical Licensure Compact Commission created pursuant to Section 11.

(6) “License” means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

(7) “Medical practice act” means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(8) “Member board” means a state agency in a member state which acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

(9) “Member state” means a state that has enacted the compact.

(10) “Offense” means a felony, high court misdemeanor, or crime of moral turpitude.

(11) “Physician” means any person who:

(a) Is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(b) Passed each component of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three attempts, or any of its

predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(c) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(d) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; however, the specialty certification or a time-unlimited specialty certificate does not have to be maintained once a physician is initially determined to be eligible for expedited licensure through the compact;

(e) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(f) Has never been convicted or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(g) Has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license;

(h) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(i) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

(12) "Practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do any of these acts.

(13) "Rule" means a written statement by the Interstate Commission adopted pursuant to Section 12 of the compact which is of general applicability; implements, interprets, or prescribes a policy or provision of the compact or an organizational, procedural, or practice requirement of the Interstate Commission; and has the force and effect of statutory law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule.

(14) "State" means any state, commonwealth, district, or territory of the United States.

(15) “State of principal license” means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.

SECTION 3

ELIGIBILITY

(1) A physician must meet the eligibility requirements as provided in subsection (11) of Section 2 to receive an expedited license under the terms of the compact.

(2) A physician who does not meet the requirements specified in subsection (11) of Section 2 may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the compact, relating to the issuance of a license to practice medicine in that state.

SECTION 4

DESIGNATION OF STATE OF PRINCIPAL LICENSE

(1) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the compact if the physician possesses a full and unrestricted license to practice medicine in that state and the state is:

(a) The state of primary residence for the physician;

(b) The state where at least 25 percent of the physician’s practice of medicine occurs;

(c) The location of the physician’s employer; or

(d) If no state qualifies under paragraph (a), paragraph (b), or paragraph (c), the state designated as the physician’s state of residence for purpose of federal income tax.

(2) A physician may redesignate a member state as state of principal license at any time, as long as the state meets one of the descriptions under subsection (1).

(3) The Interstate Commission may develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5

APPLICATION AND ISSUANCE
OF EXPEDITED LICENSURE

(1) A physician seeking licensure through the compact must file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

(2) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(a) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, are not subject to additional primary source verification if already primary source-verified by the state of principal license.

(b) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have a suitability determination in accordance with 5 C.F.R. s. 731.202.

(c) Appeal on the determination of eligibility must be made to the member state where the application was filed and is subject to the law of that state.

(3) Upon verification in subsection (2), physicians eligible for an expedited license must complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (1).

(4) After receiving verification of eligibility under subsection (2) and upon an applicant's completion of any registration process required under subsection (3), a member board shall issue an expedited license to the physician. This license authorizes the physician to practice medicine in the issuing state consistent with the medical practice act and all applicable laws and regulations of the issuing member board and member state.

(5) An expedited license is valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license within the member state.

(6) An expedited license obtained through the compact must be terminated if a physician fails to maintain a license in the state of principal license

for a nondisciplinary reason, without redesignation of a new state of principal license.

(7) The Interstate Commission may develop rules regarding the application process and the issuance of an expedited license.

SECTION 6

RENEWAL AND CONTINUED PARTICIPATION

(1) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(a) Maintains a full and unrestricted license in a state of principal license;

(b) Has not been convicted or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(c) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to nonpayment of fees related to a license; and

(d) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

(2) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(3) Physician information collected by the Interstate Commission during the renewal process must be distributed to all member boards.

(4) The Interstate Commission may develop rules to address renewal of licenses obtained through the compact.

SECTION 7

COORDINATED INFORMATION SYSTEM

(1) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under Section 5.

(2) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a licensed physician who has applied or received an expedited license through the compact.

(3) Member boards shall report to the Interstate Commission disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(4) Member boards may report to the Interstate Commission any nonpublic complaint, disciplinary, or investigatory information not required by subsection (3).

(5) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(6) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(7) The Interstate Commission may develop rules for mandated or discretionary sharing of information by member boards.

SECTION 8

JOINT INVESTIGATIONS

(1) Licensure and disciplinary records of physicians are deemed investigative.

(2) In addition to the authority granted to a member board by its respective medical practice act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(3) A subpoena issued by a member state is enforceable in other member states.

(4) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(5) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 9

DISCIPLINARY ACTIONS

(1) Any disciplinary action taken by any member board against a physician licensed through the compact is deemed unprofessional conduct that may be subject to discipline by other member boards, in addition to any violation of the medical practice act or regulations in that state.

(2) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board must remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the medical practice act of that state.

(3) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(a) Impose the same or lesser sanctions against the physician so long as such sanctions are consistent with the medical practice act of that state; or

(b) Pursue separate disciplinary action against the physician under its respective medical practice act, regardless of the action taken in other member states.

(4) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, any license issued to the physician by any other member board must be suspended, automatically and immediately without further action necessary by the other member boards, for 90 days after entry of the order by the disciplining board, to permit the member boards to investigate the basis for the action under the medical practice act of that state. A member board may terminate the automatic suspension of the license it issued before the completion of the 90-day suspension period in a manner consistent with the medical practice act of that state.

SECTION 10

INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(1) The member states hereby create the Interstate Medical Licensure Compact Commission.

(2) The purpose of the Interstate Commission is the administration of the compact, which is a discretionary state function.

(3) The Interstate Commission is a body corporate and joint agency of the member states and has all the responsibilities, powers, and duties set forth in the compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the compact.

(4) The Interstate Commission shall consist of two voting representatives appointed by each member state, who shall serve as commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall appoint one representative from each member board. Each commissioner must be one of the following:

(a) An allopathic or osteopathic physician appointed to a member board.

(b) An executive director, an executive secretary, or a similar executive of a member board.

(c) A member of the public appointed to a member board.

(5) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting must be a business meeting to address such matters as may properly come before the commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(6) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or other electronic means.

(7) Each commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of commissioners constitutes a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A commissioner may not delegate a vote to another commissioner. In the absence of its commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who must meet the qualification requirements specified in subsection (4).

(8) The Interstate Commission shall provide public notice of all meetings, and all meetings must be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the commissioners present that an open meeting would be likely to:

(a) Relate solely to the internal personnel practices and procedures of the Interstate Commission;

(b) Discuss matters specifically exempted from disclosure by federal statute;

(c) Discuss trade secrets or commercial or financial information that is privileged or confidential;

(d) Involve accusing a person of a crime, or formally censuring a person;

(e) Discuss information of a personal nature, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy;

(f) Discuss investigative records compiled for law enforcement purposes;
or

(g) Specifically relate to participation in a civil action or other legal proceeding.

(9) The Interstate Commission shall keep minutes that fully describe all matters discussed in a meeting and provide a full and accurate summary of actions taken, including a record of any roll call votes.

(10) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the compact or by its rules, available to the public for inspection.

(11) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee has the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the compact, including enforcement and compliance with the compact and its bylaws and rules, and other duties as necessary.

(12) The Interstate Commission may establish other committees for governance and administration of the compact.

SECTION 11

POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The Interstate Commission has all of the following powers and duties:

(1) Overseeing and maintaining the administration of the compact.

(2) Adopting rules, which shall be binding to the extent and in the manner provided for in the compact.

(3) Issuing, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the compact and its bylaws, rules, and actions.

(4) Enforcing compliance with the compact, the rules adopted by the Interstate Commission, and the bylaws, using all necessary and proper means, including, but not limited to, the use of judicial process.

(5) Establishing and appointing committees, including, but not limited to, an executive committee as required by Section 11, which shall have the

power to act on behalf of the Interstate Commission in carrying out its powers and duties.

(6) Paying for or providing for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission.

(7) Establishing and maintaining one or more offices.

(8) Borrowing, accepting, hiring, or contracting for services of personnel.

(9) Purchasing and maintaining insurance and bonds.

(10) Employing an executive director, who shall have the power to employ, select, or appoint employees, agents, or consultants and to determine their qualifications, define their duties, and fix their compensation.

(11) Establishing personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel.

(12) Accepting donations and grants of money, equipment, supplies, materials, and services and receiving, using, and disposing of them in a manner consistent with the conflict-of-interest policies established by the Interstate Commission.

(13) Leasing, purchasing, accepting contributions or donations of, or otherwise owning, holding, improving, or using any property, real, personal, or mixed.

(14) Selling conveying, mortgaging, pledging, leasing, exchanging, abandoning, or otherwise disposing of any property, real, personal, or mixed.

(15) Establishing a budget and making expenditures.

(16) Adopting a seal and bylaws governing the management and operation of the Interstate Commission.

(17) Reporting annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports must also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission.

(18) Coordinating education, training, and public awareness regarding the compact and its implementation and operation.

(19) Maintaining records in accordance with the bylaws.

(20) Seeking and obtaining trademarks, copyrights, and patents.

(21) Performing any other functions necessary or appropriate to achieve the purposes of the compact.

SECTION 12

FINANCE POWERS

(1) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment, subject to appropriation, must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated upon a formula to be determined by the Interstate Commission, which shall adopt a rule binding upon all member states.

(2) The Interstate Commission may not incur obligations of any kind before securing the funds adequate to meet the same.

(3) The Interstate Commission may not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(4) The Interstate Commission is subject to an annual financial audit conducted by a certified or licensed public accountant, and the report of the audit must be included in the annual report of the Interstate Commission.

SECTION 13

ORGANIZATION AND OPERATION OF
THE INTERSTATE COMMISSION

(1) The Interstate Commission shall, by a majority of commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact within 12 months after the first Interstate Commission meeting.

(2) The Interstate Commission shall elect or appoint annually from among its commissioners a chairperson, a vice chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson’s absence or disability, the vice chairperson, shall preside over all meetings of the Interstate Commission.

(3) Officers selected pursuant to subsection (2) shall serve without remuneration from the Interstate Commission.

(4) The officers and employees of the Interstate Commission are immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error,

or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person is not protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(a) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states for the purposes of any such action. Nothing in this subsection may be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(b) The Interstate Commission shall defend the executive director and its employees and, subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such persons in any civil action seeking to impose liability arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(c) To the extent not covered by the state involved, the member state, or the Interstate Commission, the representatives or employees of the Interstate Commission must be held harmless in the amount of a settlement or judgment, including attorney fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

SECTION 14

RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(1) The Interstate Commission shall adopt reasonable rules in order to effectively and efficiently achieve the purposes of the compact. However, in the event the Interstate Commission exercises its rulemaking authority in a

manner that is beyond the scope of the purposes of the compact, or the powers granted hereunder, then such an action by the Interstate Commission is invalid and has no force or effect.

(2) Rules deemed appropriate for the operations of the Interstate Commission must be made pursuant to a rulemaking process that substantially conforms to the “Model State Administrative Procedure Act” of 2010, and subsequent amendments thereto.

(3) Not later than 30 days after a rule is adopted, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition does not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court must give deference to the actions of the Interstate Commission consistent with applicable law and may not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 15

OVERSIGHT OF INTERSTATE COMPACT

(1) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and shall take all actions necessary and appropriate to effectuate the compact’s purposes and intent. The compact and the rules adopted hereunder shall have standing as statutory law but do not override existing state authority to regulate the practice of medicine.

(2) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities, or actions of the Interstate Commission.

(3) The Interstate Commission is entitled to receive all service of process in any such proceeding and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the compact, or adopted rules, as applicable.

SECTION 16

ENFORCEMENT OF INTERSTATE COMPACT

(1) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

(2) The Interstate Commission may, by majority vote of the commissioners, initiate legal action in the United States District Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the compact and its adopted rules and bylaws against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party must be awarded all costs of such litigation, including reasonable attorney fees.

(3) The remedies herein are not the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or the regulation of a profession.

SECTION 17

DEFAULT PROCEDURES

(1) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the compact, or the rules and bylaws of the Interstate Commission adopted under the compact.

(2) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, or the bylaws or adopted rules, the Interstate Commission shall:

(a) Provide written notice to the defaulting state and other member states of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

(b) Provide remedial training and specific technical assistance regarding the default.

(3) If the defaulting state fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the commissioners and all rights, privileges, and benefits conferred by the compact terminate on the effective date of the termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(4) Termination of membership in the compact must be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate must be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(5) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(6) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination, including obligations, the performance of which extends beyond the effective date of termination.

(7) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(8) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party must be awarded all costs of such litigation including reasonable attorney fees.

SECTION 18

DISPUTE RESOLUTION

(1) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes that are subject to the compact and that may arise among member states or member boards.

(2) The Interstate Commission shall adopt rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 19

MEMBER STATES, EFFECTIVE DATE, AND AMENDMENT

(1) Any state is eligible to become a member state of the compact.

(2) The compact becomes effective and binding upon legislative enactment of the compact into law by no less than seven states. Thereafter, it becomes effective and binding on a state upon enactment of the compact into law by that state.

(3) The governors of nonmember states, or their designees, must be invited to participate in the activities of the Interstate Commission on a nonvoting basis before adoption of the compact by all states.

(4) The Interstate Commission may propose amendments to the compact for enactment by the member states. No amendment becomes effective and

binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 20

WITHDRAWAL

(1) Once effective, the compact shall continue in force and remain binding upon each member state. However, a member state may withdraw from the compact by specifically repealing the statute which enacted the compact into law.

(2) Withdrawal from the compact must be made by the enactment of a statute repealing the same, but the withdrawal shall not take effect until 1 year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(3) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

(4) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within 60 days after receipt of notice provided under subsection (3).

(5) The withdrawing state is responsible for all dues, obligations, and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(6) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or upon such later date as determined by the Interstate Commission.

(7) The Interstate Commission may develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 21

DISSOLUTION

(1) The compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the compact to one member state.

(2) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, the business and affairs of the

Interstate Commission must be concluded, and surplus funds of the Interstate Commission must be distributed in accordance with the bylaws.

SECTION 22

SEVERABILITY AND CONSTRUCTION

(1) The provisions of the compact are severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact remain enforceable.

(2) The provisions of the compact must be liberally construed to effectuate its purposes.

(3) The compact may be construed to prohibit the applicability of other interstate compacts to which the states are members.

SECTION 23

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) Nothing herein prevents the enforcement of any other law of a member state which is not inconsistent with the compact.

(2) All laws in a member state in conflict with the compact are superseded to the extent of the conflict.

(3) All lawful actions of the Interstate Commission, including all rules and bylaws adopted by the commission, are binding upon the member states.

(4) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(5) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, such provision is ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 50. Section 456.4502, Florida Statutes, is created to read:

456.4502 Interstate Medical Licensure Compact; disciplinary proceedings.—A physician licensed pursuant to chapter 458, chapter 459, or s. 456.4501 whose license is suspended or revoked by this state pursuant to the Interstate Medical Licensure Compact as a result of disciplinary action taken against the physician's license in another state must be granted a formal hearing before an administrative law judge from the Division of Administrative Hearings held pursuant to chapter 120 if there are any disputed issues of material fact. In such proceedings:

(1) Notwithstanding s. 120.569(2), the department shall notify the division within 45 days after receipt of a petition or request for a formal hearing.

(2) The determination of whether the physician has violated the laws and rules regulating the practice of medicine or osteopathic medicine, as applicable, including a determination of the reasonable standard of care, is a conclusion of law that is to be determined by appropriate board and is not a finding of fact to be determined by an administrative law judge.

(3) The administrative law judge shall issue a recommended order pursuant to chapter 120.

(4) The Board of Medicine or the Board of Osteopathic Medicine, as applicable, shall determine and issue the final order in each disciplinary case. Such order shall constitute final agency action.

(5) Any consent order or agreed-upon settlement is subject to the approval of the department.

(6) The department shall have standing to seek judicial review of any final order of the board, pursuant to s. 120.68.

Section 51. Section 456.4504, Florida Statutes, is created to read:

456.4504 Interstate Medical Licensure Compact Rules.—The department may adopt rules to implement the Interstate Medical Licensure Compact.

Section 52. Section 458.3129, Florida Statutes, is created to read:

458.3129 Interstate Medical Licensure Compact.—A physician licensed to practice allopathic medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 53. Section 459.074, Florida Statutes, is created to read:

459.074 Interstate Medical Licensure Compact.—A physician licensed to practice osteopathic medicine under s. 456.4501 is deemed to also be licensed under this chapter.

Section 54. Paragraph (j) is added to subsection (10) of section 768.28, Florida Statutes, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(10)

(j) For purposes of this section, the representative appointed from the Board of Medicine and the representative appointed from the Board of Osteopathic Medicine, when serving as commissioners of the Interstate Medical Licensure Compact Commission pursuant to s. 456.4501, and any administrator, officer, executive director, employee, or representative of the Interstate Medical Licensure Compact Commission, when acting within the scope of their employment, duties, or responsibilities in this state, are considered agents of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

Section 55. Section 468.1335, Florida Statutes, is created to read:

468.1335 Audiology and Speech-Language Pathology Interstate Compact.—The Audiology and Speech-Language Pathology Interstate Compact is hereby enacted into law and entered into by this state with all other states legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE

(1) The purpose of the compact is to facilitate the interstate practice of audiology and speech-language pathology with the goal of improving public access to audiology and speech-language pathology services.

(2) The practice of audiology and speech-language pathology occurs in the state where the patient, client, or student is located at the time the services are provided.

(3) The compact preserves the regulatory authority of states to protect the public health and safety through the current system of state licensure.

(4) The compact is designed to achieve all of the following objectives:

(a) Increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' abilities to protect public health and safety.

(c) Encourage the cooperation of member states in regulating multistate audiology and speech-language pathology practices.

(d) Support spouses of relocating active duty military personnel.

(e) Enhance the exchange of licensure, investigative, and disciplinary information between member states.

(f) Allow a remote state to hold a licensee with compact privilege in that state accountable to that state's practice standards.

(g) Allow for the use of telehealth technology to facilitate increased access to audiology and speech-language pathology services.

ARTICLE II

DEFINITIONS

As used in the compact, the term:

(1) “Active duty military” means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapters 1209 and 1211.

(2) “Adverse action” means any administrative, civil, equitable, or criminal action permitted by a state’s laws which is imposed by a licensing board against a licensee, including actions against an individual’s license or privilege to practice, such as revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee’s practice.

(3) “Alternative program” means a nondisciplinary monitoring process approved by an audiology licensing board or a speech-language pathology licensing board to address impaired licensees.

(4) “Audiologist” means an individual who is licensed by a state to practice audiology.

(5) “Audiology” means the care and services provided by a licensed audiologist as provided in the member state’s rules and regulations.

(6) “Audiology and Speech-Language Pathology Interstate Compact Commission” or “commission” means the national administrative body whose membership consists of all states that have enacted the compact.

(7) “Audiology licensing board” means the agency of a state which is responsible for the licensing and regulation of audiologists.

(8) “Compact privilege” means the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its rules and regulations. The practice of audiology or speech-language pathology occurs in the member state where the patient, client, or student is located at the time the services are provided.

(9) “Current significant investigative information,” “investigative materials,” “investigative records,” or “investigative reports” means information that a licensing board, after an inquiry or investigation that includes notification and an opportunity for the audiologist or speech-language pathologist to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.

(10) “Data system” means a repository of information relating to licensees, including, but not limited to, continuing education, examination, licensure, investigative, compact privilege, and adverse action information.

(11) “Encumbered license” means a license in which an adverse action restricts the practice of audiology or speech-language pathology by the licensee and the adverse action has been reported to the National Practitioner Data Bank.

(12) “Executive committee” means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(13) “Home state” means the member state that is the licensee’s primary state of residence.

(14) “Impaired licensee” means a licensee whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions.

(15) “Licensee” means a person who is licensed by his or her home state to practice as an audiologist or speech-language pathologist.

(16) “Licensing board” means the agency of a state which is responsible for the licensing and regulation of audiologists or speech-language pathologists.

(17) “Member state” means a state that has enacted the compact.

(18) “Privilege to practice” means the legal authorization to practice audiology or speech-language pathology in a remote state.

(19) “Remote state” means a member state, other than the home state, where a licensee is exercising or seeking to exercise his or her compact privilege.

(20) “Rule” means a regulation, principle, or directive adopted by the commission which has the force of law.

(21) “Single-state license” means an audiology or speech-language pathology license issued by a member state which authorizes practice only within the issuing state and does not include a privilege to practice in any other member state.

(22) “Speech-language pathologist” means an individual who is licensed to practice speech-language pathology.

(23) “Speech-language pathology” means the care and services provided by a licensed speech-language pathologist as provided in the member state’s rules and regulations.

(24) “Speech-language pathology licensing board” means the agency of a state which is responsible for the licensing and regulation of speech-language pathologists.

(25) “State” means any state, commonwealth, district, or territory of the United States of America which regulates the practice of audiology and speech-language pathology.

(26) “State practice laws” means a member state’s laws, rules, and regulations that govern the practice of audiology or speech-language pathology, define the scope of audiology or speech-language pathology practice, and create the methods and grounds for imposing discipline.

(27) “Telehealth” means the application of telecommunication technology to deliver audiology or speech-language pathology services at a distance for assessment, intervention, or consultation.

ARTICLE III

STATE PARTICIPATION

(1) A license issued to an audiologist or speech-language pathologist by a home state to a resident in that state must be recognized by each member state as authorizing an audiologist or speech-language pathologist to practice audiology or speech-language pathology, under a privilege to practice, in each member state.

(2) A state must implement procedures for considering the criminal history records of applicants for initial privilege to practice. These procedures must include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant’s criminal history records from the Federal Bureau of Investigation and the agency responsible for retaining that state’s criminal history records.

(a) A member state must fully implement a criminal history records check procedure, within a timeframe established by rule, which requires the member state to receive an applicant’s criminal history records from the Federal Bureau of Investigation and the agency responsible for retaining the member state’s criminal history records and use such records in making licensure decisions.

(b) Communication between a member state, the commission, and other member states regarding the verification of eligibility for licensure through the compact may not include any information received from the Federal Bureau of Investigation relating to a criminal history records check performed by a member state under Pub. L. No. 92-544.

(3) Upon application for a privilege to practice, the licensing board in the issuing remote state must determine, through the data system, whether the

applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or privilege to practice held by the applicant, and whether any adverse action has been taken against any license or privilege to practice held by the applicant.

(4) Each member state must require an applicant to obtain or retain a license in his or her home state and meet the home state's qualifications for licensure or renewal of licensure and all other applicable state laws.

(5) Each member state must require that an applicant meet all of the following criteria to receive the privilege to practice as an audiologist in the member state:

(a) One of the following educational requirements:

1. On or before December 31, 2007, has graduated with a master's degree or doctoral degree in audiology, or an equivalent degree, regardless of the name of such degree, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board;

2. On or after January 1, 2008, has graduated with a doctoral degree in audiology, or an equivalent degree, regardless of the name of such degree, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

3. Has graduated from an audiology program that is housed in an institution of higher education outside of the United States for which the degree program and institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.

(b) Has completed a supervised clinical practicum experience from an accredited educational institution or its cooperating programs as required by the commission.

(c) Has successfully passed a national examination approved by the commission.

(d) Holds an active, unencumbered license.

(e) Has not been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.

(f) Has a valid United States social security number or a national provider identifier.

(6) Each member state must require that an applicant meet all of the following criteria to receive the privilege to practice as a speech-language pathologist in the member state:

(a) One of the following educational requirements:

1. Has graduated with a master's degree from a speech-language pathology program that is accredited by an organization recognized by the United States Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or

2. Has graduated from a speech-language pathology program that is housed in an institution of higher education outside of the United States for which the degree program and institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.

(b) Has completed a supervised clinical practicum experience from an educational institution or its cooperating programs as required by the commission.

(c) Has completed a supervised postgraduate professional experience as required by the commission.

(d) Has successfully passed a national examination approved by the commission.

(e) Holds an active, unencumbered license.

(f) Has not been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.

(g) Has a valid United States social security number or national provider identifier.

(7) The privilege to practice is derived from the home state license.

(8) An audiologist or speech-language pathologist practicing in a member state must comply with the state practice laws of the member state where the client is located at the time service is provided. The practice of audiology and speech-language pathology includes all audiology and speech-language pathology practices as defined by the state practice laws of the member state where the client is located. The practice of audiology and speech-language pathology in a member state under a privilege to practice

subjects an audiologist or speech-language pathologist to the jurisdiction of the licensing boards, courts, and laws of the member state where the client is located at the time service is provided.

(9) Individuals not residing in a member state shall continue to be able to apply for a member state's single-state license as provided under the laws of each member state. However, the single-state license granted to these individuals may not be recognized as granting the privilege to practice audiology or speech-language pathology in any other member state. The compact does not affect the requirements established by a member state for the issuance of a single-state license.

(10) Member states must comply with the bylaws and rules of the commission.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise compact privilege under the compact, the audiologist or speech-language pathologist must meet all of the following criteria:

- (a) Hold an active license in the home state.
- (b) Have no encumbrance on any state license.
- (c) Be eligible for compact privilege in any member state in accordance with Article III.
- (d) Not have any adverse action against any license or compact privilege within the 2 years preceding the date of application.
- (e) Notify the commission that he or she is seeking compact privilege within a remote state or states.
- (f) Report to the commission any adverse action taken by any non-member state within 30 days after the date the adverse action is taken.

(2) For the purposes of compact privilege, an audiologist or speech-language pathologist may hold only one home state license at a time.

(3) Except as provided in Article VI, if an audiologist or speech-language pathologist changes his or her primary state of residence by moving between two member states, the audiologist or speech-language pathologist must apply for licensure in the new home state, and the license issued by the prior home state shall be deactivated in accordance with applicable rules adopted by the commission.

(4) The audiologist or speech-language pathologist may apply for licensure in advance of a change in his or her primary state of residence.

(5) A license may not be issued by the new home state until the audiologist or speech-language pathologist provides satisfactory evidence of a change in his or her primary state of residence to the new home state and satisfies all applicable requirements to obtain a license from the new home state.

(6) If an audiologist or speech-language pathologist changes his or her primary state of residence by moving from a member state to a nonmember state, the license issued by the prior home state shall convert to a single-state license, valid only in the former home state.

(7) Compact privilege is valid until the expiration date of the home state license. The licensee must comply with the requirements of subsection (1) to maintain compact privilege in the remote state.

(8) A licensee providing audiology or speech-language pathology services in a remote state under compact privilege shall function within the laws and regulations of the remote state.

(9) A remote state may, in accordance with due process and state law, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, or take any other necessary actions to protect the health and safety of its residents.

(10) If a home state license is encumbered, the licensee shall lose compact privilege in all remote states until both of the following occur:

(a) The home state license is no longer encumbered.

(b) Two years have lapsed from the date of the adverse action.

(11) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain compact privilege in any remote state.

(12) Once the requirements of subsection (10) have been met, the licensee must meet the requirements in subsection (1) to obtain compact privilege in a remote state.

ARTICLE V

COMPACT PRIVILEGE TO PRACTICE TELEHEALTH

Member states shall recognize the right of an audiologist or speech-language pathologist, licensed by a home state in accordance with Article III and under rules adopted by the commission, to practice audiology or speech-language pathology in any member state through the use of telehealth under privilege to practice as provided in the compact and rules adopted by the commission.

ARTICLE VIACTIVE DUTY MILITARY PERSONNEL
AND THEIR SPOUSES

Active duty military personnel, or their spouses, as applicable, shall designate a home state where the individual has a current license in good standing. The individual may retain the home state designation during the period the servicemember is on active duty. Subsequent to designating a home state, the individual shall change his or her home state only through application for licensure in the new state.

ARTICLE VIIADVERSE ACTIONS

(1) In addition to the other powers conferred by state law, a remote state may:

(a) Take adverse action against an audiologist's or speech-language pathologist's privilege to practice within that member state.

1. Only the home state has the power to take adverse action against an audiologist's or a speech-language pathologist's license issued by the home state.

2. For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

(b) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board in a member state for the attendance and testimony of witnesses or the production of evidence from another member state must be enforced in the latter state by any court of competent jurisdiction according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state in which the witnesses or evidence is located.

(c) Complete any pending investigations of an audiologist or speech-language pathologist who changes his or her primary state of residence during the course of the investigations. The home state also has the authority to take appropriate actions and shall promptly report the conclusions of the investigations to the administrator of the data system. The administrator of the data system shall promptly notify the new home state of any adverse actions.

(d) If otherwise allowed by state law, recover from the affected audiologist or speech-language pathologist the costs of investigations and disposition of cases resulting from any adverse action taken against that audiologist or speech-language pathologist.

(e) Take adverse action based on the factual findings of the remote state, provided that the member state follows the member state's own procedures for taking the adverse action.

(2)(a) In addition to the authority granted to a member state by its respective audiology or speech-language pathology practice act or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(3) If adverse action is taken by the home state against an audiologist's or a speech language pathologist's license, the audiologist's or speech-language pathologist's privilege to practice in all other member states shall be deactivated until all encumbrances have been removed from the home state license. All home state disciplinary orders that impose adverse action against an audiologist's or a speech language pathologist's license must include a statement that the audiologist's or speech-language pathologist's privilege to practice is deactivated in all member states during the pendency of the order.

(4) If a member state takes adverse action, it must promptly notify the administrator of the data system. The administrator of the data system shall promptly notify the home state of any adverse actions by remote states.

(5) The compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action.

ARTICLE VIII

ESTABLISHMENT OF THE AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY INTERSTATE COMPACT COMMISSION

(1) The member states hereby create and establish a joint public agency known as the Audiology and Speech-Language Pathology Interstate Compact Commission.

(a) The commission is an instrumentality of the compact states.

(b) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively, in a court of competent

jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) The compact does not waive sovereign immunity except to the extent sovereign immunity is waived in the member states.

(2)(a) Each member state must have two delegates selected by that member state’s licensing boards. The delegates must be current members of the licensing boards. One delegate must be an audiologist and one delegate must be a speech-language pathologist.

(b) An additional five delegates, who are either public members or board administrators from licensing boards, must be chosen by the executive committee from a pool of nominees provided by the commission at large.

(c) A delegate may be removed or suspended from office as provided by the state law from which the delegate is appointed.

(d) The member state board shall fill any vacancy occurring on the commission within 90 days after the vacancy occurs.

(e) Each delegate is entitled to one vote with regard to the adoption of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(f) A delegate shall vote in person or by other means as provided in the bylaws. The bylaws may provide for delegates’ participation in meetings by telephone or other means of communication.

(g) The commission shall meet at least once during each calendar year. Additional meetings must be held as provided in the bylaws and rules.

(3) The commission has the following powers and duties:

(a) Establish the commission’s fiscal year.

(b) Establish bylaws.

(c) Establish a code of ethics.

(d) Maintain its financial records in accordance with the bylaws.

(e) Meet and take actions as are consistent with the compact and the bylaws.

(f) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are binding on all member states.

(g) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of an audiology licensing board or a speech-language pathology licensing board to sue or be sued under applicable law is not affected.

(h) Purchase and maintain insurance and bonds.

(i) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(j) Hire employees, elect or appoint officers, fix compensation, define duties, grant individuals appropriate authority to carry out the purposes of the compact, and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(k) Accept any appropriate donations and grants of money, equipment, supplies, and materials and services, and receive, use, and dispose of the same, provided that at all times the commission must avoid any appearance of impropriety or conflict of interest.

(l) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission shall avoid any appearance of impropriety.

(m) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed.

(n) Establish a budget and make expenditures.

(o) Borrow money.

(p) Appoint committees, including standing committees, composed of members and other interested persons as may be designated in the compact and the bylaws.

(q) Provide and receive information from, and cooperate with, law enforcement agencies.

(r) Establish and elect an executive committee.

(s) Perform other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of audiology and speech-language pathology licensure and practice.

(4) The executive committee shall have the power to act on behalf of the commission according to the terms of the compact.

(a) The executive committee must be composed of 10 members as follows:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. Two ex officio members, consisting of one nonvoting member from a recognized national audiology professional association and one nonvoting member from a recognized national speech-language pathology association.

3. One ex officio, nonvoting member from the recognized membership organization of the audiology and speech-language pathology licensing boards.

(b) The ex officio members must be selected by their respective organizations.

(c) The commission may remove any member of the executive committee as provided in the bylaws.

(d) The executive committee shall meet at least annually.

(e) The executive committee has the following duties and responsibilities:

1. Recommend to the entire commission changes to the rules or bylaws and changes to this compact legislation.

2. Ensure compact administration services are appropriately provided, contractual or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Other duties as provided by rule or bylaw.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in Article X.

(g) If a meeting or any portion of a meeting is closed under this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(h) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action must be identified in minutes. All minutes and documents of a closed meeting must remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(5) Relating to the financing of the commission, the commission:

(a) Shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) May accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) May not incur obligations of any kind before securing the funds adequate to meet the same and may not pledge the credit of any of the member states, except by and with the authority of the member state.

(d) Shall keep accurate accounts of all receipts and disbursements of funds. The receipts and disbursements of funds of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(6) Relating to qualified immunity, defense, and indemnification:

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities; provided that this paragraph may not be construed to protect any person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that this paragraph may not be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or

that the person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

ARTICLE IX

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and current significant investigative information on all licensed individuals in member states.

(2) Notwithstanding any other law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, including all of the following information:

(a) Identifying information.

(b) Licensure data.

(c) Adverse actions against a license or compact privilege.

(d) Nonconfidential information related to alternative program participation.

(e) Any denial of application for licensure, and the reason for such denial.

(f) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Current significant investigative information pertaining to a licensee in a member state must be available only to other member states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee or an individual applying for a license in any member state must be available to any other member state.

(5) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(6) Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE XRULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria provided in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, the rule has no further force and effect in any member state.

(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule or rules by the commission, and at least 30 days before the meeting at which the rule shall be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(a) On the website of the commission or other publicly accessible platform; and

(b) On the website of each member state audiology licensing board and speech-language pathology licensing board or other publicly accessible platform or the publication where each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon.

(b) The text of and reason for the proposed rule or amendment.

(c) A request for comments on the proposed rule from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before the adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(a) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons;

2. A state or federal governmental subdivision or agency; or

3. An association having at least 25 members.

(b) If a hearing is held on the proposed rule or amendment, the commission must publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the commission must publish the mechanism for access to the electronic hearing.

(c) All persons wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing not less than 5 business days before the scheduled date of the hearing.

(d) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(e) All hearings must be recorded. A copy of the recording must be made available on request.

(7) This article does not require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(8) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(9) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public hearing.

(10) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(11) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article retroactively apply to the rule as soon as reasonably possible, but in no event later than 90 days after the effective date of the rule. For purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of commission or member state funds; or

(c) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

(12) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of the commission. The revisions are subject to challenge by any person for a period of 30 days after posting. A revision may be challenged only on grounds that it results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If no challenge is made, the revision takes effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE XI

DISPUTE RESOLUTION AND ENFORCEMENT

(1)(a) Upon request by a member state, the commission shall attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(2)(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member must be awarded all costs of litigation, including reasonable attorney fees.

(c) The remedies provided in this subsection are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XII

EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

(1) The compact becomes effective and binding on the date of legislative enactment of the compact by no fewer than 10 member states. The provisions, which become effective at that time, shall be limited to the powers granted to the commission relating to assembly and the adoption of

rules. Thereafter, the commission shall meet and exercise rulemaking powers as necessary to implement and administer the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) A member state may withdraw from the compact by enacting a statute repealing the compact.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's audiology licensing board or speech-language pathology licensing board to comply with the investigative and adverse action reporting requirements of the compact before the effective date of withdrawal.

(4) The compact does not invalidate or prevent any audiology or speech-language pathology licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding upon any member state until it is enacted into the laws of all member states.

ARTICLE XIII

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to effectuate its purposes. The provisions of the compact are severable and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected. If the compact is held contrary to the constitution of any member state, it shall remain in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

ARTICLE XIV

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) This compact does not prevent the enforcement of any other law of a member state which is not inconsistent with the compact.

(2) All laws of a member state in conflict with the compact are superseded to the extent of the conflict.

(3) All lawful actions of the commission, including all rules and bylaws adopted by the commission, are binding upon the member states.

(4) All agreements between the commission and the member states are binding in accordance with their terms.

(5) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, the provision is ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 56. Present subsections (4), (5), and (6) of section 468.1135, Florida Statutes, are redesignated as subsections (5), (6), and (7), respectively, and a new subsection (4) is added to that section, to read:

468.1135 Board of Speech-Language Pathology and Audiology.—

(4) The board shall appoint two of its members to serve as the state's delegates on the Audiology and Speech-Language Pathology Interstate Compact Commission, as required under s. 468.1335, one of whom must be an audiologist and one of whom must be a speech-language pathologist.

Section 57. Subsection (6) is added to section 468.1185, Florida Statutes, to read:

468.1185 Licensure.—

(6) A person licensed as an audiologist or a speech-language pathologist in another state who is practicing under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 58. Subsections (1) and (2) of section 468.1295, Florida Statutes, are amended to read:

468.1295 Disciplinary proceedings.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2) or s. 468.1335:

(a) Procuring, or attempting to procure, a license by bribery, by fraudulent misrepresentation, or through an error of the department or the board.

(b) Having a license revoked, suspended, or otherwise acted against, including denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of speech-language pathology or audiology.

(d) Making or filing a report or record which the licensee knows to be false, intentionally or negligently failing to file a report or records required by state or federal law, willfully impeding or obstructing such filing, or inducing another person to impede or obstruct such filing. Such report or record shall include only those reports or records which are signed in one's capacity as a licensed speech-language pathologist or audiologist.

(e) Advertising goods or services in a manner which is fraudulent, false, deceptive, or misleading in form or content.

(f) Being proven guilty of fraud or deceit or of negligence, incompetency, or misconduct in the practice of speech-language pathology or audiology.

(g) Violating a lawful order of the board or department previously entered in a disciplinary hearing, or failing to comply with a lawfully issued subpoena of the board or department.

(h) Practicing with a revoked, suspended, inactive, or delinquent license.

(i) Using, or causing or promoting the use of, any advertising matter, promotional literature, testimonial, guarantee, warranty, label, brand, insignia, or other representation, however disseminated or published, which is misleading, deceiving, or untruthful.

(j) Showing or demonstrating or, in the event of sale, delivery of a product unusable or impractical for the purpose represented or implied by such action.

(k) Failing to submit to the board on an annual basis, or such other basis as may be provided by rule, certification of testing and calibration of such equipment as designated by the board and on the form approved by the board.

(l) Aiding, assisting, procuring, employing, or advising any licensee or business entity to practice speech-language pathology or audiology contrary to this part, chapter 456, or any rule adopted pursuant thereto.

(m) Misrepresenting the professional services available in the fitting, sale, adjustment, service, or repair of a hearing aid, or using any other term or title which might connote the availability of professional services when such use is not accurate.

(n) Representing, advertising, or implying that a hearing aid or its repair is guaranteed without providing full disclosure of the identity of the guarantor; the nature, extent, and duration of the guarantee; and the existence of conditions or limitations imposed upon the guarantee.

(o) Representing, directly or by implication, that a hearing aid utilizing bone conduction has certain specified features, such as the absence of anything in the ear or leading to the ear, or the like, without disclosing clearly and conspicuously that the instrument operates on the bone conduction principle and that in many cases of hearing loss this type of instrument may not be suitable.

(p) Stating or implying that the use of any hearing aid will improve or preserve hearing or prevent or retard the progression of a hearing impairment or that it will have any similar or opposite effect.

(q) Making any statement regarding the cure of the cause of a hearing impairment by the use of a hearing aid.

(r) Representing or implying that a hearing aid is or will be “custom-made,” “made to order,” or “prescription-made,” or in any other sense specially fabricated for an individual, when such is not the case.

(s) Canvassing from house to house or by telephone, either in person or by an agent, for the purpose of selling a hearing aid, except that contacting persons who have evidenced an interest in hearing aids, or have been referred as in need of hearing aids, shall not be considered canvassing.

(t) Failing to notify the department in writing of a change in current mailing and place-of-practice address within 30 days after such change.

(u) Failing to provide all information as described in ss. 468.1225(5)(b), 468.1245(1), and 468.1246.

(v) Exercising influence on a client in such a manner as to exploit the client for financial gain of the licensee or of a third party.

(w) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee or certificateholder knows, or has reason to know, the licensee or certificateholder is not competent to perform.

(x) Aiding, assisting, procuring, or employing any unlicensed person to practice speech-language pathology or audiology.

(y) Delegating or contracting for the performance of professional responsibilities by a person when the licensee delegating or contracting for performance of such responsibilities knows, or has reason to know, such person is not qualified by training, experience, and authorization to perform them.

(z) Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined pursuant to s. 468.1296.

(aa) Being unable to practice the profession for which he or she is licensed or certified under this chapter with reasonable skill or competence as a result of any mental or physical condition or by reason of illness, drunkenness, or use of drugs, narcotics, chemicals, or any other substance. In enforcing this paragraph, upon a finding by the State Surgeon General, his or her designee, or the board that probable cause exists to believe that the licensee or certificateholder is unable to practice the profession because of the reasons stated in this paragraph, the department shall have the authority to compel a licensee or certificateholder to submit to a mental or physical examination by a physician, psychologist, clinical social worker, marriage and family therapist, or mental health counselor designated by the department or board. If the licensee or certificateholder refuses to comply with the department's order directing the examination, such order may be enforced by filing a petition for enforcement in the circuit court in the circuit in which the licensee or certificateholder resides or does business. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice for which he or she is licensed or certified with reasonable skill and safety to patients.

(bb) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

(b) The board may take adverse action against an audiologist's or a speech-language pathologist's compact privilege under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335 and may impose any of the penalties in s. 456.072(2) if an audiologist or a speech-language pathologist commits an act specified in subsection (1) or s. 456.072(1).

Section 59. Paragraph (j) is added to subsection (10) of section 768.28, Florida Statutes, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(10)

(j) For purposes of this section, the individuals appointed under s. 468.1135(4) as the state's delegates on the Audiology and Speech-Language Pathology Interstate Compact Commission, when serving in that capacity pursuant to s. 468.1335, and any administrator, officer, executive director, employee, or representative of the commission, when acting within the scope of his or her employment, duties, or responsibilities in this state, is considered an agent of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

Section 60. Section 486.112, Florida Statutes, is created to read:

486.112 Physical Therapy Licensure Compact.—The Physical Therapy Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE AND OBJECTIVES

(1) The purpose of the compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The compact preserves the regulatory authority of member states to protect public health and safety through their current systems of state licensure. For purposes of state regulation under the compact, the practice of physical therapy is deemed to have occurred in the state where the patient is located at the time physical therapy is provided to the patient.

(2) The compact is designed to achieve all of the following objectives:

(a) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.

(b) Enhance the states' ability to protect the public's health and safety.

(c) Encourage the cooperation of member states in regulating multistate physical therapy practice.

(d) Support spouses of relocating military members.

(e) Enhance the exchange of licensure, investigative, and disciplinary information between member states.

(f) Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

ARTICLE II

DEFINITIONS

As used in the compact, and except as otherwise provided, the term:

(1) “Active duty military” means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapter 1209 or chapter 1211.

(2) “Adverse action” means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

(3) “Alternative program” means a nondisciplinary monitoring or practice remediation process approved by a state’s physical therapy licensing board. The term includes, but is not limited to, programs that address substance abuse issues.

(4) “Compact privilege” means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or physical therapist assistant in the remote state under its laws and rules.

(5) “Continuing competence” means a requirement, as a condition of license renewal, to provide evidence of participation in, and completion of, educational and professional activities relevant to the practice of physical therapy.

(6) “Data system” means the coordinated database and reporting system created by the Physical Therapy Compact Commission for the exchange of information between member states relating to licensees or applicants under the compact, including identifying information, licensure data, investigative information, adverse actions, nonconfidential information related to alternative program participation, any denials of applications for licensure, and other information as specified by commission rule.

(7) “Encumbered license” means a license that a physical therapy licensing board has limited in any way.

(8) “Executive board” means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(9) “Home state” means the member state that is the licensee’s primary state of residence.

(10) “Investigative information” means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

(11) “Jurisprudence requirement” means the assessment of an individual’s knowledge of the laws and rules governing the practice of physical therapy in a specific state.

(12) “Licensee” means an individual who currently holds an authorization from a state to practice as a physical therapist or physical therapist assistant.

(13) “Member state” means a state that has enacted the compact.

(14) “Physical therapist” means an individual licensed by a state to practice physical therapy.

(15) “Physical therapist assistant” means an individual licensed by a state to assist a physical therapist in specified areas of physical therapy.

(16) “Physical therapy” or “the practice of physical therapy” means the care and services provided by or under the direction and supervision of a licensed physical therapist.

(17) “Physical Therapy Compact Commission” or “commission” means the national administrative body whose membership consists of all states that have enacted the compact.

(18) “Physical therapy licensing board” means the agency of a state which is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

(19) “Remote state” means a member state other than the home state where a licensee is exercising or seeking to exercise the compact privilege.

(20) “Rule” means a regulation, principle, or directive adopted by the commission which has the force of law.

(21) “State” means any state, commonwealth, district, or territory of the United States of America which regulates the practice of physical therapy.

ARTICLE III

STATE PARTICIPATION IN THE COMPACT

(1) To participate in the compact, a state must do all of the following:

(a) Participate fully in the commission’s data system, including using the commission’s unique identifier, as defined by commission rule.

(b) Have a mechanism in place for receiving and investigating complaints about licensees.

(c) Notify the commission, in accordance with the terms of the compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

(d) Fully implement a criminal background check requirement, within a timeframe established by commission rule, which uses results from the Federal Bureau of Investigation record search on criminal background checks to make licensure decisions in accordance with subsection (2).

(e) Comply with the commission's rules.

(f) Use a recognized national examination as a requirement for licensure pursuant to the commission's rules.

(g) Have continuing competence requirements as a condition for license renewal.

(2) Upon adoption of the compact, a member state has the authority to obtain biometric-based information from each licensee applying for a compact privilege and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. s. 534 and 34 U.S.C. s. 40316.

(3) A member state must grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise the compact privilege under the compact, a licensee must satisfy all of the following conditions:

(a) Hold a license in the home state.

(b) Not have an encumbrance on any state license.

(c) Be eligible for a compact privilege in all member states in accordance with subsections (4), (7), and (8).

(d) Not have had an adverse action against any license or compact privilege within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the compact privilege within a remote state.

(f) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a compact privilege.

(g) Report to the commission adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) The compact privilege is valid until the expiration date of the home license. The licensee must continue to meet the requirements of subsection (1) to maintain the compact privilege in a remote state.

(3) A licensee providing physical therapy in a remote state under the compact privilege must comply with the laws and rules of the remote state.

(4) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any member state until the specific period of time for removal has ended and all fines are paid.

(5) If a home state license is encumbered, the licensee loses the compact privilege in any remote state until the following conditions are met:

(a) The home state license is no longer encumbered.

(b) Two years have elapsed from the date of the adverse action.

(6) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in any remote state.

(7) If a licensee's compact privilege in any remote state is removed, the licensee loses the compact privilege in all remote states until all of the following conditions are met:

(a) The specific period of time for which the compact privilege was removed has ended.

(b) All fines have been paid.

(c) Two years have elapsed from the date of the adverse action.

(8) Once the requirements of subsection (7) have been met, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in a remote state.

ARTICLE V

ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may choose any of the following locations to designate his or her home state:

- (1) Home of record.
- (2) Permanent change of station location.
- (3) State of current residence, if it is different from the home of record or permanent change of station location.

ARTICLE VI

ADVERSE ACTIONS

(1) A home state has exclusive power to impose adverse action against a license issued by the home state.

(2) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(3) The compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

(4) A member state may investigate actual or alleged violations of the laws and rules for the practice of physical therapy committed in any other member state by a physical therapist or physical therapist assistant practicing under the compact who holds a license or compact privilege in such other member state.

(5) A remote state may do any of the following:

(a) Take adverse actions as set forth in subsection (4) of article IV against a licensee's compact privilege in the state.

(b) Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a member state for the attendance and testimony of witnesses or for the production of evidence from another member state must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage,

and other fees required by the service laws of the state where the witnesses or evidence is located.

(c) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

(6)(a) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

ARTICLE VII

ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION

(1) COMMISSION CREATED.—The member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

(a) The commission is an instrumentality of the member states.

(b) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) The compact may not be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP, VOTING, AND MEETINGS.—

(a) Each member state has and is limited to one delegate selected by that member state's physical therapy licensing board to serve on the commission. The delegate must be a current member of the physical therapy licensing board who is a physical therapist, a physical therapist assistant, a public member, or the board administrator.

(b) A delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring on the commission must be filled by the physical therapy licensing board of the member state for which the vacancy exists.

(c) Each delegate is entitled to one vote with regard to the adoption of rules and bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(d) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(e) The commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in Article IX.

(g) The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission must discuss any of the following:

1. Noncompliance of a member state with its obligations under the compact.

2. The employment, compensation, or discipline of, or other matters, practices, or procedures related to, specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation against the commission, executive board, or other committees of the commission.

4. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.

5. An accusation of any person of a crime or a formal censure of any person.

6. Information disclosing trade secrets or commercial or financial information that is privileged or confidential.

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.

8. Investigatory records compiled for law enforcement purposes.

9. Information related to any investigative reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact.

10. Matters specifically exempted from disclosure by federal or member state statute.

(h) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(i) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of a closed meeting must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(3) DUTIES.—The commission shall do all of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(4) POWERS.—The commission may do any of the following:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are binding in all member states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(e) Hire employees and elect or appoint officers; fix the compensation of, define the duties of, and grant appropriate authority to such individuals to carry out the purposes of the compact; and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(f) Accept any appropriate donations and grants of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed,

provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(i) Establish a budget and make expenditures.

(j) Borrow money.

(k) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in the compact and the bylaws.

(l) Provide information to, receive information from, and cooperate with law enforcement agencies.

(m) Establish and elect an executive board.

(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(5) THE EXECUTIVE BOARD.—

(a) The executive board may act on behalf of the commission according to the terms of the compact.

(b) The executive board shall be composed of the following nine members:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. One ex officio, nonvoting member from the recognized national physical therapy professional association.

3. One ex officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(c) The ex officio members shall be selected by their respective organizations.

(d) The commission may remove any member of the executive board as provided in its bylaws.

(e) The executive board shall meet at least annually.

(f) The executive board shall do all of the following:

1. Recommend to the entire commission changes to the rules or bylaws, compact legislation, fees paid by compact member states, such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractually or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Perform other duties as provided in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must total to an amount sufficient to cover the commission's annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the commission, which shall adopt a rule binding upon all member states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet such obligations; nor may the commission pledge the credit of any of the member states, except by and with the authority of the member state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, whether personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, this paragraph may not be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection may not be construed to prohibit any member, officer, executive director, employee, or representative of the commission from retaining his or her own counsel or to require the commission to defend such person if the actual or alleged act, error, or omission resulted from that person's intentional, willful, or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, which data set must include all of the following:

- (a) Identifying information.
 - (b) Licensure data.
 - (c) Investigative information.
 - (d) Adverse actions against a license or compact privilege.
 - (e) Nonconfidential information related to alternative program participation.
 - (f) Any denial of application for licensure and the reason for such denial.
 - (g) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.
- (3) Investigative information in the system pertaining to a licensee in any member state must be available only to other member states.
- (4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license in a member state. Adverse action information pertaining to a licensee in any member state must be available to all other member states.
- (5) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.
- (6) Any information submitted to the data system which is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE IX

RULEMAKING

- (1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.
- (2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.
- (3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule by the commission, and at least 30 days before the meeting at which the rule will be considered and voted upon, the commission must file a notice of proposed rulemaking on all of the following:

(a) The website of the commission or another publicly accessible platform.

(b) The website of each member state physical therapy licensing board or another publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed date, time, and location of the meeting in which the rule or amendment will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule or amendment from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before adoption of a proposed rule or amendment, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(7) The commission must grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is requested by any of the following:

(a) At least 25 persons.

(b) A state or federal governmental subdivision or agency.

(c) An association having at least 25 members.

(8) If a scheduled public hearing is held on the proposed rule or amendment, the commission must publish the date, time, and location of the hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must notify the executive director of the commission or another designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This article may not be construed to require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(10) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public hearing.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article are retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

(a) Meet an imminent threat to public health, safety, or welfare.

(b) Prevent a loss of commission or member state funds.

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule.

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of the commission. The revision is subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing and delivered to the chair of the commission before the end of the notice period. If a challenge is not made, the revision takes

effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE X

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(1) OVERSIGHT.—

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to carry out the compact's purposes and intent. The provisions of the compact and the rules adopted pursuant thereto shall have standing as statutory law.

(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities, or actions of the commission.

(c) The commission is entitled to receive service of process in any such proceeding and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission renders a judgment or an order void as to the commission, the compact, or the adopted rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or the adopted rules, the commission must do all of the following:

1. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and any other action to be taken by the commission.

2. Provide remedial training and specific technical assistance regarding the default.

(b) If a state in default fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges, and benefits conferred by the compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(c) Termination of membership in the compact may be imposed only after all other means of securing compliance have been exhausted. The commission shall give notice of intent to suspend or terminate a defaulting member

state to the governor and majority and minority leaders of the defaulting state's legislature and to each of the member states.

(d) A state that has been terminated from the compact is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(e) The commission does not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(f) The defaulting state may appeal the action of the commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a member state, the commission must attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact and the commission's rules.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies under this article are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XI

DATE OF IMPLEMENTATION OF THE
PHYSICAL THERAPY COMPACT

AND ASSOCIATED RULES; WITHDRAWAL;
AND AMENDMENTS

(1) The compact becomes effective on the date that the compact statute is enacted into law in the tenth member state. The provisions that become effective at that time are limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary for the implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date that the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) Any member state may withdraw from the compact by enacting a statute repealing the same.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act before the effective date of withdrawal.

(4) The compact may not be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the provisions of the compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding upon any member state until it is enacted into the laws of all member states.

ARTICLE XII

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to carry out the purposes thereof. The provisions of the compact are severable, and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If the compact is held contrary to the constitution of any member state, the compact remains in full force and effect as to the remaining member states

and in full force and effect as to the member state affected as to all severable matters.

Section 61. Subsection (10) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.—Disciplinary proceedings for each board shall be within the jurisdiction of the department.

(10)(a) The complaint and all information obtained pursuant to the investigation by the department are confidential and exempt from s. 119.07(1) until 10 days after probable cause has been found to exist by the probable cause panel or by the department, or until the regulated professional or subject of the investigation waives his or her privilege of confidentiality, whichever occurs first.

(b) The department shall report any significant investigation information relating to a nurse holding a multistate license to the coordinated licensure information system pursuant to s. 464.0095; any investigative information relating to an audiologist or a speech-language pathologist holding a compact privilege under the Audiology and Speech-Language Pathology Interstate Compact to the data system pursuant to s. 468.1335; any investigative information relating to a physical therapist or physical therapist assistant holding a compact privilege under the Physical Therapy Licensure Compact to the data system pursuant to s. 486.112; any significant investigatory information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075; and any significant investigatory information relating to a health care practitioner practicing under the Professional Counselors Licensure Compact to the data system pursuant to s. 491.017, ~~and any significant investigatory information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075.~~

(c) Upon completion of the investigation and a recommendation by the department to find probable cause, and pursuant to a written request by the subject or the subject's attorney, the department shall provide the subject an opportunity to inspect the investigative file or, at the subject's expense, forward to the subject a copy of the investigative file. Notwithstanding s. 456.057, the subject may inspect or receive a copy of any expert witness report or patient record connected with the investigation if the subject agrees in writing to maintain the confidentiality of any information received under this subsection until 10 days after probable cause is found and to maintain the confidentiality of patient records pursuant to s. 456.057. The subject may file a written response to the information contained in the investigative file. Such response must be filed within 20 days of mailing by the department, unless an extension of time has been granted by the department.

(d) This subsection does not prohibit the department from providing the complaint and any information obtained pursuant to the department's investigation ~~such information~~ to any law enforcement agency or to any other regulatory agency.

Section 62. Subsection (5) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

(5) A consultant shall enter into a participant contract with an impaired practitioner and shall establish the terms of monitoring and shall include the terms in a participant contract. In establishing the terms of monitoring, the consultant may consider the recommendations of one or more approved evaluators, treatment programs, or treatment providers. A consultant may modify the terms of monitoring if the consultant concludes, through the course of monitoring, that extended, additional, or amended terms of monitoring are required for the protection of the health, safety, and welfare of the public. If the impaired practitioner is an audiologist or a speech-language pathologist practicing under the Audiology and Speech-Language Pathology Interstate Compact pursuant to s. 468.1335, a physical therapist or physical therapist assistant practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, a psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075, or a health care practitioner practicing under the Professional Counselors Licensure Compact pursuant to s. 491.017, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact unless authorized by a member state. ~~If the impaired practitioner is a psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact.~~

Section 63. Subsection (5) is added to section 486.023, Florida Statutes, to read:

486.023 Board of Physical Therapy Practice.—

(5) The board shall appoint an individual to serve as the state's delegate on the Physical Therapy Compact Commission, as required under s. 486.112.

Section 64. Section 486.028, Florida Statutes, is amended to read:

486.028 License to practice physical therapy required.—~~A~~ ~~No~~ person may not ~~shall~~ practice, or hold herself or himself out as being able to practice, physical therapy in this state unless she or he is licensed under ~~in~~ ~~accordance with the provisions of this chapter or holds a compact privilege in this state under the Physical Therapy Licensure Compact as specified in s. 486.112.;~~ however, ~~Nothing in This chapter does not~~ shall prohibit any

person licensed in this state under any other law from engaging in the practice for which she or he is licensed.

Section 65. Section 486.031, Florida Statutes, is amended to read:

486.031 Physical therapist; licensing requirements; exemption.—

(1) To be eligible for licensing as a physical therapist, an applicant must:

(a)(1) Be at least 18 years old;

(b)(2) Be of good moral character; and

(c)1.(3)(a) Have ~~been~~ graduated from a school of physical therapy which has been approved for the educational preparation of physical therapists by the appropriate accrediting agency recognized by the Council for Higher Education Accreditation or its successor Commission on Recognition of Postsecondary Accreditation or the United States Department of Education at the time of her or his graduation and have passed, to the satisfaction of the board, the American Registry Examination ~~before prior to~~ 1971 or a national examination approved by the board to determine her or his fitness for practice as a physical therapist under this chapter as hereinafter provided;

2.(b) Have received a diploma from a program in physical therapy in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapists in this country, as recognized by the appropriate agency as identified by the board, and have passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist under this chapter as hereinafter provided; or

3.(e) Be entitled to licensure without examination as provided in s. 486.081.

(2) A person licensed as a physical therapist in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 66. Section 486.081, Florida Statutes, is amended to read:

486.081 Physical therapist; issuance of license without examination to person passing examination of another authorized examining board; fee; exemption.—

(1) The board may grant cause a license without examination, to be issued ~~by through~~ the department, ~~without examination~~ to any applicant who presents evidence satisfactory to the board of having passed the American Registry Examination ~~before prior to~~ 1971 or an examination in physical therapy before a similar lawfully authorized examining board of another state, the District of Columbia, a territory, or a foreign country, if

the standards for licensure in physical therapy in such other state, district, territory, or foreign country are determined by the board to be as high as those of this state, as established by rules adopted under pursuant to this chapter. Any person who holds a license pursuant to this section may use the words “physical therapist” or “physiotherapist” or the letters “P.T.” in connection with her or his name or place of business to denote her or his licensure hereunder. A person who holds a license pursuant to this section and obtains a doctoral degree in physical therapy may use the letters “D.P.T.” and “P.T.” A physical therapist who holds a degree of Doctor of Physical Therapy may not use the title “doctor” without also clearly informing the public of his or her profession as a physical therapist.

(2) At the time of filing an ~~making~~ application for licensure without examination under ~~pursuant to the terms of~~ this section, the applicant shall pay to the department a nonrefundable fee not to exceed \$175, as determined fixed by the board, ~~no part of which will be returned.~~

(3) A person licensed as a physical therapist in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 67. Section 486.102, Florida Statutes, is amended to read:

486.102 Physical therapist assistant; licensing requirements; exemption.—

(1) To be eligible for licensing by the board as a physical therapist assistant, an applicant must:

(a)(1) Be at least 18 years old;

(b)(2) Be of good moral character; and

(c)1.(3)(a) Have been graduated from a school providing ~~giving~~ a course of at least ~~not less than~~ 2 years for physical therapist assistants, which has been approved for the educational preparation of physical therapist assistants by the appropriate accrediting agency recognized by the Council for Higher Education Accreditation or its successor Commission on Recognition of Postsecondary Accreditation or the United States Department of Education, at the time of her or his graduation and have passed to the satisfaction of the board an examination to determine her or his fitness for practice as a physical therapist assistant under this chapter ~~as herein-after provided;~~

2.(b) Have been graduated from a school providing ~~giving~~ a course for physical therapist assistants in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapist assistants in this country, as recognized by the appropriate agency as identified by the board, and passed to the satisfaction of the board an examination to determine her or his fitness for

practice as a physical therapist assistant under this chapter as hereinafter provided;

3.(e) Be entitled to licensure without examination as provided in s. 486.107; or

4.(d) Have been enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in this state which was accredited at the time of enrollment; and

a.1. Have ~~been~~ graduated or be eligible to graduate from such school no later than July 1, 2018; and

b.2. Have passed to the satisfaction of the board an examination to determine his or her fitness for practice as a physical therapist assistant as provided in s. 486.104.

(2) A person licensed as a physical therapist assistant in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 68. Section 486.107, Florida Statutes, is amended to read:

486.107 Physical therapist assistant; issuance of license without examination to person licensed in another jurisdiction; fee; exemption.—

(1) The board may grant ~~cause~~ a license without examination, to be issued ~~by through~~ the department, ~~without examination~~ to any applicant who presents evidence to the board, under oath, of licensure in another state, the District of Columbia, or a territory, if the standards for registering as a physical therapist assistant or licensing of a physical therapist assistant, as applicable the case may be, in such other state are determined by the board to be as high as those of this state, as established by rules adopted under pursuant to this chapter. Any person who holds a license pursuant to this section may use the words “physical therapist assistant,” or the letters “P.T.A.,” in connection with her or his name to denote licensure hereunder.

(2) At the time of filing an making application for licensing without examination under pursuant to the terms of this section, the applicant shall pay to the department a nonrefundable fee not to exceed \$175, as determined fixed by the board, ~~no part of which will be returned~~.

(3) A person licensed as a physical therapist assistant in another state who is practicing under the Physical Therapy Licensure Compact pursuant to s. 486.112, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 69. Section 486.125, Florida Statutes, is amended to read:

486.125 Refusal, revocation, or suspension of license; administrative fines and other disciplinary measures.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2) or s. 486.112:

(a) Being unable to practice physical therapy with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition.

1. In enforcing this paragraph, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the licensee is unable to practice physical therapy due to the reasons stated in this paragraph, the department shall have the authority to compel a physical therapist or physical therapist assistant to submit to a mental or physical examination by a physician designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or serves as a physical therapy practitioner. The licensee against whom the petition is filed may ~~shall~~ not be named or identified by initials in any public court records or documents, and the proceedings must ~~shall~~ be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011.

2. A physical therapist or physical therapist assistant whose license is suspended or revoked pursuant to this subsection shall, at reasonable intervals, be given an opportunity to demonstrate that she or he can resume the competent practice of physical therapy with reasonable skill and safety to patients.

3. Neither the record of proceeding nor the orders entered by the board in any proceeding under this subsection may be used against a physical therapist or physical therapist assistant in any other proceeding.

(b) Having committed fraud in the practice of physical therapy or deceit in obtaining a license as a physical therapist or as a physical therapist assistant.

(c) Being convicted or found guilty regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of physical therapy or to the ability to practice physical therapy. The entry of any plea of nolo contendere is ~~shall~~ be considered a conviction for purpose of this chapter.

(d) Having treated or undertaken to treat human ailments by means other than by physical therapy, as defined in this chapter.

(e) Failing to maintain acceptable standards of physical therapy practice as set forth by the board in rules adopted pursuant to this chapter.

(f) Engaging directly or indirectly in the dividing, transferring, assigning, rebating, or refunding of fees received for professional services, or having been found to profit by means of a credit or other valuable consideration, such as an unearned commission, discount, or gratuity, with any person referring a patient or with any relative or business associate of the referring person. ~~Nothing in This chapter may not~~ shall be construed to prohibit the members of any regularly and properly organized business entity which is comprised of physical therapists and which is recognized under the laws of this state from making any division of their total fees among themselves as they determine necessary.

(g) Having a license revoked or suspended; having had other disciplinary action taken against her or him; or having had her or his application for a license refused, revoked, or suspended by the licensing authority of another state, territory, or country.

(h) Violating a lawful order of the board or department previously entered in a disciplinary hearing.

(i) Making or filing a report or record which the licensee knows to be false. Such reports or records shall include only those which are signed in the capacity of a physical therapist.

(j) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the licensee knows or has reason to know that she or he is not competent to perform, including, but not limited to, specific spinal manipulation.

(k) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) ~~of this section~~ or who is found guilty of violating any provision of s. 456.072(1).

(b) The board may take adverse action against a physical therapist's or a physical therapist assistant's compact privilege under the Physical Therapy Licensure Compact pursuant to s. 486.112 and may impose any of the penalties in s. 456.072(2), if a physical therapist or physical therapist assistant commits an act specified in subsection (1) or s. 456.072(1).

(3) The board ~~may~~ shall not reinstate the license of a physical therapist or physical therapist assistant or ~~approve~~ cause a license to be issued to a person it has deemed unqualified until such time as it is satisfied that she or he has complied with all the terms and conditions set forth in the final order and that such person is capable of safely engaging in the practice of physical therapy.

Section 70. Paragraph (j) is added to subsection (10) of section 768.28, Florida Statutes, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(10)

(j) For purposes of this section, the individual appointed under s. 486.023(5) as the state's delegate on the Physical Therapy Compact Commission, when serving in that capacity pursuant to s. 486.112, and any administrator, officer, executive director, employee, or representative of the Physical Therapy Compact Commission, when acting within the scope of his or her employment, duties, or responsibilities in this state, is considered an agent of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

Section 71. Section 486.025, Florida Statutes, is amended to read:

486.025 Powers and duties of the Board of Physical Therapy Practice. The board may administer oaths, summon witnesses, take testimony in all matters relating to its duties under this chapter, establish or modify minimum standards of practice of physical therapy as defined in s. 486.021, including, but not limited to, standards of practice for the performance of dry needling by physical therapists, and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this chapter. The board may also review the standing and reputability of any school or college offering courses in physical therapy and whether the courses of such school or college in physical therapy meet the standards established by the appropriate accrediting agency referred to in s. 486.031(1)(c) ~~s. 486.031(3)(a)~~. In determining the standing and reputability of any such school and whether the school and courses meet such standards, the board may investigate and personally inspect the school and courses.

Section 72. Paragraph (b) of subsection (1) of section 486.0715, Florida Statutes, is amended to read:

486.0715 Physical therapist; issuance of temporary permit.—

(1) The board shall issue a temporary physical therapist permit to an applicant who meets the following requirements:

(b) Is a graduate of an approved United States physical therapy educational program and meets all the eligibility requirements for licensure under ch. 456, s. 486.031(1)(a), (b), and (c)1. ~~s. 486.031(1)-(3)(a)~~, and related rules, except passage of a national examination approved by the board is not required.

Section 73. Paragraph (b) of subsection (1) of section 486.1065, Florida Statutes, is amended to read:

486.1065 Physical therapist assistant; issuance of temporary permit.—

(1) The board shall issue a temporary physical therapist assistant permit to an applicant who meets the following requirements:

(b) Is a graduate of an approved United States physical therapy assistant educational program and meets all the eligibility requirements for licensure under ch. 456, s. ~~486.102(1)(a), (b), and (c)~~^{1. s. 486.102(1)-(3)(a)}, and related rules, except passage of a national examination approved by the board is not required.

Section 74. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$30 million in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids – Health Care Education Reimbursement and Loan Repayment Program category to the Department of Health for the Florida Reimbursement Assistance for Medical Education Program established in s. 381.402, Florida Statutes.

Section 75. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$8 million in recurring funds from the General Revenue Fund is appropriated in the Dental Student Loan Repayment Program category to the Department of Health for the Dental Student Loan Repayment Program established in s. 381.4019, Florida Statutes.

Section 76. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$23,357,876 in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids – Minority Health Initiatives category to the Department of Health to expand statewide the telehealth minority maternity care program established in s. 383.2163, Florida Statutes. The department shall establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe maternal morbidity and maternal mortality. The department shall identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the region, the neonatal intensive care unit levels of hospitals within the region, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.

Section 77. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$25 million in recurring funds from the General Revenue Fund is appropriated to the Agency for Health Care Administration to implement the Training, Education, and Clinicals in Health (TEACH) Funding Program established in s. 409.91256, Florida Statutes, as created by this act.

Section 78. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$2 million in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school articulated health care programs

required by s. 1002.32, Florida Statutes. Each of these state universities shall receive \$500,000 from this appropriation.

Section 79. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$5 million in recurring funds from the General Revenue Fund is appropriated in the Aid to Local Governments Grants and Aids – Nursing Education category to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund established in s. 1009.8962, Florida Statutes.

Section 80. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$21,315,000 in recurring funds from the General Revenue Fund and \$28,685,000 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration for the Slots for Doctors Program established in s. 409.909, Florida Statutes.

Section 81. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$42,630,000 in recurring funds from the Grants and Donations Trust Fund and \$57,370,000 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration to provide to statutory teaching hospitals as defined in s. 408.07(46), Florida Statutes, which provide highly specialized tertiary care, including comprehensive stroke and Level 2 adult cardiovascular services; NICU II and III; and adult open heart; and which have more than 30 full-time equivalent (FTE) residents over the Medicare cap in accordance with the CMS-2552 provider 2021 fiscal year-end federal Centers for Medicare and Medicaid Services Healthcare Cost Report, HCRIS data extract on December 1, 2022, worksheet E-4, line 6 minus worksheet E-4, line 5, shall be designated as a High Tertiary Statutory Teaching Hospital and be eligible for funding calculated on a per Graduate Medical Education resident-FTE proportional allocation that shall be in addition to any other Graduate Medical Education funding. Of these funds, \$44,562,400 shall be first distributed to hospitals with greater than 500 unweighted fiscal year 2022-2023 FTEs. The remaining funds shall be distributed proportionally based on the total unweighted fiscal year 2022-2023 FTEs. Payments to providers under this section are contingent upon the nonfederal share being provided through intergovernmental transfers in the Grants and Donations Trust Fund. In the event the funds are not available in the Grants and Donations Trust Fund, the State of Florida is not obligated to make payments under this section.

Section 82. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$57,402,343 in recurring funds from the General Revenue Fund and \$77,250,115 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology. The fiscal year 2024-2025 General Appropriations Act shall establish the DRG

reimbursement methodology for hospital inpatient services as directed in s. 409.905(5)(c), Florida Statutes.

Section 83. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of \$14,888,903 in recurring funds from the General Revenue Fund and \$20,036,979 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for dental care services. The funding shall be held in reserve. The agency shall develop a plan to increase Medicaid reimbursement rates for preventive dental care services by September 1, 2024. The agency may submit a budget amendment pursuant to chapter 216, Florida Statutes, requesting release of the funding. The budget amendment must include the final plan to increase Medicaid reimbursement rates for preventive dental care services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 84. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$83,456,275 in recurring funds from the General Revenue Fund and \$112,312,609 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community-Based Services Waiver category to the Agency for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase.

Section 85. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$11,525,152 in recurring funds from the General Revenue Fund is appropriated in the Grants and Aids – Community Mental Health Services category to the Department of Children and Families to enhance crisis diversion through mobile response teams established under s. 394.495, Florida Statutes, by expanding existing or establishing new mobile response teams to increase access, reduce response times, and ensure coverage in every county.

Section 86. Effective July 1, 2024, for the 2024-2025 fiscal year, the sum of \$10 million in recurring funds from the General Revenue Fund is appropriated to the Department of Health to implement the Health Care Screening and Services Grant Program established in s. 381.9855, Florida Statutes, as created by this act.

Section 87. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$150,000 in nonrecurring funds from the General Revenue Fund and \$150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers. The agency shall submit the reimbursement methodology and estimated fiscal impact to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Appropriations Committee, and the chair of the House Appropriations Committee no later than December 31, 2024.

Section 88. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of \$12,365,771 in recurring funds from the General Revenue Fund, \$127,300 in recurring funds from the Refugee Assistance Trust Fund, and \$16,514,132 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 89. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of \$14,580,660 in recurring funds from the General Revenue Fund and \$19,622,154 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 90. Effective October 1, 2024, for the 2024-2025 fiscal year, the sums of \$5,522,795 in recurring funds from the General Revenue Fund and \$7,432,390 in recurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

Section 91. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$585,758 in recurring funds and \$1,673,421 in nonrecurring funds from the General Revenue Fund, \$928,001 in recurring funds and \$54,513 in nonrecurring funds from the Health Care Trust Fund, \$100,000 in nonrecurring funds from the Administrative Trust Fund, and \$585,758 in recurring funds and \$1,573,421 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the Agency for Health Care Administration, and 20 full-time equivalent positions with the associated salary rate of 1,247,140 are authorized for the purpose of implementing this act.

Section 92. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$2,389,146 in recurring funds and \$1,190,611 in nonrecurring funds from the General Revenue Fund and \$1,041,578 in recurring funds and \$287,633 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health, and 25 full-time equivalent positions with the associated salary rate of 1,739,740, are authorized for the purpose of implementing this act.

Section 93. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

Approved by the Governor March 21, 2024.

Filed in Office Secretary of State March 21, 2024.