The Nurse Practitioner Association
New York State

Practice Resource Guide
Introduction

To assist you with your practice questions, this guide has been developed by The Nurse Practitioner Association New York State (The NPA) as a resource for our members. It is intended as a compendium of useful information for you to use as a general reference.

Practice assistance is a member supported service provided by The NPA to our members. We would encourage all NPs to join this association, not only to receive individual benefits such as practice assistance, but to support and protect their practice.

Disclaimer

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Nurse Practitioner Modernization Act

Nurse Practitioner Modernization Act (NPMA)

The Nurse Practitioner Modernization Act (NPMA) was passed as part of the 2014-15 Education, Labor & Family Assistance (Article VII) New York Budget on April 1, 2014. The new law is a result of enormous efforts of the Governor, the Senate and the Assembly, as well as The NPA leadership and volunteers.

This new law removes the requirement of a written practice agreement for an experienced nurse practitioner as a condition of practice. Consistent with NP practice, and federal requirements for Medicare reimbursement, the law recognizes the collaboration that exists among health care professionals. Thus, it is important to understand the details of the new law.

Highlights of the New Law

Newly licensed Nurse Practitioners with 3,600 or less hours of practice continue to be subject to current requirements, including:

- Maintaining a Written Practice Agreement (WPA) signed by the NP and physician
- Identifying practice protocols approved by the State Education Department
- Chart reviews

For Nurse Practitioners with greater than 3600 hours of practice (approximately 2 years full-time), regardless of the NP's specialty (i.e. Acute, Adult, Family, Mental Health, etc...):

- No signed written practice agreement is required
- No practice protocols need to be identified
- NP shall maintain collaborative relationships

Collaborative relationships

Are consistent with Medicare’s billing requirement about NPs and collaboration

In New York, this means:

When the NP communicates, by phone, in person, in writing or electronically with a physician qualified to collaborate in the specialty involved or in the case of a licensed health care facility, communicates with a physician qualified to collaborate in specialty involved who has privileges at such health care facility for the purpose of exchanging information in order to provide comprehensive care or to make referrals, as necessary.
SED Attestation Form

An attestation form will be maintained in the NP's files, and is NOT filed with SED. The NP attests that they hold one or more collaborative relationships (Law does not require identifying physician names/license numbers and no signatures are required. See copy of Nurse Practitioner form NP-CR, Collaborative Relationships Attestation Form in Appendix F.

- Will include a dispute resolution process
- Dispute resolution process is established by NP and physician, but, if conflict, physician prevails (similar to prior law). The NP always has the option of consulting with another physician.

NPs maintain evidence of such collaborative relationships

- For example, throughout the course of a patient encounter, should the NP need to consult with a physician, the NP may document the discussion in the patient record. This is one form of evidence of a collaborative relationship.
- This type of record keeping is not required for all encounters, only necessary for purposes of showing compliance with requirement of "collaborative relationships," as needed.

NP to produce attestation form/collaborative relationship evidence upon SED's request

- Failure to do so is considered professional misconduct
- This is consistent with midwives' statute

There will be Data Collection and a Report on the NP Profession

- The State Education Department (SED) to collect data about profession and availability of NPs as part of triennial certification process
- Similar to physician data collection
- De-identified information posted to website
- SED to issue the report to the Legislature by September 1, 2018

NPMA Effective Date: January 1, 2015

Sunset

- NPMA will expire on June 30, 2021. This provides an opportunity to revisit, and determine further expansions.
- This is NOT a demonstration project.
- The NPA will continue to work with all stakeholders throughout the time period to recommend enhancements as needed.
Definition
(Taken from Title VIII, Article 139 of New York State Education Law)

The practice of the profession of nursing as a Registered Professional Nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist, or other licensed health care provider legally authorized under this Title and in accordance with the Commissioner’s regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen. (Section 6902 (1)).

The practice of registered professional nursing by a Nurse Practitioner, certified under section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols. The written practice agreement shall include explicit provisions for the resolution of any disagreement between the collaborating physician and the nurse practitioner regarding a matter of diagnosis or treatment that is within the scope of practice of both. To the extent the practice agreement does not so provide, then the collaborating physician’s diagnosis or treatment shall prevail. (Section 6902 (3) a)

Prescriptions for drugs, devices, and immunizing agents may be issued by a nurse practitioner, under this subdivision and section six thousand nine hundred ten of this article, in accordance with the practice agreement and practice protocols. The nurse practitioner shall obtain a certificate from the department upon successfully completing a program including an appropriate pharmacology component, or its equivalent, as established by the commissioner’s regulations, prior to prescribing under this subdivision. The certificate issued under section six thousand nine hundred ten of this article shall state whether the nurse practitioner has successfully completed such a program or equivalent and is authorized to prescribe under this subdivision. (Section 6902 (3) b)

Each Practice Agreement shall provide for patient records review by the collaborating physician in a timely fashion but in no event less often than every three months. The names of the Nurse Practitioner and the collaborating physician shall be clearly posted in the practice setting of the Nurse Practitioner. (Section 6902 (c))

The Practice Protocol text shall be selected from the list of protocol texts approved by the New York State Education Department. The practice protocol shall reflect current accepted medical and nursing practice. The protocols shall be filed with the department within ninety days of the commencement of the practice and may be updated
periodically. The commissioner shall make regulations establishing the procedure for the review of protocols and the disposition of any issues arising from such review. (Section 6902 (3) d)

“No Physician shall enter into practice with more than four Nurse Practitioners who are not located on the same physical premises as the collaborating physician.” (Section 6902. (3) e)

Nothing in this subdivision shall be deemed to limit or diminish the practice of the profession of nursing as a registered professional nurse under this article or any other law, rule, regulation, or certification, nor to deny any registered professional nurse the right to do any act or engage in any practice authorized by this article or any other law, rule, regulation, or certification. (Section 6902 (3) f)

The provisions of this subdivision shall not apply to any activity authorized, pursuant to statute, rule, or regulation, to be performed by a registered professional nurse in a hospital as defined in Article twenty-eight of the New York State Public Health Law. (Section 6902 (3) g)

Education

(Taken from Section 64.4 (b) and (e) of the Regulations of the Commissioner of Education of New York State).

To meet the professional education requirements for certification in this State, the applicant shall present evidence of:

(b)(1) (i) Completion of an educational program registered by the department, or a program determined by the department to be equivalent to a registered nurse program, which is designed and conducted to prepare graduates as Nurse Practitioners; or

(ii) Certification as a Nurse Practitioner by a national certifying body acceptable to the department; and

(2) Completion of not less than three semester hours or the equivalent in pharmacology either in an acceptable Nurse Practitioner program or after other educational requirements for certification as Nurse Practitioner have been satisfied. An acceptable course in pharmacology shall be equivalent in scope and content to that required by Section 52.12 of this Title.

(e) Prescriptive Privilege. An applicant who satisfies all requirements for certification as a Nurse Practitioner may be authorized to issue prescriptions pursuant to Section 6902(3) (b) of the Education Law after completing instruction, satisfactory to the department, in New York State
Practice Requirements for Nurse Practitioners

Collaborative Practice

According to New York State Education Law §6902, a nurse practitioner (NP) diagnoses illnesses and physical conditions and performs therapeutic and corrective measures within the specialty area of practice in which the NP is certified. New York certifies NPs to practice in the following specialty areas: Adult Health; Family Health; Gerontology; Neonatology; Obstetrics; Oncology; Pediatrics; Perinatology; Psychiatry; School Health; Women's Health; Holistic; and Palliative Care.

New York State Education Law holds NPs independently responsible for the diagnosis and treatment of their patients and does not require an NP to practice under physician supervision. As described in more detail below, this law requires each NP to practice in accordance with written practice protocols and a written practice agreement with a collaborating physician. However, effective January 1, 2015, an NP with more than 3600 hours of qualifying NP practice experience can opt to:

- Continue to practice pursuant to a written practice protocols and a written practice agreement with a collaborating physician
- Practice and have collaborative relationships with one or more qualified physician(s) or New York State Health Department licensed health care facility (i.e. hospital, nursing home, ambulatory surgery center, or diagnostic and treatment center)

As a new nurse practitioner, in New York State, you are required to have a written collaborative practice agreement with one physician in your area of specialty prior to beginning practice. The collaborating physician must be licensed in New York State and also qualified to practice in the specialty involved. Please consult the 2/1/2012 memorandum (located in Appendix D) of the NYS Education Department outlining what constitutes an acceptable collaborator.

You must maintain that agreement in the practice setting(s) where it will be available for inspection by the State Education Department (SED). A NP may only practice while there is a written collaborative practice agreement in place. This includes performing any act or service as a NP including signing forms and documents as a NP or issuing prescriptions. Should the agreement be terminated by any means or event, the nurse practitioner MUST immediately cease practice. There is no “grace period”.

Quick Reference Tip:

- New nurse practitioners are required to submit Form 4NP Verification of Collaborative Agreement and Practice Protocol only once to SED’s Office of the Professions no later than 90 days after beginning professional practice. Please
Collaborative Relationships (effective 1/1/15)

This section describes a new law, The Nurse Practitioners Modernization Act, which allows certain experienced NPs to practice more autonomously. Effective January 1, 2015 each NP with more than 3,600 hours of qualifying NP practice experience can opt to:

- Practice in accordance with a written practice agreement with a collaborating physician as described below; or,

- Practice and have collaborative relationships with a qualified physician or a New York State health Department licensed health care facility (i.e. hospital, nursing home, ambulatory surgery center, or diagnostic and treatment center), as described in more detail in this section.

The new law defines “collaborative relationships” as when a NP communicates, by phone, in person, in writing, or electronically with a physician qualified to collaborate in the specialty involved or in the case of a licenses health care facility, communicates with a physician qualified to collaborate in specialty involved who has privileges at such health care facility for the purposes of exchanging information in order to provide comprehensive care or to make referrals, as necessary.

The NP may practice and have collaborative relationships, provided that the following criteria below are met:

- The NP must have more than 3,600 hours of experience practicing as a licensed NP pursuant to the laws of New York or another state or practicing as an NP while employed by the United States veteran’s administration, the United States armed forces or the United States public health service.

- The NP must have collaborative relationships with one or more physicians qualified to collaborate in the specialty involved or with a New York State Health Department licensed health care facility (i.e. hospital, nursing home, ambulatory surgery center, or diagnostic and treatment center.) The health care facility must provide services through physicians qualified to collaborate in the specialty involved and who have professional privileges at the health care facility.

- The NP has filled out and signed a “Collaborative Relationships Attestation Form” prepared by the State Education Department (SED) which describes the NP’s current collaborative relationships. (see copy of form in Appendix F)
• The NP must maintain documentation in written or electronic format that supports his or her collaborative relationships. Such may include, but is not limited to the following:
  
  o Documentation of an agreement or an arrangement with a hospital or physician practice, pursuant to which an NP may transfer or refer patients for care;
  
  o Documentation of communication between the NPA and a physician qualified to collaborate in the specialty involved relating to the care of the NP’s patients or referral of the NP’s patients;
  
  o Documentation of an employment relationship between an NP and a physician practice or a hospital, hospice program, licensed home care services agency or licensed mental health care facility with a physician medical director; or,
  
  o Documentation of a contractual relationship with a physician, physician practice or a hospital pursuant to which the NP provides professional services.

• The NP must make the “Collaborative Relationships Attestation Form and documentation in support of collaborative relationships available to SED for inspection.

The New law does not require NPs who practice and have legally authorized collaborative relationships to:

• Sign an agreement with a physician;
• Practice in accordance with a written agreement or written practice protocols;
• Be supervised by a physician; or,
• Have a physician to co-sign or review any of the NP’s orders, prescriptions, or other clinical records.

The new law does not prohibit NPs who practice and have legally authorized collaborative relationships from:

• Practicing pursuant to clinical guidelines, policies or protocols;
• Entering into agreements or other clinical or business arrangements;
• Communicating with purveyors of health care services; or,
• Engaging in any quality assurance or other care related activities.

Newly certified NPs are NOT required to file with the New York State Education Department (SED) Form 4NP- Verification of Collaborative Agreement and Practice Protocol, if the NP opts to practice and have collaborative relationships consistent with the new law.
Written Practice Agreement with a Collaborating Physician

New York State Education Law requires all nurse practitioners (NPs) to practice in accordance with written practice protocols and a written practice agreement with a collaborating physician, unless the NP practices and has collaborative relationships as allowed by law and as described in the Collaborative Relationships below.

New York State Education Law has specific requirements for practicing in accordance with written practice protocols and a written practice agreement with a collaborating physician. This law requires that the NP collaborate with a physician who is qualified to collaborate in the NPs specialty area of practice. The NP must practice in accordance with written practice protocols and a written practice agreement with the collaborating physician.

Written Practice Agreements

In order to practice, an NP with less than 3,600 hours of qualifying NP practice experience must enter into a written collaborative practice agreement with a physician qualified to practice in the NP’s specialty area of practice. Written collaborative practice agreements include provisions addressing:

- Patient referral and consultation.
- Coverage for emergency absences of either the NP or the collaborating physician.
- Resolution of disagreements between the NP and the collaborating physician’s diagnosis or treatment. If the agreement does not address this, the collaborating physician’s diagnosis or treatment shall prevail.
- Peer review by the collaborating physician of patient records in a timely fashion, but no less often than every 3 months. New York Law does not specify the number of charts that must be reviewed by the collaborating physician. That decision is left to the judgement of the NP and collaborating physician, and may vary depending on such factors as: the NP’s experience, the collaborating physician’s knowledge of the NP’s abilities, the population to be served and the practice setting.
- Identification of written practice protocols that the NP will use.
- Additional provisions as agreed to by the NP and the collaborating physician.
Quick Reference Tip:

- A sample written collaborative practice agreement may be obtained from the State Education Department’s website: http://www.op.nysed.gov/prof/nurse/np.htm
  
  A sample collaborative practice agreement is located in Appendix C.

- A copy of the collaborative practice agreement must be kept at the NP’s practice setting(s) and made available for inspection by the New York State Education Department (SED).

Where the written collaborative practice agreement does not specify explicit provisions for dispute resolution between the nurse practitioner and the physician regarding a matter of diagnosis and treatment that is within the scope of practice of both, the collaborating physician’s diagnosis or treatment shall prevail.

As a licensed NP, you are always ultimately responsible for your actions and your patient.

When the physician and NP are both at the same practice site a physician can collaborate with as many NPs as s/he wishes. If the NP is based at a practice site other than that of the collaborating physician’s, the physician is limited to collaborating with NO more than four (4) NPs off site.

You are required to establish a collaborative agreement with one physician prior to beginning practice and maintain that agreement in the practice setting(s) where it will be available for inspection by the State Education Department (SED).

Many NPs work for 2 or more health care providers or at a facility with patients who are being cared for by several different physicians. SED does not necessarily require that the NP to enter into multiple collaborative agreements in such situations. For example:

- If an OB-GYN NP works at an obstetrician’s practice 3 days a week and at Planned Parenthood for 2 days a week, the NP could enter into a collaborative practice agreement with the obstetrician. The collaborative practice agreement could identify a physician (other than the obstetrician) at Planned Parenthood to review the charts of the NP’s Planned Parenthood patients, or, alternatively, the obstetrician could review the NP’s charts at Planned Parenthood. The NP is not required to enter into a second collaborative agreement.

- If an NP works in a nursing home, the medical director may serve as the collaborating physician. In case of a disagreement between the NP and an attending physician, the collaborating physician could mediate the dispute and make the final treatment decision. It is not required that the NP has collaborative agreements with all of the attending physicians.
Form 4NP Verification of Collaborative Agreement and Practice Protocol

A newly certified nurse practitioner is required to file with the New York State Education Department (SED) Form 4NP Verification of Collaborative Agreement and Practice Protocol within 90 days after starting professional practice. The NP is not required to file any additional Form 4NP with SED. A completed Form 4NP is not equivalent to a collaborative practice agreement. Copies of Form 4NP can be downloaded from SED’s website at www.op.nysed.gov/prof/nurse/nurseformsnp.htm.

Note: The Education Law does not require physicians to supervise the NP or to co-sign the NP’s orders or medical records. It does require the collaborating physician to review the NP’s patient records at least every three months.

Financial Arrangements with Collaborating Physicians

A variety of New York and federal laws affect financial relationships between health care practitioners. Some types of financial relationships between nurse practitioners and collaborating physicians are prohibited by the Education Law or professional misconduct regulations (see Education Law §6513, 8 NYCRR §29.1) or other state or federal laws.

New York State Education Law and professional misconduct regulations prohibit a collaborating physician and an NP from engaging in “fee-splitting” or “kick-backs.” These legal prohibitions on “fee-splitting” and “kick-backs” are designed to ensure that medical and nursing decisions are based on sound clinical judgement, uncompromised by economic or business considerations.

A “kick-back” typically occurs when a person gives or receives or agrees to give or receive money or other consideration to or from a third party in exchange for the referral of patient services. For example, if a physician pays a NP $100 each and every time the NP refers a patient to the physician for medical care, then it is very likely that the physician is giving and the NP is receiving “kick-backs.”

“Fee-splitting” can occur is an NP shares his or her practice income or fees with a physician who is not the NP’s employer. “Fee-splitting” also includes arrangements or agreements in which the NP pays the collaborating physician an amount of money that constitutes a percentage of, or is otherwise dependent upon the income or receipts of the NP in exchange for the collaborating physician’s services. For example, if an NP pays 20% of the NP’s professional income to the collaborating physician (who works at a separate medical practice) in exchange for the collaborating physician’s services, the NP and the physician are probably engaging in illegal "fee-splitting."

The Education Laws prohibiting “fee-splitting” or “kick-backs” do not prohibit a NP from paying a collaborating physician the fair market value of the physician’s personal services (i.e. chart review and consultation), unless:
- The payment includes remuneration for the referral of patient services;
- The NP is required to refer patients to the physician; or,
- The payment is based on a percentage of or dependent on the NP’s professional fees or income.

NPs may refer patients to their collaborating physician(s) when medically necessary, provided that the NP receives nothing in exchange for the referral. New York law does not require that a collaboration agreement include a payment provision.

Questions about collaborative relationships, collaborative practice agreements or practice protocols may be referred to the Nursing Board office by emailing nursebd@nysed.gov or by calling 518-474-3817 ext. 120. It is not within the purview of the Nursing Board office to interpret laws governing financial relationships between NPs and collaborating physicians.

Practice Protocols

Nurse practitioners (NPs) are required to practice pursuant to written protocols reflecting the specialty area(s) of practice in which the NP is certified. The protocols must also reflect current, accepted medical and nursing practice. Additional protocols in subspecialty areas (i.e. hematology, orthopedics, dermatology) that are appropriate to the NP’s practice may be used but need be reflected in the collaborative practice agreement.

Quick Reference Tip:
- To obtain a list of approved protocol texts from the State Education Department go to http://www.op.nysed.gov and search for “approved protocol text”.

See Appendix C for approved protocol texts – updated June 2013.

Nurse Practitioner Description

Professional Role

Nurse Practitioners (NPs) are health care providers practicing in settings across the complete spectrum of health care in New York State. To receive a certificate to practice in New York State (NYS), NPs must hold an active license as a Registered Professional Nurse and meet certain educational requirements. Certified by NYS in 16 specialties, NPs provide health care services to patients from infants to geriatrics. As health care providers, NPs diagnose and manage acute, episodic, and chronic health conditions. Their nursing foundation allows nurse practitioners to emphasize health promotion, health education, disease prevention, and patient advocacy. NP services include ordering, conducting, and interpreting diagnostic/laboratory tests. In addition, nurse practitioners are authorized to prescribe medications and non-pharmacologic therapies.
Nurse practitioners are solely responsible for their clinical decisions and collaborate with other health care professionals as needed. NPs do not require the supervision of physicians or other providers rather, NPs work collaboratively with all health disciplines. NPs are involved in health care research and can serve as consultants.

**Accountability**

Being a licensed health care provider in NYS requires accountability for health care outcomes. To provide the highest quality of care, NPs obtain national certification in their specialty, participate in periodic peer review, evaluate clinical outcomes, provide evidence-based interventions, and subscribe to a code of ethical practice. They actively participate in continuing professional development and are responsible for board recertification in their specialty every five years. NPs disseminate and integrate this knowledge into their daily clinical practice.

**Responsibility**

As members of the Nurse Practitioner profession, it is incumbent upon NPs to advance the role of the profession as health care providers. NPs are responsible for keeping the profession current while looking forward. There are many forces that impact the profession and through membership in statewide and national NP associations, NPs work to ensure that the highest professional standards are adhered to. By maintaining the highest standards possible, NPs are leaders in health care as clinicians, educators, preceptors, and administrators.

The scope of NP practice will vary from practice to practice and state to state, depending upon each practice and state’s regulations. The broadest scope of practice is defined in law. Practices cannot expand the scope as defined in law, but an individual practice or institution may choose to limit that scope.

**Professional Conduct**

Every licensed/certified nurse practitioner in New York State must follow rules of professional conduct as set forth in the Education Law. The Education Law also provides definitions of professional misconduct while the Board of Regents rules define unprofessional conduct for all professions. In addition every license holder is governed by the complete set of Laws, Rules and Regulations for the practice of the profession. Should you ever receive notice of an allegation of professional misconduct DO NOT ignore it. It is recommended that you immediately contact your professional liability insurance carrier to determine if coverage exists for license defense and if so how to access that coverage.

**Nurses Service Organization (NSO), The NPA’s endorsed partner offers license defense coverage to its policy holders.** Be sure to consult with your insurer to be absolutely certain of coverage you may have.
In addition, The NPA should consult with an attorney about the notice so that a proper response can be prepared and submitted in a timely fashion. If you do nothing, the Office of Professions will move forward with the complaint without your input or response which can result in an outcome that can usually be to your detriment.

Nurse Practitioners and Malpractice Insurance: Frequently Asked Questions by Nurses Service Organization (NSO)

1. **Who do I contact with questions about professional liability insurance – NSO or NPA?**
   
   **Answer:** NSO has a team of members dedicated to the specialized needs of nurse practitioners in New York. You can reach them at 1-800-521-7013

2. **Does having my own individual professional liability insurance policy make me a more likely target for a lawsuit?**
   
   **Answer:** No, having your own professional liability insurance coverage does not make you a more likely target for a lawsuit. When something happens and a patient is injured, most attorneys will name everyone who was involved in the patient’s care in the lawsuit – whether you have your own coverage or not.

3. **Why do I need an individual professional liability policy? Won’t my employer’s insurance policy cover me?**
   
   **Answer:** Professional liability insurance safeguards you against allegations of malpractice. While your employer may provide coverage for you, it may not be enough to cover you in all cases. Your employer’s policy is designed to preserve the employer’s needs and interests first.

4. **I have an active license, but I am not going to be working for a while. Should I keep my coverage active?**
   
   **Answer:** If you plan on keeping your license active, you have a responsibility to anyone to whom you give advice, any place you volunteer, and any situation that requires emergency care. Your nursing license needs to be insured at all times. One option is to take advantage of our Retirement/Leave Discount, which can include family leave, change to non-nursing occupation, retirement, or disability. This discount offers limited coverage at 50% off of our full-time nursing premium. All you need to do is change your licensure on your policy is send us an email outlining your particular situation. Be sure to include your name and policy number.
5. What is the difference between occurrence and claims-made coverage, do I need “tail” coverage?

**Answer:** An occurrence policy provides coverage for a claim that occurs during the policy period, regardless of when the claim is reported. For example, let’s assume you carried a malpractice policy from December 1, 2012 to November 30, 2013 and it was an occurrence policy. You never renewed the policy. On June 16, 2014 you receive notice that you were named in a malpractice lawsuit for something that happened on February 4, 2013. Because the incident occurred during your coverage period, you would be covered for that claim, even though you received notice of the claim after your policy ended.

A claims-made policy provides coverage for an incident that occurs during an active policy period only if the claim is also filed during an active policy period. For example, let’s assume you had a claims-made policy from December 1, 2012 to November 30, 2013 and you did not renew that policy. On June 16, 2014 you receive notice that you were named in a malpractice lawsuit for something that happened on February 4, 2013. You would not have coverage under your claims-made policy because your coverage was not active when the claim was made.

If you own a claims-made policy, you will need to give some additional thought before you decide to cancel or non-renew your current policy.

If you decide to end a claims-made policy, you can purchase “tail” coverage. Tail coverage will extend the time that a claim can be reported, but the incident will need to occur while the policy was active.

If you are not sure whether your policy through NSO is occurrence or claims-made, please call us with your policy number, and we will confirm your coverage for you.

6. I work for several different employers. Will that affect my coverage or rate?

**Answer:** No, your policy is designed to provide coverage for you anywhere you work within your scope of your license. It is not necessary to record worksites on your policy and there is no additional premium. You are safeguarded 24 hours a day at any location.

7. Are there any discounts that I can apply for with NSO in order to reduce my professional liability insurance rates?

**Answer:** NSO acknowledges that higher premiums are difficult to manage especially in today’s economy but there are ways you can pay less. Consider the following discounts to save you money on your premium:

- Risk management discount of 10% for attaining approved CE credit at NPA’s conference
- New graduate discount of 25%
• Retired discount of 50%

NSO also offers financing for Nurse Practitioner premiums. Please feel free to reach out to NSO to see if you qualify for a discount, or to discuss strategies for reducing or financing your premium. NSO also offers many free risk management resources for NPs, housed on their website, [http://www.nso.com/risk-education/individuals/index](http://www.nso.com/risk-education/individuals/index)

8. How much coverage should I have, are defense costs taken from my policy limits?

**Answer:** These are excellent questions that require some additional insight in order for NSO to provide you with assistance. Please contact NSO's team of members dedicated to the specialized needs of nurse practitioners in New York. You can reach them at 1-800-521-7013.

9. What is the relationship between The Nurse Practitioner Association New York State (The NPA) and Nurses Service Organization (NSO)? Why did the NPA choose Nurses Service Organization (NSO) to provide its members with professional liability insurance?

**Answer:** In our efforts to provide our members with valuable products and services, the NPA has endorsed Nurses Service Organization (NSO) to offer liability insurance for our members. With the constant increase in litigation, it is becoming more and more important to take steps to protect yourself and secure your financial well-being. The NPA has elected to endorse NSO to offer our nurse practitioner professional liability insurance for several reasons. NSO is the leading provider of professional liability insurance for nursing professionals. NSO insures over 675,000 nursing professionals – including more than 24,000 advanced practice nurses. They have a strong reputation in the professional liability insurance industry and their policy offers several features, such as license protection, personal injury protection, defendant expense benefit, and assault coverage. NSO has gained the confidence and support of over 25 national, state, and specialty nursing associations who endorse NSO exclusively. NSO also provides excellent service with a team of knowledgeable, licensed Customer Service Representatives dedicated to serving nursing professionals and trained specifically for the needs of advanced practice nurses in New York State.
Properly Listing Credentials

The proper use of credentials is essential in designating levels of education, licensure, certification, and other professional achievements among nursing professionals. Credentials are represented as a set of letters which is shorthand for the attestation of qualification, competence, or authority issued to an individual by a third party with a relevant or de facto authority to do so. Credentials also give the consumer the ability to recognize the competence or credibility of an individual, but only if the consumer comprehends the meaning of the initials as listed.

In order to lessen the confusion that surrounds credentials and their significance, the National Council of State Boards of Nursing Advanced Practice Advisory Committee and the Advanced Practice Registered Nurse Consensus Work Group is currently working with numerous other bodies of nursing organizations to ease the “alphabet soup” confusion caused by the lack of regulation from state to state by advocating for the Advanced Practice Registered Nurse Consensus Model (APRNCM). One of several goals outlined by the APRNCM is to secure one uniformed title which will be used for all advanced practice nurses in each of the 50 United States. If this initiative is approved, it will provide title consistency among all advanced practice nurses, including certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists, and certified nurse practitioners.1 Having a standard way of listing credentials among all advanced practice registered nurses ensures that everyone including nurses, healthcare providers, consumers, third party payers, and government officials-understands the significance and value of credentials.1 To date, New York State has not adopted the APRN Consensus Model.

On December 11, 2009, the Congress on Nursing Practice and Economics published a position statement titled Credentials for the Professional Nurse: Determining a Standard Order of Credentials for the Professional Nurse that was adopted by the American Nurses Association (ANA) Board of Directors. This position statement, specifically states the order in which all professional nurses should list their credentials. The following order of credentials is recommended: Highest academic degree, licensure, state designations or requirements, national certifications, awards and honors, other certifications.2

Listing your highest degree earned is fairly standard. Academic degrees are listed first because they are earned, are considered permanent, and in most cases cannot be taken away from you. Academic degrees include associate degrees (AD, ADN), bachelor’s degrees include (BA, BS, BSN), master’s degrees (MA, MS, MSN), and doctoral degrees (PhD, EdD, DNS, DNP). In most cases, listing one degree is enough, but if your second degree is in another relevant field, you may choose to list it.

Licensure provides the legislated authority to practice in a state. Each state independently determines the legal title that a nurse practitioner may use when identifying themselves such as advanced practice registered nurse (APRN), nurse
practitioner (NP), advanced practice nurse (APN) or certified registered nurse practitioner (CRNP).

In New York, the state's licensure body for medical professions is the State Board of Regents. Use of the title "Nurse Practitioner" in New York State requires a certificate to be issued by the New York State Education Department after all necessary requirements have been met which include: having a currently registered New York State license as a Registered Professional Nurse (RN); and having met all the necessary educational requirements as outlined by New York State Department of Education. Once authorized to receive a certificate, you are permitted to use the credential title NP after your name to signify that you have met all the requirements of the state to practice as a Nurse Practitioner. However, since state law can dictate that a specific mandated title be used, such as advanced practice registered nurse (APRN), advanced practice nurse (APN) or certified registered nurse practitioner (CRNP), these titles are not recognized from state-to-state and using them as part of your formal credentials is likely not warranted.

National certifications are usually voluntary and require the recipient to renew every few years. Certifications can be taken away, expire, or not renewed. The process for renewal varies among the different certification bodies, but commonalities do exist. A requirement for all certification bodies is that the NP must practice in the NP role during the certification period and maintain registered nurse licensure. The applicant must also demonstrate professional growth through approved continuing education activities during the certification period which include: conference attendance, academic credits, research or publication, or acting as a preceptor. If a candidate does not meet the criteria for recertification, the individual is offered the opportunity to retake the certification exam. The length of the certification period will vary depending on the certification body granting the certification. Multiple nursing certifications may be listed in the order you prefer, but consider listing them either in order of relevance to your practice or in the order they were obtained, with the most recent first. Always list non-nursing certifications last.

National certification bodies provide a way in which nurse practitioners are able to validate their knowledge and qualifications as an advanced practice nurse in their area of expertise. The following is a list of various national certifying bodies that provide national certification exams in a specialty; as well as the approved credential designate permitted by the credentialing body.

American Academy of Nurse Practitioners Certification Program  
Capital Station, LBJ Building  
P.O. Box 12926  
Austin, TX 78711-2926  
https://www.aanpcert.org
Candidates who meet the requirements to become certified by AANPCP will be qualified to use the credentials NP-C (Nurse Practitioner-Certified) to indicate their certification status. Example: Adult Nurse Practitioner (ANP-C); Family Nurse Practitioner (FNP-C).

American Nurses Credentialing Center
P.O. Box 791321
Baltimore, MD 21279-1321
http://www.nursecredentialing.org

Certifying through the American Nurses Credentialing Center (ANCC), allows the NP to use the initials BC after their population-foci. Example: Acute Care Nurse Practitioner (ACNP-BC); Adult Nurse Practitioner (ANP-BC); Family Nurse Practitioner (FNP-BC); Pediatric Primary Care Nurse Practitioner (PPCNNP-BC); Adult Psychiatric-Mental Health Nurse Practitioner (PMHNP-BC).

National Board for Certification of Hospice and Palliative Nurses
One Penn Center West
Pittsburgh, Pa 15276-0100
E-mail: http://www.nbchpn.org/

NBCHPN currently offers the Advanced Certified Hospice and Palliative Nurse indicated by the credential (ACHPN). (Certification for women's health, neonatal and gynecologic/reproductive nurse practitioners.)

The National Certification Corporation offers two national certification exams: Neonatal Nurse Practitioner indicated by the credential (NNP-BC) and Women's Health Care Nurse Practitioner indicated by the credential (WHNP-BC).

Oncology Nursing Certification Corporation
125 Enterprise Drive
Pittsburgh, PA 15275
http://www.oncc.org/

Oncology Nursing Certification Corporation offers an Advanced Oncology Certified Nurse Practitioner Certificate indicated by the credential (AOCNP®).
After successful completion of the Pediatric Nursing Certification exam, one is allowed to use the trademark credential CPNP® (Certified Pediatric Nurse Practitioner). However, according to the Pediatric Nursing Certification Board website some CPNPs choose to list CPNP-AC or CPNP-PC as their credential; and dually certified CPNPs sometimes use both CPNP-PC and CPNP-AC, or CPNP-PC/AC (or CPNP-AC/PC). 

Awards and honors recognize outstanding achievements in nursing. These are awarded as affirmation or confirmation of a large body of work, achievements and mastery in a professional specialty and/or service to an organization. These awards are usually bestowed after years of work and the awards are given in the form of promotion to Fellow or Distinguished Fellow status. This credential is listed last and must follow the instructions of the organization. Examples: Fellow of the American Academy of Nursing (FAAN), or the Fellows of the American Association of Nurse Practitioners (FAANP).

Continuing educational activities are a requirement for maintenance of licensure and certifications, but are never listed as a credential after the recipients name. Confusion may occur because the recipient will often receive a certificate of attendance or completion for the given program. Continuing education programs are provided by a multitude of companies either in person or online, including The Nurse Practitioner Association of New York State.

Credentials are attestations of competence and qualifications issued to an individual by a third party. The proper listing of a professional’s credentials will serve to decrease confusion and improve overall communication among all interested parties. You have earned these well-deserved credentials, so display them with pride! If you require further clarification about how to list your credentials contact The Nurse Practitioner Association of New York State at www.thenpa.org.

References


National Certification: A General Overview

New York is one of the few states that does not currently require national certification as a prerequisite for NP licensure. Nevertheless, national certification has become critically important to NP practice today and is a nationwide standard within the profession. Today, national certification is required by, among others, Medicare, the Veterans Administration, and most third-party commercial insurers as a condition of provider participation.

There are two major national NP certifying bodies that offer national certifying exams in most specialties. They are the American Academy of Nurse Practitioners National Certification Program (AANPCP) and the American Nurses Credentialing Center (ANCC). Other national organizations also offer NP certification within certain specialties but none currently cover all NP specialties. It is important to always check with the national certifying body directly to obtain current program information.

Graduation from an accredited nurse practitioner program is one requirement for eligibility for national certification. However, there are several other eligibility criteria that may be unique to the certifying body and/or NP specialty for purposes of either the initial certification or recertification. It is recommended that you consult directly with that particular certifying body to obtain current information on the eligibility criteria and specific requirements of each.

Regardless of the certifying body, you can expect to be required to submit official transcripts of your advanced degree education. An official transcript is one provided by the school directly to the certifying body, although some will accept the official transcript when provided by the applicant in a sealed school envelope from the school issuing that transcript.
Review courses are offered by several vendors to assist in preparation for the various specialty certification examinations. Through The NPA’s partnership with Fitzgerald Health Education Associates, Inc. (FHEA) you have access to one of the leaders in NP certification preparation and education. Most review courses are offered either online as a self-study program or through live classroom presentations. Certification review courses vary in cost and location. You are advised to not only shop carefully, but also to network and speak with others who have taken the review course to gain their personal impressions. As with many of the issues discussed in this guide your NP colleagues can be an excellent resource to assist you.

NPA members receive substantial discounts on Fitzgerald Health Education Associates, Inc. certification review courses. You may access the discounted courses only from The NPA website, www.TheNPA.org, by clicking on the education tab and then selecting Fitzgerald Health Education from the drop down list. You will need to login to access the discount.

Recertification: It is important to point out that once you sit for and pass your national certification examination, at some future time interval established by the certifying body, you will need to be re-certified within your specialty area(s) of practice. Should you fail to recertify within the time period (and grace period IF ANY) allotted and your national certification lapses you will need to meet the then current requirements for eligibility to take the examination. This can result in a NP having to go back to school to meet those requirements.

Quick Reference Tip:

- It is highly recommended that you rely upon yourself for knowing when your current certification expires and when you must reapply to maintain that certification. The certifying body may or may not notify you of your recertification application deadline. It is important to note that a lack of notification by the certifying body will not extend the deadline for your recertification. Always remember to keep track and be mindful of your recertification schedule.

Continuing Education (CE):

For national certification purposes, you will need to take continuing education classes within a specified period of time with enough credits to satisfy your certifying body’s requirements. You will be required to submit documentation as verification of continuing education classes/courses that you have completed. CE certificates are usually issued subsequent to your coursework and serve to provide such proof. To avoid losing this important documentation, it is a good idea to maintain a “Notebook of Continuing
Education” where each CE certificate is kept in chronological order. With this tool your verification of completed continuing education credits will be readily available to you and easily provided to your certifying body.

Each NPA member has their own “Professional Development” area on The NPA website. Credits earned at The NPA’s educational conferences are stored here for members to access. Credits earned elsewhere can be uploaded for the purpose of record keeping. The Professional Development area is accessed by selecting “Manage Profile” located on the home page of The NPA website.

The NPA is required to maintain records of attendance to NPA hosted educational events for six (6) years. You should verify how long records of CE attendance are maintained by other providers and how you may obtain proof of them.

However, there is no substitute for maintaining your own records to ensure that you have them at all times.

**Quick Reference Tip:**

- Maintaining both an electronic and hardcopy “Notebook of Continuing Education” records can prevent last minute scrambling for credit as the notebook allows you to know at all times exactly how many CE hours you have accumulated compared to how many hours you need to complete. Both electronic and hardcopy files offer redundancy that can prove critical, should either be lost.

Timely recertification is extremely important as a failure to re-certify on time can interrupt your career and have dire consequences. For example: The NPA was informed by one of its members, that if you are employed by the Veterans Administration (VA) and fail to re-certify on time you will not be permitted to continue to function as a nurse practitioner within the VA and may face dismissal. (In this particular instance the NP, due to longevity in the position, was allowed to continue employment within the VA, as a floor nurse, not a NP, but at reduced compensation until re-certified). Always be sure to recertify at least 8 weeks ahead of your expiration, have your CE records complete and up-to-date, and never rely on just one source to remind you. As previously stated, lapse of a NPs national certification can result in the NP having to retake the exam and/or re-qualify to take the certification examination according to the standards in place at that time and possibly having to go back to school in order to do so.

**Obtaining Government Approvals in Order to Prescribe**

After completing New York State Education Department approved coursework and meeting other requirements for being licensed as a midwife or nurse practitioner, the New York State Education Department certifies the midwife or nurse practitioner to prescribe. However, nurse practitioners and midwives must obtain additional
government approvals, and meet other requirements in order to issue prescriptions or other certain medications or medical devices in New York. Here’s a brief summary of these additional government requirements.

- **A National Provider Identifier (NPI) issued by the US Center for Medicaid and Medicare Services (CMS).** All electronic and most written prescriptions issued in New York State must include a NPI. Federal law requires health care providers (including hospitals, nurse practitioners and midwives) to use NPIs on electronic health care transactions (i.e., processing claims, status inquiries, eligibility inquiries). CMS issues NPIs to institutional health care providers (i.e., hospitals) and to licensed health care practitioners (including nurse practitioners and midwives). If a prescriber works in a hospital, the prescriber may use the hospital's NPI when issuing prescriptions. In most other cases, the prescriber must include his or her personal NPI on the prescription. For more information about applying for a NPI visit https://nppes.cms.hhs.gov/NPPES/Welcome.do Applications may be submitted online or by regular mail.

- **A Federal Drug Enforcement Administration Registration (DEA) number issued by the U.S. Department of Justice – Drug Enforcement Administration.** In New York, a DEA number must be on every prescription for a controlled substance issued by a prescriber. The DEA issues DEA numbers to institutional health care providers (i.e., hospitals) and to licensed health care practitioners (including nurse practitioners and midwives). In most cases, a nurse practitioner and midwife must obtain a DEA number in order to prescribe or dispense controlled substances. In some cases, prescribers who are employed at a hospital may, when acting in the usual course of employment, dispense or prescribe controlled substances under the DEA number of the hospital. To apply for a DEA number, visit http://www.deadiversion.usdoj.gov/ or call 1-877-883-5789, 1-800-882-9539 or 212-337-1593. Prescribers who do not prescribe controlled substances do not need a DEA number.

- **New York State Official Prescription Forms (ONYSRx).** Each nurse practitioner and midwife is legally required to issue all written, non-electronic prescriptions on New York State Official Prescription Forms (ONYSRx forms). After obtaining a Health Commerce System Account and registering with the New York State Department of Health’s Bureau of Narcotic Enforcement (as described below) each nurse practitioner or midwife may obtain from the New York State Department of Health ONYSRx forms or authorization to computer print ONYSRx forms. For more information on obtaining official prescription forms, contact the New York State Department of Health Bureau of Narcotic Enforcement by telephone 866-811-7957 or 518-402-0708 or go to the New York State Department of Health website: http://www.health.ny.gov/professionals/narcotic/official_prescription_program/

- **A Health Commerce System Account (HCSA) from the New York State Department of Health.** Nurse practitioners and midwives must have HCSA in
order to electronically order New York State Official Prescription forms (ONYRx forms) and to access an online Prescription Monitoring Program when prescribing controlled substances. When prescribing controlled substances, a nurse practitioner or midwife must access the Prescribing/Prescription Monitoring Program (PMP) using a Health Commerce System Account provided by the New York State Department of Health. Instructions for establishing a Health Commerce System Account are available at the New York State Department of Health’s Bureau of Narcotic Enforcement website: http://www.health.ny.gov/professionals/narcotic/

- **Registration with the New York State Department of Health Bureau of Narcotic Enforcement.** Each nurse practitioner and midwife must register with the New York State Department’s of Health Bureau of Narcotic Enforcement in order to obtain ONYSRx forms and to prescribe controlled substances. This registration must be renewed every two years. Instructions on registering are available at the New York State Department of Health’s Bureau of Narcotic Enforcement website: http://www.health.ny.gov/professionals/narcotic/

- **Registration of Electronic Prescribing Computer Software.** The computer applications used when electronically prescribing must meet federal regulatory requirements and the prescribers must make sure that their software vendor applications meet these requirements. Prescribers must then register the computer applications with the New York State Department of Health’s Bureau of Narcotic Enforcement. For additional information on electronic prescribing is available at: http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/

A **Medicaid Provider Number.** A nurse practitioner or midwife must obtain a Medicaid Provider Number in order to prescribe for Medicaid beneficiaries. To access application forms for Medicaid reimbursement, go to www.emedny.org and click on the provider enrollment tab at the top of the page.

**Clinical Considerations When Prescribing**

To be valid, a prescription for a drug must be issued for a legitimate medical purpose by a practitioner acting with the usual course of professional practice. Nurse Practitioners and midwives must make effective clinical judgements to minimize poor quality or erroneous prescribing. Ideally, prescribers should: (1) evaluate and clearly define the patient’s problem; (2) specify the therapeutic objective; (3) select the appropriate drug therapy, taking in consideration drug costs; (4) provide appropriate information, instructions and warnings to patients and dispensers; (5) after therapy is initiated, monitor treatment results (i.e., consider discontinuation of the drugs).

In most cases, nurse practitioner or midwife must examine a patient before a drug or medical device is initially prescribed for the patient. New York laws specifically requires
a patient to undergo an examination before a controlled substance is initially prescribed. 10 NYCRR (New York Codes Rules Regulations) §80.63. However, once an initial examination has been made, the need for future examinations is a matter of clinical judgement based on generally accepted standards of medical, nurse practitioners or midwifery practice.
In order to protect public health, New York law allows nurse practitioners and midwives to issue a prescription without examining the ultimate user of the prescription in the following instances:

- **New York State’s Expedited Partner Therapy Program.** A nurse practitioner or midwife may provide a patient with either antibiotics or a written prescription for antibiotics intended for the patient’s sexual partner(s) to treat suspected or actual Chlamydia trachomatis infections. For more information on prescribing and New York State’s Expedited Partner Therapy Program, visit the New York State Department of Health website. [http://www.health.ny.gov/](http://www.health.ny.gov/)

- **Non-Patient Specific Prescriptions and Protocols.** New York law allows RNs to execute non-patient specific orders and protocols that are prescribed by a physician or nurse practitioner for administering: (1) immunizations; (2) emergency anaphylaxis treatment; (3) TB tests; (4) HIV tests; (5) HCV tests; or (6) opioid related overdose treatments. In addition, New York law allows pharmacists to execute non-patient specific orders and protocols that are prescribed by a physician or nurse practitioner for administering certain immunizations. The ordering physician or nurse practitioner is not required to have a treatment relationship with the recipients of the prescribed treatments or tests. For specific information on prescribing non-patient specific orders and protocols, visit the New York State Education Department’s Nursing Profession and Pharmacy Profession website.

### Laws Governing Prescribing

A prescription is an order from an authorized prescriber for a drug or medical device that is dispensed by a pharmacist to or for a patient.

New York law currently requires nurse practitioners, midwives, dentists, podiatrists, physicians, physician assistants and optometrists to issue most prescriptions electronically. However, New York law still allows (in limited circumstances) nurse practitioners and midwives to issue prescriptions written on official New York State forms (ONYSRx forms); and oral prescriptions. Some New York laws apply to all forms of prescriptions; other laws apply only to specific form of prescription or only when prescribing controlled substances or prescribing as a Medicaid provider. Ultimately, the prescriber is responsible for ensuring that the prescription conforms to all federal and state requirements.
New York laws governing prescribing include, but are not limited to:

- New York State Education Law §6902(3)(b) and §64.4(e) of the Title 8 of Codes, Rule and Regulations of New York, NYCRR (authorizes nurse practitioners to prescribe after completing pharmacology coursework)

- New York State Education Law §6951(2) and §79-5.5 of Title 8 of the Codes, Rule and Regulations of New York (authorizes midwives to prescribe after completing pharmacology coursework)

- New York State Public Health Law Article 33 and Part 80 of Title 10 of the Codes, Rules, Regulations of New York (requirements for administering, dispensing and prescribing controlled substances)

- Part 910 of Title 10 of the Codes, Rules, Regulations of New York (requirements for prescription forms, electronically transmitted prescriptions, security requirements for prescription forms)

- New York State Education Law §6810 (requirements for prescribing and prescription forms) and §29.2 of Title 8 of the Codes, Rules, and Regulations of New York (information required on prescriptions)

- New York State Public Health Law §281 (requirements for prescription forms and electronic prescribing)

- New York State Public Health Law §2312 and §23.5 of Title 10 of the Codes, Rules and Regulations of New York (expedited partner therapy)

- New York State Education Law §6909 and Part 63 and §64.7 of Title 8 of the Codes, Rules, and Regulations of New York (non-patient specific orders and protocols)

**Requirements for Written Prescriptions**

As described in more detail in the next section, New York law requires most nurse practitioners and midwives to issue most prescriptions electronically. This section covers the requirements for written “non-electronic” prescriptions issued by nurse practitioners and midwives.

New York State Public Health Law §281 requires that ALL non-electronic written prescriptions in New York State be issued on official New York State prescription forms (ONYSRx Forms). This law was passed in order to combat prescription fraud. All ONYSRx forma are serially numbered and include many security features to prevent fraudulent use of the prescription form. For example, when an ONYSRx form is photocopied, the words, “Void” will appear on the photocopy. Page 27 shows an
example of the ONYSRx form. Information on how to obtain ONYSRx forms is included on page 21. Nurse Practitioners and midwives should ensure that the information described below is included on each ONYSRx form that is issued.

- **Prescriber Information.** The ONYSRx form must include in print: the prescriber's name, address, telephone number, profession (i.e., nurse practitioner or midwife) and the prescriber's professional registration number. In addition, the ONYSRx forms should include the prescriber’s NPI number or an institutional NPI number (if the prescriber is employed by a hospital or other qualifying healthcare institution). If a controlled substance is being prescribed, the ONYSRx form must include the prescriber’s DEA number or an institutional number (if the prescriber is employed by a hospital or other qualifying healthcare institution). Inclusion of a prescriber’s preprinted DEA number on a regular prescription form has been known to increase the incidence of prescription pad thefts and attempts at forging prescriptions for controlled substances.

- **Patient Information.** The ONYSRx form must include: the patient’s full name, complete address and date of birth or age. If the prescription is for a Schedule II controlled substance, the form must identify the patient’s sex. In cases where the prescriber wants to issue a prescription for more than a 30 day supply of a controlled substance, the pharmacist cannot fill the prescription unless the prescriber is prescribing controlled substances for the treatment of certain medical conditions, and the prescriber provides the patient’s diagnosis or the appropriate code (as described on page 37) is written on the ONYSRx form.

- **Drug Information.** The ONYSRx forms must include: the complete drug name (no abbreviations); drug strength; amount of drug, the route and frequency that the drug should be taken, and other necessary directions for use by the patient. In addition, the form must include the quantity of the prescribed drug to be dispensed by the pharmacist and other directions for the pharmacist.

The **superscription** symbol (the Rx symbol) is not required on the ONYSRx forms.

The **inscription** identifies the drug name, dosage, dosage form, and strength. Prescribers who are unsure about a drug should refer to a Physician Desk Reference (PDR) or similar reference or consult with a pharmacist to ensure that appropriate and accurate drug information is being described on the prescription form.

The **subscription** identifies the quantity of a drug to be dispensed by the pharmacist. The amount written must indicate the exact number prescribed for the patient for a designated amount of time. For example, if an antibiotic is prescribed as q 12h for ten days, “dispense #20” tells the pharmacist that only 20 capsules/pills can be dispensed.
to the patient. When controlled substances are prescribed, New York law requires quantity of the drug to be written in word and number form. See 10 NYCRR Part 80.

The **signa** includes patient directions for taking the drug. These directions must be clear since they will be written on the prescription label. For example, TID may be interpreted in more than one way. Should the patient take with meals? Should the medication be equally spaced apart? Should the patient wake up to take the third dose? Prescribers must consider these issues when writing the dosing directions. Likewise, BID may or may not mean every 12 hours, and can be interpreted differently by each patient. Consider the consequences of irregular dosing patterns on the effect of the medication before writing BID instead of q12h. When prescribing controlled substances, New York law requires the prescriber to write the maximum daily dose to be taken by the patient.

- **Prescriber’s Signature and Date.** The ONYSRx form includes a line on which the prescriber must personally write his or her signature. A prescriber is not legally permitted to use a signature stamp or to have another person sign the ONYSRx form on the behalf of the prescriber. The ONYSRx must include the date the prescription is issued (signed). It is illegal to pre or post-date a prescription for a controlled substance.

- **Refills.** The ONYSRx form includes a space where the prescriber indicates the number of times the prescription can be refilled. If the space is left blank, the prescription will not be refilled. To eliminate the possibility that someone else will inappropriately write in the space, prescribers usually write “NR” or “no refills” in the space (when no refills are ordered). If a prescriber wants the prescription to be refilled three times, the prescriber may either write the number itself or spell the number (e.g. x3 or “three”). Remember, the number “3” can be altered by the patient (to a 5, an 8 or 13) much more easily than if the prescriber writes the word “three”. Prescribers should not write “PRN” in the refill box. Pharmacists are legally allowed to “refill” a prescription for non-controlled substances ONCE when “PRN” is written in the refill box. Pharmacists are not legally allowed to refill any prescription for controlled substances with “PRN” written in the refill box. See, 8 NYCRR §29.7. When controlled substances are prescribed, New York law requires the number of refills to be written in word and written form. See 10 NYCRR Part 80, New York law prohibits prescription refills of Schedule II controlled substances or Benzodiazepines.

- **Dispense as Written.** Near the bottom of the ONYSRx form is an empty box with the phrase: “Dispense as Written” below it. The following is written above the box “Prescription will be filled generically unless prescriber write “DAW” in the box below”. The prescriber may choose to leave the box empty or may enter in her/his own handwriting the letters “DAW” within the box. If the box is left empty, then New York law usually requires the pharmacist to fill the prescription with a generic form of the prescribed drug. If the prescriber writes “DAW”, then the medication will be dispensed as written. For the NYS Medicaid program, prescriptions written “DAW” must also include the notation “Brand medically
necessary” on the face of the prescription and in the prescriber’s own handwriting.

- **Limited English Proficiency.** New York law requires ONYSRx forms to include a space where prescribers may indicate whether the patient is limited English proficient and indicate the preferred language of the patient. Currently, New York law requires many pharmacies to offer prescription information to patients in: Spanish, Italian, Chinese, and Russian. In New York City there are additional Limited English Proficiency requirements for pharmacies.

- **Child Resistant Containers.** Federal law requires that most prescription and over the counter drugs be packaged in child resistant packaging in order to prevent children from accessing potentially dangerous medications. Exceptions to this law include nitroglycerin, Medrol® dosepacks and birth control pills. In addition, federal law allows the prescriber or the patient to request that drugs be dispensed in non-child resistant containers. The prescriber can include a statement on each prescription as follows “use non-child resistant container”. Alternatively, the patient can request a non-child resistant container for all prescriptions. The pharmacist must document this request in the pharmacy records.

Important points to remember when writing prescriptions on ONYSRx forms:

- The prescriber must use ONYSRx forms that have the prescriber’s name, address, telephone number, profession and registration number pre-printed on them.

- The prescription must be written in ink, an indelible pencil, or a typewriter and personally signed by the prescriber. An individual may be designated by the prescriber to prepare prescriptions for his or her review and signature (except for controlled substances).

- Only one drug or type of medical device can be prescribed on each ONYSRx form.

- ONYSRx prescriptions are non-transferrable to another patient.

- All faxed prescriptions must be written on ONYSRx forms.

- Many additional restrictions apply when prescribing controlled substances. See information below.
Preventing Common Errors in Prescription Writing

Poorly written prescriptions result in many negative consequences, including misinterpretation of instructions, medication taken for the incorrect indication, doses taken at incorrect times or the administration of an incorrect dose. Some of the most common prescription errors will be described below.

Probably the most frequent errors are errors of omission, especially the date, patient name, address, age, quantity to be dispensed, strength of dose and complete directions to patient. There may be more than one error on one prescription blank. NYS Department of Health has submitted a ruling that Pharmacists may have the authority to enter or change certain information on controlled substance prescriptions (including ONYSRx) that may have been written incorrectly or omitted inadvertently by the prescribing practitioner.
The ruling permits the pharmacist to appropriately obtain the following data:

<table>
<thead>
<tr>
<th></th>
<th>If Missing</th>
<th>May be entered by Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full Name</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>• Age/Date of Birth</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>• Gender</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>• Address</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Prescriber</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• DEA#</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>• Telephone #</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>• Name Imprint</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>• Signature</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>• Address</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Prescription Content</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Date Written</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>• Drug Name</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>• Strength of drug</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>• Maximum daily dosage</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Directions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• For Use</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>• Drug Quantity</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

**Inappropriate/incorrect dosing** is another problem commonly encountered. This is most commonly seen with prescriptions for children or older adults. Geriatric patients normally have a drop in kidney function by about 50% or more. When writing a prescription for a more potent drug, the prescriber needs to consider a common sense rule when prescribing for the elderly: Start low and go slow (titrate up slowly). Other common areas of mistakes include incorrect quantity ordered per prescription, incorrect directions regarding how to take the medicine, and incorrect indication for the prescribed medication.

**Illegibility** is often a problem and may predispose to the prescription being filled incorrectly. For example; Isordil® is similar in spelling to Inderal®. While both drugs are cardiac related, each has a very different purpose and could be dangerous if erroneously dispensed. It is not against the law to typewrite a prescription, if illegible handwriting is a problem. This is a current recommendation in an effort to reduce medication errors. However, “DAW” must be handwritten by the prescriber within the box.
Other areas of concern include miswriting or misinterpretation of abbreviations (e.g. QD vs. QOD or QID). If you are concerned that interpretation might be an issue, opt to write it out instead of using an abbreviation. Another example is OD. Does this mean every day or in the right eye? Another frequently seen error is the use of HS. Does this mean half strength or should the patient take the medicine at bedtime? Be clear in your use of abbreviations to prevent error.

Decimal errors are also a problem. Probably the most frequent error is related to the prescribing of Synthroid®, which may be written in micrograms (mcg) or milligrams (mg). The decimal placement is a very important when considering these strengths. If the dose is .1 mg, then put a zero in the front of the .1 to prevent error in interpretation (0.1mg). Never place “0” after the decimal point: it may be misinterpreted or illegally changed to read “10”. Placement of instructions in relation to the drug is also important. Consider the following instructions Inderal® ½ tablet 40 mg four times daily. Is this intent 20 mg. per dose or is the dose to be ½ of an 80 mg pill? Since there is ambiguity in this directive, one would hope that the pharmacist would call the prescriber prior to filling this prescription.

The prescriber writer needs to consider it carefully before writing the prescription for several reasons. First, it is a legal document that may need to be defended in court. Therefore, one must be careful and make sure that it is done accurately. The prescription must be written in ink and legible to the pharmacist who must fill the prescription. Never alter the prescription in any way, since it may be construed as a forgery by the pharmacist; s/he then may refuse to fill it for the patient. Proofread it, if necessary. Never become too busy to attend to the details of something so important. The prescriber has a responsibility to assure the accuracy of the prescription, and there is a corresponding responsibility on the part of the pharmacist to accurately fill the prescription. The use of e-prescribing has increased over the past few years. The impetus for this is to reduce transcription errors. All prescribers should be encouraged to modify their practices to incorporate this technology. (See Requirements for Electronic Prescriptions).

All too often, the provider makes prescription mistakes that then must be addressed by the pharmacist who must determine whether there is an error; decide what is really prescribed and then follow up with the provider for these corrections. Avoid ambiguous abbreviations, roman numerals and Latin. Abbreviations may be misread, misunderstood and misinterpreted. Roman numerals can be potentially changed and/or modified by someone else. For example, the roman numeral one (I) has been changed into a ten (X) or IX (9) or XIV (14). The goal, above all, is to have the prescription accurately interpreted, so that the right medication gets to the right person, with the appropriate dosing schedule. In addition, avoid the leading trailing “zero” when writing prescriptions so strengths are not misinterpreted, (i.e. Coumadin 1.0 may be misread as Coumadin 10).

There has been a great deal of concern regarding patients and stolen prescription blanks. Therefore, another consideration when writing a prescription is to make sure
that you know the patient before writing or calling a prescription. Do not leave prescription blanks unattended.

**Department of Health Notification Requirements for Written Prescriptions** (on a ONYSRx form)

New York law currently requires nurse practitioners and midwives to issue most prescriptions electronically. However, New York law still allows (in limited circumstances) nurse practitioners and midwives to issue oral or written prescriptions.

Unless a prescriber has a waiver from the New York State Commissioner of Health pursuant to Public Health Law Section 281, all prescribers who issue written prescriptions must notify the New York State Department of Health by EMAIL at ERX@health.ny.gov the notice must include the following information with respect to each written prescription:

- That it is a notification to the Department of Health pursuant to Public Health Law Section 281(4) or (5);
- Practitioner’s name;
- Practitioner’s license number;
- Practitioner’s preferred telephone number;
- Practitioner’s preferred work email address;
- Practitioner’s work address;
- Patient’s initials **only** (the Department of Health does not want patient confidential information to be sent); and,
- The reason(s) for not issuing an electronic prescription, including the citation(s) to PHL Section(s) 281(3)(b), (d), and (e)
- Issued in circumstances where electronic prescribing is not available due to temporary technological or electrical failure
- Issued by a practitioner under circumstances where, notwithstanding the practitioner’s present ability to make an electronic prescription, such practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient’s medical condition.
- Issued by a practitioner to be dispensed by a pharmacy located outside the state.


**Requirements for Electronic Prescriptions**

New York law requires nurse practitioners, midwives, podiatrists, physicians, physician assistants and optometrists in New York State (“prescribers”) to issue prescriptions electronically directly to a pharmacy, with limited exceptions. This law does not require a prescriber to issue a prescription electronically when:
Electronic prescribing is not available due to temporary technological or electronic failure;

The prescriber has a waiver granted by the New York State Commissioner of Health;

The prescriber reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner; or,

The prescription will be dispensed at a pharmacy located outside of New York State.

The new law requires electronic prescribing for all types of medications (controlled substances and non-controlled substances) and for syringes and other medical devices dispensed at a pharmacy in New York State.

An electronic prescription is a prescription that is:

- Created, recorded, transmitted or stored by electronic means;
- Issued and validated with the prescriber’s electronic signature;
- Electronically encrypted to prevent unauthorized access, alteration or use of the prescription; and,
- Transmitted electronically directly from the prescriber to a pharmacy or pharmacist.

Electronic prescription computer technology must comply with federal and New York regulations. These regulations require prescribers and pharmacists to have a secure (encrypted and encoded) system for electronic transmission of the prescription from computer to computer in order to protect the confidentiality and security of patient information. Electronic prescribing computer applications must also be “certified” (i.e., audited by an organization or certified by the Federal Drug Enforcement Agency to ensure it meets technical standards acceptable to the federal government. EMAILED prescriptions are NOT considered to be electronic prescriptions since EMAIL is not considered a secure method of electronically transmitting a prescription. A faxed prescription is NOT considered an electronic prescription.

New York law does not prohibit an agent or an employee of a prescriber from preparing an electronic prescription for the prescriber’s review and electronic signature. The electronic signing of an electronic prescription and the transmission of an electronic prescription are two separate and distinct actions. However, the prescriber is legally required to personally review and electronically sign an electronic prescription and is not legally allowed to delegate this responsibility to other individuals. Once the prescription
is signed by the prescriber, and agent or employee of the prescriber may transmit the prescription on behalf of the prescriber.

Electronic prescriptions for controlled substances must include the same information that written prescriptions do except that:

- All electronic prescriptions must include a NPI number;
- Electronic prescriptions must be electronically signed; and,
- The prescriber should always specify whether a prescription must be dispensed as written.

For Practitioners Who Issue Less than 25 Prescriptions per Year

There is a certification process from the Bureau of Narcotic Enforcement (BNE) for a practitioner to certify he or she will not issue more than twenty-five prescriptions during a twelve month period. A practitioner submitting a certification will not be required to issue prescriptions electronically.

A practitioner can either submit a certification online through the Electronic Prescribing Waiver (EPW) application on the NYS Health Commerce System (HCS) or by submitting Certification form, DOH-5221, to the BNE. (Form located in Appendix)

Complete the following steps below to submit a certification online in HCS:

1. Log on into the HCS at https://commerce.health.state.ny.us
2. Under “My Content” click on “All Applications”
3. Click on “E”
4. Scroll down to Electronic Prescribing Waivers and double click to open the application. You may also click on the “+” sign to add this application under “My Applications” on the left side of the Home screen.
5. Select the practitioner name from the list. If the name appears more than once, select the option that starts with the profession (i.e., Medicine-#####Doe John).
6. Provide contact information for the person who should be contacted regarding the certification,
7. Click on the “Submit Certification”
8. Enter the “Begin Date” of the twelve month period.
9. Enter in the mailing address of the practitioner submitting the certification.
10. Click “Submit”
11. Click “Certify”
12. You will be returned to the “Waiver Requests and Certifications Summary” screen. The certification period will be displayed.
Certification FAQ's

1. Can a practitioner submit a certification with an effective date prior to the date of submission?

During the first year of the certification process, certifications postmarked or submitted to the Department by July 1, 2016, may specify a begin date as early as March 27, 2016. Certifications submitted to the Department after July 1, 2016 cannot be backdated.

2. Can a practitioner submit a certification with a future effective date?

Yes, up to 3 months in the future.

3. Does the 25 count script limit include all prescriptions?

Prescriptions in both oral and written form for both controlled and non-controlled substances must be included in determining whether or not a practitioner will reach the limit of twenty-five prescriptions.

4. What should a practitioner do if he or she exceeds twenty-five prescriptions within the twelve month period?

The practitioner is required to issue prescriptions electronically or obtain a waiver from the requirement to electronically prescribe. Please see information related to electronic prescribing waivers at www.health.ny.gov/professionals.narcotic/electronic_prescribing/waiver.htm

5. Does my certification need to be approved?

There is no review and approval process for certifications.

6. Who can submit the certification for a practitioner?

Each individual practitioner must certify independently. A hospital or group practice organization cannot submit certification on behalf of the practitioner.

7. How long is the certification valid?

A certification is valid for one year from the begin date.

8. Does a practitioner need to submit a certification each year?

Yes. A practitioner must recertify each year.
9. Can a practitioner submit a certification for a period that begins prior to the end date of its current certification period?

No. The certification periods can’t overlap. The begin date of a new certification period must be after the end date of the previous certification.

10. Does a practitioner who already has an approved waiver from the requirement to electronically prescribe also need to submit a certification?

No. The practitioner is covered by the waiver until March 26, 2017.

11. Does a practitioner who issues less than 25 prescriptions per year and already has an approved waiver from the requirement to electronically prescribe also need to submit a certification?

No. The practitioner is covered by the waiver until March 26, 2017

**Telephone Prescriptions (Oral Prescriptions)**

**Telephone Prescriptions for Drugs other than Controlled Substance**

New York law currently requires nurse practitioners, midwives, and other prescribers to issue most prescriptions electronically. However, New York law still allows (in limited circumstances) nurse practitioners and midwives to issue oral prescriptions. The prescriber or her/his designee may call in a telephone prescription for non-controlled substances to a pharmacist. The information must include all the data included in a written prescription: patient’s name, address, birth date, name of drug, strength of drug, refill instructions and whether or not it may be generically filled, the name of the provider, provider’s address and telephone number as well as the name of the individual who is calling in the medication. Please make special note that verbal telephone orders are the highest cause of medical errors so care should be taken when using this method.

**Telephone Prescriptions for Controlled Substances**

New York law includes many restrictions when orally prescribing controlled substances. For example, New York law requires prescribers to personally call in telephone prescriptions for controlled substances to a pharmacist. The prescriber must provide the same information that is required on a written prescription for controlled substances: patient’s name, address, birth date, gender, name of drug, strength of drug, maximum daily dose, quantity, as well as the prescriber’s name, address, telephone number, profession, license number and DEA number, etc. There are many additional rules that apply when orally prescribing controlled substances, which are covered in the next section.
Department of Health Email Notification Requirement for Oral Prescriptions

New York State Public Health Law requires all prescribers who issue oral prescriptions to notify the New York State Department of Health by EMAIL (unless the prescriber has a waiver from the New York State Commissioner of Health). The prescriber’s EMAIL notification to the Department should be sent to erx@health.ny.gov and include the following:

- That it is a notification to the Department of Health pursuant to Public Health Law Section 281(4) or (5)
- Practitioner’s Name
- Practitioner’s license number
- Practitioner’s telephone number
- Practitioner’s preferred work email address
- Practitioner’s work address
- Patient’s initials ONLY (the Department of Health does not want patient confidential information to be sent)
- The reason(s) for the exception(s) including the citations to PHL Sections 281(3) (b), (d), (e).
  - Issued in circumstances where electronic prescribing is not available due to temporary technological or electrical failure.
  - Issued by practitioner under circumstances where, notwithstanding the practitioner’s present ability to make an electronic prescription, such practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient’s medical condition.
  - Issued by a practitioner to be dispensed by a pharmacy located outside the state.

For more information, visit:
http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/

Requirements for Prescribing Controlled Substances

New York law recognizes five categories of controlled substances, which are listed below. The addiction potential is highest for Schedule I, and decreases as the categories progress to Schedule V. A current and complete list of controlled substances for each Schedule is available on the New York State Department of Health website.
http://www.health.state.ny.us/professionals/narcotic/ and then click on the “Laws & Regulations” tab on the left side of the page. Then follow the instructions under the heading “Part 80 Controlled Substance Regulations” on the page that opens.

**Schedule I** – Schedule I drugs have no currently accepted medical use in treatment in the United States (e.g. Heroin) and have a high potential for abuse. Experimental drugs are also included in this category. Examples of Schedule I drugs include: Heroin, LSD, Marijuana, and Methaqualone (Quaalude®). Nurse practitioners are not legally authorized to prescribe Schedule I drugs.

**Schedule II** – Schedule II drugs have a high potential for abuse and have a currently accepted medical use in treatment in the United States or a current medical use with severe restrictions. Examples include Amobarbital [Amytal®], Cocaine, Hydromorphone [Dilauidid®], Meperidine [Demerol®], Methylphenidate [Ritalin®], Morphine [Roxanol®], Opium derivatives [Tincture of Opium], Oxycodone [Percodan® or Percocet®], Pentobarbital [Nembutal®], Phencyclidine [Preludin®], Secobarbital [Seconal®], Hydrocodone [e.g. Lortab®, Lorcel®, Tussionex®, Hycodan®].

**Schedule III** – Schedule III drugs have a potential for abuse less than the drugs in Schedules I and II and have currently accepted medical use in the United States. Examples include: Acetaminophen with Codeine [Tylenol with Codeine®], Amobarbital suppository [Amytal®], Aspirin with Butalbital and Codeine [Fiorinal with Codeine®], Aspirin with Codeine [Empirin with Codeine®], Aspirin with Butalbital [Fiorinal®], Barbituric acid derivatives, Butabarbutal [Butisol®], Pentobarbital suppository [Nembutal®], and Seconal suppository [Seconal®].

**Schedule IV** – Schedule IV drugs have a low potential for abuse than Schedule III and have a currently accepted medical use in the United States. Examples include: Butophranol [Stadol®], Carisoprodol [Soma®], Chloral Hydrate [Noctec®], Meprobamate, Pentazocine [Talwin NX®], Phenobarbital, Tramadol [Ultram®, Ultracet®, Ryzolt™] and Zolpidem [Ambien®], and Benzodiazepines.

**Schedule V** – Schedule V drugs have a low potential for abuse relative to Schedule IV drugs and have a currently accepted medical use in the United States. Examples include: Codeine cough syrups [Robitussin AC®, Actifed with Codeine®] and Diphenoxylate with atropine [Lomotil®].

**General Information Concerning Prescribing Controlled Substances**

New York Law authorizes nurse practitioners to prescribe or dispense controlled substances (from Schedules II through IV) for treatment of patients within the specialty area of practice for which they have been certified by the New York State Education Department. In addition, federal law appears to prohibit nurse practitioners and midwives from prescribing or dispensing Suboxone® for treating drug dependence. An electronic prescription or written prescription for controlled substances must be for a 7-day supply or less, unless the prescriber is prescribing controlled substances for the
treatment of certain medical conditions identified as “Code A to Code F”, (as described below).

- **Code A**: Panic Disorders
- **Code B**: Attention Deficit Disorder
- **Code C**: Chronic debilitating neurological disorders (i.e. movement disorders, seizure disorders, convulsive activity or spasm activity)
- **Code D**: Pain relief (from diseases considered to be chronic and incurable)
- **Code E**: Narcolepsy
- **Code F**: Hormone deficiency males, gynecologic conditions and breast cancer in women, anemia and angioedema, which are responsive to treatment with anabolic steroids or chorionic gonadotropin. (A current list of Anabolic Steroids is available on the New York State Department of Health’s Bureau of Narcotic Enforcement website).

The prescriber may prescribe up to a 3 month supply of controlled substances to treat conditions, identified in Codes A-E and up to a 6 month supply of such drugs for Code F. The prescriber must write for the entire quantity to be dispensed at once (e.g. 300 not #100 and 2 refills). The patient's medical condition or Code must be written on the prescription.

A written* or electronic prescription for controlled substances must be filled within 30 days of the date it is issued. In addition to information required when issuing a written prescription for non-controlled drugs, a prescription for controlled substances must also include the following information:

1. A DEA number (the prescriber’s or hospitals’, as appropriate).
2. The patient’s gender.
3. The maximum daily dose of the controlled drug to be taken by the patient.
4. The quantity of the drug ordered must be written in both numerical and written word form (e.g. 2/two).
5. The date must reflect when the prescription was signed since pre or post-dating the prescription is illegal.
6. When prescribing greater quantities of controlled substances (i.e., a 3 month supply for Code A-F), the code or patient’s condition must be noted on the prescription.
7. The rules for prescribing refills for controlled substances are described below.

Prescribing Schedule III-V Controlled Substances (excluding Benzodiazepines)

Refilling Written* and Electronic Prescriptions for Schedule III, IV and V Drugs (not including Benzodiazepines).

When issuing a prescription for a 30 day supply of Schedule III-V drugs (excluding Benzodiazepines), a prescriber may authorize up to 5 refills. However, a prescriber may authorize only one refill when issuing a prescription for up to a 3 month supply of Schedule III-V controlled substances (except Benzodiazepines) for Code A-E conditions. Schedule III-V controlled substances (except Benzodiazepines) refills are honored for up to 180 days. New York law requires that the number of refills authorized be in numeric and word form. See 10 NYCRR Part 80.

A pharmacist will not issue a refill for Schedule III-V drugs (excluding Benzodiazepines) until the patient has exhausted all but a 7 day supply of the drug if taken as directed. For example, if a patient has a prescription for a 30 day supply of a Schedule III drug, the patient must wait to obtain a refill until seven days before the 30-day supply would be used (e.g. the prescription may be refilled on the 23rd day of the last supply). This 7-day rule applies to the duration of the prescription, including each refill.

Telephone Prescriptions for Schedule III, IV and V Drugs (not including Benzodiazepines)

A prescriber may prescribe by telephone up to a 5 day supply of Schedule III, Schedule IV drugs except (Benzodiazepines) or Schedule V drugs. The prescriber must personally call in the prescription to the pharmacist. Telephone (oral) prescriptions may not be refilled.

Within 72 hours of issuing a telephone prescription, the prescriber must send to the pharmacist an ONYSRx form* or electronic prescription that reflects the telephone order exactly as called into the pharmacist and include the statement “Authorization for Emergency Dispensing”. An electronic prescription must also include the statement “Follow-up prescription to oral order”. If the pharmacist does not receive the prescription within 72 hours, he or she must note in the record that written* or electronic prescription was not received with 72 hours. The pharmacist is not required to notify the New York State Department of Health or the DEA if the written* follow-up prescription is not received with 72 hours.

Prescribing Schedule II Controlled Substances and Benzodiazepines

Emergency Telephone Prescriptions for Schedule II Drugs and Benzodiazepines

Schedule II drugs and Benzodiazepines may be prescribed by telephone only in an emergency. An emergency is when: immediate administration of the controlled
substance is necessary for proper treatment; no alternative treatment is available (including non-controlled substances), and it is not possible for the prescriber to issue a written* or electronic prescription for the drug at the time. The telephone prescription may provide for up to a 5 day supply of the drug. The prescriber must personally call in the prescription to the pharmacist. No refills are allowed.

Within 72 hours of issuing the telephone prescription, the prescriber must send to the pharmacist an original ONSRYx form* or electronic prescription to reflect the telephone order exactly as called into the pharmacist and includes the statement “Authorization for Emergency Dispensing”. If the pharmacist does not receive the prescription within 72 hours, he or she must report it to the New York State Department of Health’s Bureau of Narcotic Enforcement. If the pharmacist does not receive the prescription within 7 days, he or she must report it to the Federal Drug Enforcement Agency.

**Written and Electronic Prescriptions for Schedule II Drugs and Benzodiazepines**

A prescriber may issue an electronic prescription or a written* prescription (on an ONYSRx form) for Schedule II drugs and Benzodiazepines. The prescription cannot be refilled. The prescriber must not issue another prescription for the drug until the patient has exhausted all but a 7 day supply of the drug if taken as directed on the previously issued prescription (the 7 day rule).

**Internet System for Tracking over Prescribing Law (I-STOP)**

I-STOP is a New York law that requires nurse practitioners, midwives and other prescribers to consult the Prescription Monitoring Program (PMP) Registry when writing prescriptions for Schedule II, III and IV controlled substances. The PMP Registry is a “real time” electronic prescription tracking system maintained by New York State Department of Health that provides prescribers and pharmacists with enhanced information about prescriptions for controlled substances obtained by patients. This is known as the Prescription Monitoring Program or PMP. The benefits of the PMP are:

- PMP allows for better understanding of a patient’s controlled substance utilization based on recent controlled substance prescription history.
- Provides a quick, confidential online report to the prescriber and the pharmacist.
- Available 24 hours a day, 7 days a week.
- Information is based on controlled substance prescription data from nearly 5,000 pharmacies.
- No cost to the prescriber or pharmacist.

The information about dispensed controlled substances as reported by pharmacies is available to prescribers who, in addition to pharmacies, have a duty to consult the I-STOP database (PMP) prior to prescribing Schedule II-IV medications. A prescriber
may designate the consultation duty to a member of their office staff, but each prescriber is ultimately responsible for the confidentiality of the information.

To access the PMP a practitioner must obtain a Health Commerce System Account (HCSA) from the New York State Department of Health.

The complete requirements and regulations of the I-STOP/PMP are published at the New York State Department of Health’s Bureau of Narcotics Enforcement website. It is most important to note that with limited exceptions (e.g. veterinarians), every prescriber and pharmacy in New York is required to participate in I-STOP/PMP. Failure to participate in and comply with I-STOP/PMP requirements can result in fines and other penalties, as well as charges of professional misconduct, being assessed against the practitioner. Nurse practitioners must be sure that they stay up to date on these requirements and any changes in the system.

**Combatting Opioid Addiction**

An aggressive package of bills designed to break the cycle of opioid addiction was signed into law June 23, 2016. The focus of the package was to combat heroin and opioid addiction through enhanced prevention, comprehensive education, and improved access to treatment. Some of the most notable provisions of these new laws include:

- Reducing the limit for opioid prescriptions for acute pain to no more than a 7-day supply (with the exceptions for chronic pain and other conditions);

- Mandating health care professionals, including nurse practitioners, complete 3 hours of education every 3 years on addiction, pain management, and palliative care;

- Requiring insurers to cover necessary inpatient treatment for two weeks (14 days) of covered care before implementing utilization review;

- Prohibiting insurers from requiring prior approval for emergency supplies of medications to control withdrawal symptoms and accessing buprenorphine and injectable naltrexone;

- Requiring insurers to use state-approved criteria in making coverage determinations for substance use disorder treatment;

- Mandating insurers cover cost of naloxone when prescribed to an addicted person;

- Allowing families to seek 72 hours of emergency treatment (expanded from 48 hours) to help stabilize an individual suffering from addiction;
- Requiring hospital medical staff to provide discharge-planning services to coordinate patients at-risk for substance abuse with treatment programs;

- Authorizing trained professionals, including nurse practitioners, to administer naloxone in emergencies;

- Expanding wrap around services including education and employment resources, legal and social services, and other supports to assist individuals completing treatment;

- Requiring pharmacists to distribute easy to understand educational materials to consumers about the risks of addiction and local treatment services; and,

- Requiring the State Commissioner of Health to report county-level data on opioid overdoses and usage of over-dose reversal medications.

**Security and Record Keeping Requirements**

**Record Keeping Requirements**: Both the prescriber and the pharmacist will have the following responsibilities regarding documentation:

- **Prescriber responsibility**: The prescriber must document on the patient’s chart the name of drug, dosage, strength, directions, etc. Nurse practitioners must also maintain a written record of prescribing all of the controlled substances to each patient. The patient record must include sufficient information to justify the diagnosis that warrants the controlled substance treatment. Nurse practitioners must maintain a record of disposition of all ONYSRx forms, including but not limited to use as a prescription, cancellation, return, loss, destruction, unauthorized use and non-receipt.

- **Pharmacist responsibility**: The pharmacist is required to electronically transmit the prescription data to New York State every month.

**Security Requirements**:

Nurse practitioners and are legally required to take adequate security measures to assure against the loss, destruction, theft or unauthorized use of ONYSRx forms. The forms may be used only be the practitioner to whom they are issued and are not transferrable. Nurse practitioners must immediately notify the New York State Department of Health of the loss, destruction, theft or unauthorized use of any ONYSRx forms issued to them.

Each nurse practitioner who issues electronic prescriptions must retain sole possession and safeguard credentials used to sign electronic prescriptions for controlled substances and shall not share such credentials with any other person. The practitioner must not allow any other person to use such credentials to sign prescriptions for
controlled substances. They must immediately notify the Bureau of Narcotic Enforcement that his or her credentials used to sign electronic prescriptions for controlled substances have been lost, stolen or compromised. Practitioner shall immediately notify the Bureau of Narcotic Enforcement upon discovery that one or more prescriptions issued under that practitioner DEA registration were prescriptions that the practitioner had not signed or were not consistent with the prescription the practitioner signed.

Always be aware of the class of drug you are prescribing and if using electronic prescription software, know the correct e-prescribing rules.

Prescriptions for Needles and Syringes

Anyone authorized by the New York State Commissioner of Health may prescribe hypodermic needles and hypodermic syringes; these are considered devices, not a controlled substance.

A prescription for syringes and needles shall include:

- The name, address and age of the ultimate user;
- The name, address, telephone number and signature or electronic signature of the practitioner;
- The date on which it was issued; and,
- The name and strength of the drug, if applicable, the directions for use, the quantity of the syringes or needles prescribed, and the number of authorized refills.

Health care practitioners who can prescribe hypodermic needles or syringes may register with the New York State Department of Health to sell or furnish up to 10 hypodermic needles or syringes to persons 18 years of age or older. The public health measure, known as the Expanded Syringe Access Program (ESAP) is designed to prevent blood borne disease, most notably HIV/AIDS and hepatitis B and hepatitis C.

Additional information about this program can be found at: [http://www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/esap/overview.htm](http://www.health.ny.gov/diseases/aids/consumers/prevention/needles_syringes/esap/overview.htm)

New York State Medicaid Program

The New York State Medicaid Pharmacy program covers medically necessary FDA approved prescription and non-prescription drugs for Medicaid fee-for-service enrollees.
Enrollees in mainstream Medicaid Managed Care and Family Health Plus plans receive pharmacy benefits directly through the managed care plans. Prescription drugs require a prescription order with appropriate required information. Non-prescription drugs, often referred to as Over-the-Counter or OTC drugs, require a fiscal order (a fiscal order contains all the same information contained on a prescription). Certain drugs/drug categories require the prescribers to obtain prior authorization.

The Medicaid Program has several cost savings initiatives including:

- Preferred Drug Program (PDP)
- Clinical Drug Review Program (CDRP)
- Mandatory Generic Program
- Dose Optimization Initiative
- Brand Less Than Generic Program (BLTGP)
- Preferred Diabetic Supply Program

Detailed information regarding these programs can be found at: https://newyork.fhsc.com/ Information regarding the Medicaid Pharmacy Programs can be accessed at: http://health.ny.gov/health_care/medicaid/program/pharmacy.htm

**Medicaid Enrollment**

Provisions of the Affordable Care Act (ACA) requires prescribers to be enrolled in state Medicaid programs to be eligible to order or refer services reimbursed by the fee-for-service (FFS) Medicaid program. This means that any practitioner not currently enrolled in New York State Medicaid Program must do so to continue to order or refer services for FFS beneficiaries.

Provider enrollment forms and instructions can be found at: www.emedny.org/info/ProviderEnrollment/index.aspx

Nurse practitioners and midwives who plan to provide care to FFS Medicaid beneficiaries should check the New York State Department of Health website for current information relating to prescribing.
Miscellaneous

Dispensing

New York law allows pharmacists, pharmacy interns and practitioners authorized by law to issue prescriptions to dispense drugs. There are some limitations on dispensing drugs. Prescribers should not provide more than a 72-hour supply unless:

- There is no cost to the patient (e.g. Samples)
- There is no pharmacy within 10 miles of the patient
- The patient is in the hospital
- The medication must be compounded, reconstituted or diluted by the prescriber or is provided under certain protocols (e.g. AIDS or cancer)
- The dispensing is within certain clinics
- There is an emergency

For information concerning dispensing controlled substances see 10 NYCRR §80.71.

Generic Drug Substitution Law

New York State law requires that a pharmacist fill a prescription with a generic substitute unless the prescriber writes DAW (dispense as written) in the designated box at the bottom of each prescription form or, in case of electronic prescriptions, inserts an electronic direction to dispense drug as written, when the brand name is prescribed. Substitution is required only when an approved generic drug is commercially available and cost less than the brand name written on the prescription. If the prescriber writes the prescription generically, the pharmacist has a choice in terms of which generic substitute may be provided to the patient. The pharmacist does not have to substitute with the least expensive generic equivalent but only needs to substitute a less expensive generic equivalent. When the pharmacist does not have a generic substitute, the brand name drug may be dispensed but at the generic price. The pharmacist uses selected references to assist in generic substitutions. These include the FDA Orange Book or the United States Pharmcopeia Drug Information (USPDI). Both resources are updated regularly.

The requirement to substitute may not be rescinded by the pharmacist or the patient. The patient cannot ask for a generic drug once the prescriber has written the prescription. The pharmacist is bound by law to fill the prescription exactly as written. If the DAW box is left empty, a generic substitute (less expensive drug product) must be dispensed. On the other hand, if you prescribe the drug with DAW written in the box, a generic substitute may not be dispensed to the patient. The prescriber, in order to
change the directions on the written prescription, would have to rewrite it or call in the change to the pharmacist. It is important for the prescriber to understand the patient’s feelings, misconceptions and perceptions regarding generic substitution. It is the prescriber’s responsibility to explain the law to the patient regarding generic substitution. Additionally, HMOs have specific requirements that must be attended to when prescribing medications for their enrolled patients.

**DEA Numbers**

The Federal Drug Enforcement Administration (DEA) issues numbers (DEA numbers) to authorized health care providers. A DEA number is required to prescribe and dispense narcotic and controlled substances. A DEA number may be obtained by applying to the DEA at the address below.

U.S. Department of Justice
Drug Enforcement Administration
99 10th Avenue
New York, NY 10011

Phone: 1-877-883-5789, 1-800-882-9539 or 212-337-1593
www.DEAdversion.USDOJ.gov

**Reimbursement Guidelines: Medicare**

Questions about Medicare Part B may be referred to:

Professional Relations Department
Upstate Medical Division – Part B
1901 Main Street
Buffalo, NY 14208
Telephone: 877-869-6504
Website: http://www.cms.hhs.gov/

Professional Relations Department
Empire Blue Cross/Blue Shield
11 W. 42nd Street
New York, NY 10036
Telephone: 212-476-7111

**Nurse Practitioner Services**

“Effective for services rendered after January 1, 1998 any individual who is participating under the Medicare program as a nurse practitioner (NP) for the first time ever, may have his or her professional services covered if he or she meets the qualifications listed below, and he/she is legally authorized to furnish NP services in the State where the services are performed. NPs who were issued billing provider numbers prior to January 1, 1998 may continue to furnish services under the nurse practitioner benefit.

Payment for NP services is effective on the date of service that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.
Qualifications for NPs

In order to furnish covered NP services, an NP must meet the conditions as follows:

1. a. Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as an NP in accordance with State law; and

   b. Be certified as an NP by a recognized national certifying body that has established standards for NPs; or

2. Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as an NP by December 31, 2000.

The following organizations are recognized national certifying bodies:

   a. American Academy of Nurse Practitioners Certification Program (855-822-6727)

   b. American Nurse Credentialing Center (1-800-284-2378)

   c. National Certification Corporation for Obstetrics, Gynecologic and Neonatal Nursing Specialties (312-951-0207)

   d. National Certification Board of Pediatric Nurse Practitioners and Nurses (888-641-2767)

   e. Oncology Nurses Certification Corporation (412-859-6104)

   f. Critical Care Certification Corporation (949-362-2050 x 334)

3. NPs applying for a Medicare billing number for the first time on or after January 1, 2001 must meet the requirements as follows:

   a. Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a NP in accordance with State law; and

   b. Be certified as a NP by a recognized national certifying body that has established standards for NPs.

4. NPs applying for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements as follows:

   a. Be a registered professional nurse who is authorized by the State in which services are furnished to practice as a NP in accordance with State law;
b. Be certified as a NP by a recognized national certifying body that has established standards for NPs; and

c. Possess a master’s degree in nursing.

*Please note: The American Academy of Nurse Practitioners Certification Program certifies: Adult Nurse Practitioners, Family Nurse Practitioners and Adult-Gerontology Primary Care Nurse Practitioners.

The American Nurse Credentialing Center certifies: Adult, Adult-Gerontology Acute Care, Adult-Gerontology Primary Care, Family, Pediatric Primary Care and Psychiatric-Mental Health Nurse Practitioners.

Covered Services

Coverage is limited to the services a NP is legally authorized to perform in accordance with New York State law or State regulatory mechanisms established by State law.

1. General
   The services of a NP provided in a facility may be covered under Part B if all of the following conditions are met:
   - The service is the type that is considered a physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO).
   - The service is performed by a person who meets the definition of a NP.
   - The NP is legally authorized to furnish the services in the State in which the services are performed.
   - The service is performed in collaboration with an MD/DO as required by state law.
   - The service is not otherwise precluded from coverage because of one of the statuary exclusions.

2. Types of Services That May Be Covered
   The following are examples of the types of service that NPs may provide:
   - Services that traditionally may have been reserved to physicians, such as physical examinations, minor surgeries, setting casts for simple fractures, interpreting x-rays and other activities that involve an independent evaluation or treatment of the patient’s condition.
   - Services and supplies furnished “incident-to” a NP’s services that would have been covered if furnished “incident-to” the services of an MD/DO.
State law or regulations governing NP scope of practice applies.


NP services **may not** be covered if they are otherwise excluded from coverage even though a NP may be authorized by New York State law to perform them. For example, Medicare excludes from coverage routine foot care, routine physical checkups with the exception of Annual Wellness Visits (AWVs) under the Medicare Fee-For-Service program (Original Medicare), and other services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body members. Also payment will not be made under Part B for services that could be covered under Part A. Therefore these services are precluded from coverage as NP services even though they may be within a NP’s scope of practice under New York State law.

The American Academy of Nurse Practitioners (now the American Association of Nurse Practitioners) in their March 1997 issue of Academy Update, clarified current Medicare regulations regarding payment for services of nurse practitioners in hospitals. They noted, “recently”, directives have been sent to Medicare providers from certain carriers clarifying reimbursement policies for all providers in hospital settings. These directives were written to clarify already established rules regarding the billing for “bundled” services to patients in hospitals. These rules state that all services provided to hospital inpatients and outpatients “except for the (defined) professional services of physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists, must be provided by the hospital directly or by others under arrangements made by the hospital and only the hospital may bill its Medicare intermediary for (those) services.”

“Incident-to” services provided in hospitals in this instance have been very narrowly defined; such services are defined to be the responsibility of the hospital for implementation and are “included in the Medicare payment to the hospital.” If it is desired that the staff of a particular physician provide “incident-to services in the hospital” arrangement for payment must be made with the hospital. According to this interpretation, there is no payment for “supervisory services” in the circumstances listed above. (Source: Department of Health and Human Services Health Care Financing Administration Memorandum to All Associate Regional Administrators, Division of Medicare (10/28/96). For further information contact the AANP Federal Government Affairs office at (703) 740-2529.

Effective 1/1/98, legislation authorized direct Medicare reimbursement for NPs regardless of geographic setting.
“Incident-To” Billing

“Incident-To” Requirement

"Incident-to" services are those that are performed by ancillary personnel under the supervision of a qualified Medicare provider. Furthermore, any person performing an "incident-to" service must be a part-time, full-time, or leased employee of the organization or an employee of the legal entity that employs the supervising qualified Medicare provider.

The incident-to rules permit a physician to bill for the services of non-physician mid-level providers and auxiliary personnel as if the physician performed those services him/herself. To be covered on an incident-to basis, the services and supplies must be:

- an integral, although incidental, part of the physician’s professional service
- commonly rendered without charge or included in the physician’s bill
- of a type that are commonly furnished in physician offices or clinics
- furnished by the physician or by auxiliary personnel under the physician’s direct supervision

Incident-To the Physician’s Services

Incident-to services must be integral though incidental to the physician’s services. The Centers for Medicare and Medicaid Services (CMS) has interpreted this to mean that there must have been a physician’s service rendered to which the auxiliary personnel services are incidental.

According to CMS, this does not mean that a physician’s service must precede every single incident-to service. There must have been a physician’s service which initiates the course of treatment during which incident-to services will be rendered.

Example:
- A new patient evaluation and management visit could never be performed on an incident-to basis by auxiliary personnel.
- However, follow-up low-level visits after the new patient visit has been conducted could be performed on an incident-to basis by non-physician personnel.

CMS has also interpreted the "incidental" requirement to mean that the physician must not only perform a service initiating a course of treatment, but also performs subsequent services of a frequency which reflect his or her active participation in and management of the course of treatment. CMS has not,
however, established any specific frequency of subsequent services the physician must perform in order to meet this standard.

It should be noted that in some state Medicare carriers have adopted local coverage determination policies on the incident-to requirements and, in fact, some carriers do, in their local policies, prescribe the frequency of subsequent services that must be provided by the treating physician. It is important, therefore, that physicians check with their Medicare carriers for local coverage determinations relating to the incident-to rules.

Only In the Office Setting

Incident-to rules only apply to services rendered in the physician office setting. The regulations expressly state that services and supplies must be furnished in a "non-institutional setting to non-institutional patients" in order to be covered as incident-to. CMS has also provided guidance on this provision stating that where auxiliary personnel perform services outside of the office setting, such as in a patient’s home or an institution (other than a hospital or skilled nursing facility), their services may be covered under the incident-to rules only if there is direct supervision by the physician. The supervision requirements require that the physician be in the office suite where the services are being rendered, in a non-office setting, direct supervision would require that the physician be in the immediate presence of the auxiliary personnel while the services are being rendered.

Direct Physician Supervision

To be covered as incident-to services, the services must be performed under the direct supervision of the physician. Direct supervision is defined as presence in the office suite where the services are being rendered, at all times while the services are being rendered. Additionally, the physician must be immediately available to assist if needed.

The supervision must be provided at all times while the services are being rendered. Neither the regulations nor CMS’s Manual guidance allow for any flexibility in this rule! Lunch breaks, coffee breaks and even bathroom breaks that take the physician out of the office suite or otherwise render the physician unavailable to immediately respond if needed could potentially violate the rule.

In a group practice setting, the incident-to rules do provide for some flexibility when it comes to the supervision requirement. Specifically, in a "physician-directed clinic" any physician in the clinic may serve as the supervising physician. According to the Medicare Benefit Policy Manual, a "physician-directed clinic" is one where (1) a physician (or a number of physicians) is present to perform medical rather than administrative services at all times while the clinic is open, (2) each patient is under the care of a clinic physician, and (3) the non-physician services are under medical supervision.
The physician must be immediately available to assist at all times that the incident-to services are being rendered. CMS has not provided clarification on the immediate availability requirement so, while physicians may be tempted to apply their own definition of "immediate," the safest approach is to assume that "immediate" means without delay. In addition, even if the physician is in the office suite, office barriers could prevent his or her immediate access to the patient receiving the incident-to services. So, locked doors, hallways or staircases within the office suite should be given consideration when determining where the supervising physician must be in order to be capable of immediately responding if needed.

**Who Can Perform Incident-To Services**

The incident-to rules were originally designed to permit physicians to bill for the services of office personnel such as technicians, medical assistants and nurses. CMS has extended the incident-to rules to services rendered by mid-level providers such as certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists. Even though these mid-level providers may obtain their own Medicare provider numbers and bill for services directly, the incident-to rules would enable a physician to bill for these services under the physician’s number.


Here is a more lay explanation of how incident-to services work as well as another Medicare concept called split/shared services and the reimbursement tied to these services.

**Medicare’s Incident-To Concept**

The concept behind incident-to billing is that Medicare will pay for services and supplies furnished incident-to a physician’s (or other practitioner’s) services that are commonly included in the physician’s or practitioner’s bills and for which payment is not made under a separate Medicare benefit category. To be covered as incident-to the services of a physician, the services and supplies furnished by the auxiliary personnel must meet the following conditions:

- they must be an integral, although incidental, part of the physician’s professional service
- they must be commonly rendered without charge or included in the physician’s bills
- they must be of a type that is commonly furnished in physician offices or clinics
- they must be furnished by the physician or by auxiliary personnel under the physician’s direct supervision
Beyond the aforementioned basic conditions of incident-to billing, there are other important considerations associated with such billing. These include, but are not limited to:

1. An incident-to service must fall under the definition of “direct supervision” (having the physician present in the office suite and immediately available to provide assistance and direction throughout the time that the auxiliary personnel are performing incident-to services;

2. An incident-to service cannot be rendered by the physician extender or other auxiliary personnel on the patient’s first visit or to address a new problem; and,

3. An incident-to service cannot be billed for hospital patients and for patients in a skilled nursing facility that is in a Medicare-covered stay. (The alternative for these situations often is to bill such services under the provider number of the nurse practitioner or physician assistant, as will be discussed later.)

Incident-to services are paid as if the physician provided them. As such, these services are reimbursed at 100% of the Medicare physician fee schedule. In contrast, payments for services rendered by physician assistants and nurse practitioners and billed directly using their individual Medicare billing numbers each have certain limits.

**Medicare Payment Rates for Non-Physician Practitioners (NPP)**
To be considered an “employee,” the non-physician performing incident-to services may be part-time, full-time or a leased employee of the supervising physician, group practice or legal entity that employs the physician (clinic).

The Balanced Budget Act of 1997 established payment rates for the following non-physician practitioners when they are billing under their own provider numbers and not incident-to:

- NP – 85% of the fee schedule amount
- CNS – 85% of the fee schedule amount
- CNM – 100% of the fee schedule amount
- CP – fee schedule amount
- CSW – fee schedule amount

**Incident-To Basics**

Medicare defines incident-to services as those “furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness”. Medicare further requires “direct personal supervision” of the NPP: “the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services”. The patient must also be an established patient and have an established problem with a treatment plan in place. If the shared office encounter
between your physician and an NPP doesn’t fulfill these requirements, bill using the NPP’s National Provider Identifier (NPI). (CMS Pub. 100-02. Chap 15, Sect. 60.1)

**Who Can Perform These Services**

Incident-to services are commonly furnished without charge, or are included in the physician’s bill. They can only be furnished by an individual who qualifies as an employee of the physician. These services are rendered in the office setting under the direct personal supervision (present in the office suite) of a physician. Again, these services cannot be billed by the physician in a hospital setting (see section on split/shared).

CMS’s instruction to carriers states that these rules apply to the practice’s personnel (employed or leased) “such as nurses, technicians and therapists.” CMS also explains that physicians can bill incident-to for the services of “certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists.” (However, make sure you check your state licensing requirements and Medicare’s requirements for billing incident-to services.) (CMS Pub. 100-02. Chap 15, Sect. 60.2)

[Note: To ensure proper reimbursement according to the fee schedule, documentation submitted to support billing incident-to services must link the non-physician practitioner (NPs and CNSs) with the supervising physician. Evidence of this link may include: co-signature/legible identity of the practitioner providing care and the supervising physician on documentation entries; notation of supervising physician’s involvement within the text of the associated medical record entry; documentation from additional dates of service, other than those requested, which establishes the link between the two providers.]

As a result of the Balanced Budget Act of 1997, and effective 01/01/1998, nurse practitioners (NPs) and certified nurse specialists (CNSs) practicing independently may choose to bill Medicare directly for services within their “scope of practice.” Claims may be submitted under their National Provider Identifier (NPI), using their own tax identification number (TIN), and are reimbursed according to a separate fee schedule.

While NPs and CNSs can bill for their own services directly, there are instances in which their services may be billed incident-to a physician. Services provided incident-to a physician service must meet all incident-to criteria. These services are reimbursed under the physician fee schedule as if the physician actually performed them. They are billed with the employing/supervising physician’s NPI in item 33 of the CMS claim form.

**What Services May Be Performed**

There are certain services allowed under the incident-to billing rules. Non-physician practitioners can render incident-to a physician’s professional services “not only services ordinarily rendered by a physician’s office staff person (e.g., medical services such as taking blood pressures and temperatures, giving injections, and changing
dressings) but also services ordinarily performed by the physician such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient’s condition.” (CMS Pub. 100-02. Chap 15, Sect. 60.2)

Supervision Requirements for Incident-To Services

Did you know that when your non-physician practitioner (NPP) services are billed ‘incident-to’ one physician, but that physician is out of the office on a day when the NPP sees his patient, another physician in the same group can provide direct supervision to meet the incident-to requirements?

Here’s an example: Let’s say that Dr. Smith treated the patient on his first visit for hypertension. The patient comes back for a follow-up exam four weeks later and is treated by the NP. Dr. Jones, another physician in the practice, is on-site when the NP provides that follow-up care. The NP can provide the follow-up care under the “incident-to” billing mechanism, but the service must be billed under the physician who is physically on-site providing supervision. The CMS-1500 claim form would show the name of Dr. Jones and payment would be made to the practice at 100%.

Where Services May Be Performed [CMS SE0041]

Physician Office

In a physician office, qualifying “incident-to” services must be provided by a caregiver whom is directly supervise by a physician, and who represents a direct financial expense to the physician (such as “W-2” or leased employee, or an independent contractor.)

The physician does not have to be physically present in the treatment room while the service is being provided, but must be present in the immediate office suite to render assistance if needed. If the physician is a solo practitioner, they must directly supervise the care. If the physician is in a group, any physician member of the group may be present in the office to supervise.

The patient must also be an established patient and have an established problem with a treatment plan in place. If the shared office encounter between the physician and the Non Physician Provider (NPP) doesn’t fulfill these requirements, bill using the NPP’s NPI. (CMS Pub. 100-02. Chap 15, Sect. 60.1)

Hospital or Skilled Nursing Facility (SNF)

For inpatient or outpatient hospital services and services to residents in a Part A covered stay in a SNF, the unbundling provision (1862(a)(14) provides that payment for all services are made to the hospital or SNF by a Medicare intermediary (except for certain professional services personally performed by physicians and other allied health
professionals.) Therefore, incident-to services are not separately billable to the carrier or payable under the physician fee schedule.

**Offices in Institutions**

In institutions including SNF, your office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility. Your staff may provide service incident-to your service in the office to outpatients, to patients who are not in a Medicare covered stay or in a Medicare certified part of a SNF. If your employee (or contractor) provides services outside of your “office”, these services would not qualify as “incident-to” unless you are physically present where the service is being provided. One exception is that certain chemotherapy “incident-to” services are excluded from the bundled SNF payments and may be separately billable to the carrier.

**In Patients’ Homes**

In general, you must be present in the patient’s home for the service to qualify as an “incident-to” service. There are some exceptions to this direct supervision requirement that apply to homebound patients in medically underserved areas where there are no available home health services only for certain limited services found in Pub. 100-02. Chapter 15, Sect 60.4 (B). In this instance, you need not be physically present in the home when the service is performed, although general supervision of the service is required. You must order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the service. All other incident-to requirements must be met. A second exception applies when the service at home is an individual or intermittent service performed by personnel meeting pertinent state requirements (e.g., nurse, technician, or physician extender), and is an integral part of the physician’s services to the patient.

**More Incidents-To Regulations to Note**

Note that in order to be considered “direct” supervision, the physician must be present in the office suite and immediately available to provide assistance throughout the time the employee is performing the incident-to service. In addition, the physician must initiate the course of treatment and provide subsequent services of a frequency that reflects active participation and management. Having the physician available by phone does not constitute direct supervision.

There is no Part B Medicare payment for incident-to in a hospital setting.

Professionals such as dietitians and pharmacists, working as part time or full time employees or leased employees of a physician, (per federal criteria), may perform services incident-to a physician in the office site of service. The services must be medically necessary and the physician must perform the initial encounter for the condition being treated. The only code these providers may bill as incident-to is 99211 (established patient visit). (Medicare)
Non-Physician Practitioner Rules

There will be times when your NPP’s services won’t fit under the incident-to provision. In those cases, you must bill directly under the NPP’s own provider number.

Nurse Practitioners (CMS Pub. 100-02. Chap 15, Sect. 200)

In order to bill for the services of a nurse practitioner in his or her name and Medicare billing number (and not as an incident-to service), several requirements must be met. If a nurse practitioner already has received a Medicare billing number, a physician or physician group may add the nurse practitioner to its Medicare assignment account. If a nurse practitioner applies for a Medicare billing number for the first time on or after January 1, 2003, he or she must be licensed by the state in which he or she intends to practice and meet certain educational and certification requirements set forth in Medicare’s rules and regulations.

Coverage for the services of nurse practitioners is limited to the services that a nurse practitioner is legally authorized to perform in accordance with state law and regulations. In addition, all of the following conditions must be met for the services of a nurse practitioner to be covered when billed by a physician or physician group using the nurse practitioner’s Medicare billing number:

- They are the types of services that are considered to be physician’s services when furnished by a doctor of medicine or osteopathy;

- They are furnished by a person who has received a Medicare billing number as having satisfied the aforementioned qualifications to obtain such a number;

- The nurse practitioner is legally authorized to furnish the services in the state in which they are performed;

- The services are furnished in collaboration with a physician as required by state law; and,

- The services are not otherwise precluded from coverage because of a statutory exclusion.

Medicare defines “collaboration” as being a process in which a nurse practitioner works with one or more physicians to deliver health care services, with medical direction and appropriate supervision as required by the law of the state in which the services are furnished. Where a state does not have a law or regulations that govern collaboration, it is to be evidenced for Medicare purposes by the nurse practitioner documenting the scope of his or her practice and the relationships that he or she has with physicians to handle issues that arise which are outside the scope of his or her practice.
For Medicare billing purposes, when billing under the nurse practitioner benefit (and not as an incident-to service), the collaborating physician does not need to be present with the nurse practitioner when the services are furnished. Supervision requirements are set by state law.

When a physician or group practice bills in the name of a nurse practitioner and uses his or her Medicare billing number, payment will be made at the lower of 80% of the actual charge or 85% of the physician fee schedule amount.

Services and supplies furnished incident-to the services of nurse practitioners may also be covered if they would have been covered when furnished incident-to the services of a physician. Nurse practitioners may be employees or independent contractors of a physician or physician group in order to allow the physician or group to bill for their services. Nurse practitioners are also permitted to bill independently or to form their own entities to bill and receive payment from Medicare.

**Split/Shared Billing**

**Medicare’s Split/Shared Concept**

This policy allows you to bill an Evaluation and Management (E/M) visit that was shared by an NP, PA or CNS and a physician – combining the documentation of both practitioners to come up with the E/M level – under either the physician’s or the non-physician practitioner’s (NPP’s) Medicare billing number.

There are a few catches to this, and some differences between the office or clinic setting and the outpatient, inpatient or emergency department settings. Here are some rules to remember so you know you are billing it correctly.

**For the office/clinic setting**, the rules seem pretty straightforward:

1. The visit MUST meet incident-to rules to be billed under the physician’s National Provider Identifier (NPI). The only problem, of course, is many individuals still don’t understand incident-to rules. To meet the incident-to rule, the patient must be an established patient, with a treatment plan already established by the physician for the specific condition(s). And, if there’s a new diagnosis, you are walking on thin ice – because “incident-to” means that there was a service by the physician prior to this encounter, to which the NPP’s service is incidental.

2. If the physician and NPP share/split an E/M visit in the office setting, and the visit doesn’t meet incident-to rules (i.e., new patient or a new problem/symptom), the service must be billed under the non-physician’s NPI, and payment will be made at 85% of the physician fee schedule amount.

3. Also, CMS has made it very clear that you cannot bill a consultation visit as a shared E/M visit.
You also cannot bill a consultation as an incident-to visit, because it would never meet the definition of incident-to. To bill a shared visit in the office/clinic under the physician’s NPI, it has to meet the definition of incident-to. Therefore, you would never bill a consultation as a shared visit because the physician has not performed the initial visit to satisfy “incident-to” regulations.

**For the hospital inpatient, outpatient, or emergency department settings**, the rules are a bit more complicated because there’s no incident-to in these settings. (You may never bill incident-to services in these settings, shared or otherwise.) CMS had to spell out the rules a little more:

1. The NPP and physician who are sharing the Evaluation and Management (E/M) visit must be from the same group practice or employed by the same employer.

2. The physician must provide a face-to-face encounter with the patient and perform a portion of the E/M visit. This means he/she can’t just pop in the room and say hello, then leave. The portion of the E/M encounter must be face-to-face in order to bill under the physician’s NPI, and the visit must be medically necessary.

3. The physician must document his/her part of the E/M encounter.

4. Consultations cannot be billed as a shared E/M visit in the hospital setting.

5. Critical care services do not apply to shared E/M visits.

**Split/Shared Basics**

**Office/Clinic Setting**

In the office/clinic setting when the physician performs the Evaluation and Management (E/M) service, the service must be reported using the physician’s National Provider Identifier (NPI). When an E/M service is a shared/split encounter between a physician and an NPP, the service is considered to have been performed incident-to if the requirements for incident-to are met and the patient is an established patient. If incident-to requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s NPI, and payment will be made at the appropriate Medicare Physician Fee Schedule (MPFS) payment.

**Hospital Inpatient/Outpatient/Emergency Department Setting**

When a hospital inpatient/hospital outpatient or emergency department E/M service is shared between a physician and an NPP from the same group practice, and the physician provides any face-to-face portion of the E/M encounter with the patient, then the service may be billed under either the physician’s or the NPP’s NPI. However, if
there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s NPI. Payment will be made at the appropriate MPFS rate based on the NPI entered on the claim. (CMS Pub. 100-02. Chap 15, Sect. 190)

Who Can Perform These Services

Medicare instructs on how to bill shared services – visits where both non-physician practitioners (NPP) and physicians provide an E/M service to the same patient on the same day. For these types of services, NPPs are defined as those health care professionals such as physician assistants, nurse practitioners and clinical nurse specialists who perform physician services.

Evaluation and management services provided by a physician and an NPP can be combined and the total service is billable at 100% of the physician fee schedule amount for a shared visit.

Meeting the Requirements

To help you navigate reimbursement for various services in various settings, here is an overview:

Office or Clinic Setting

Bill incident-to (paid at 100% fee schedule) if CMS requirements are met; if not, you must bill under the NPP’s NPI (85%).

Medicare is very clear on this issue. According to CMS Transmittal 1776, “When an E/M service is a shared/split encounter between a physician and a non-physician practitioner…the service is considered to have been performed ‘incident-to’ if the requirements for ‘incident-to’ are met and that patient is an established patient. If the ‘incident-to’ requirements are not met…the service must be billed under the NPP’s UPIN/NPI.”

The concept of “shared visit” is not particularly relevant to office visits. Under shared visit rules, the physician has to provide some portion of care. But under incident-to rules, the MD is required only to be on-site and need not personally render a professional service. In this scenario, it makes more sense simply to bill an office visit incident-to.

Hospital Inpatient, Outpatient or Emergency Department Setting

If the physician and non-physician provider (NPP) are employed by the same entity and the physician provides part of the face-to-face encounter, bill the visit under the
physician’s NPI (for 100% payment). If these conditions aren’t met, bill the visit under the NPP’s NPI (for 85% payment).

While NPPs still can’t bill incident-to in the hospital, you can still get full reimbursement if they share their services with the physician. Perhaps the NP conducts rounds at the hospital in the morning and the physician follows with a face-to-face visit later in the day. You can report only one inpatient visit per day but, with the change in Medicare rules, you can now choose to bill it under either the NPP’s or the MD’s NPI. Obviously, you benefit by using the MD’s NPI, since you’ll earn 15% more in fees.

Remember that this rule applies only if the NPP and the MD work for the same entity. It does not apply, for instance, if both provided a service, but the NP was employed by the hospital and the MD for a private practice. If there are two employers, both providers would have to bill the visit with 99499 (unlisted evaluation and management service) and submit the patient’s medical record to the carrier. The payer then would determine how much of the fee associated with the service would be allocated to each, with the physician’s portion being paid at 100% and the NPP’s portion being paid at 85%.

Going the 99499 route can be very inconvenient and time consuming, since it requires a paper claim (as opposed to an electronic one). In cases like this, it’s not unusual for one of the providers to simply file the claim based on their individual portion of the work with no charge being submitted for the work done by the other health care professional.

**Medicare PTAN & UPIN Numbers**

All NP providers enrolled in Medicare may still be issued a Provider Transaction Access Number (PTAN) in order to bill for services through Medicare. This number is to be used when billing for Medicare recipients or ordering durable medical equipment. However, National Health Information Center (NHIC) has discontinued issuing Unique Physician Identification Numbers (UPIN), effective June 29, 2007. CMS extended its UPIN public “look-up” functionality and registry website until May 23, 2008. Under the Medicare Fee for Service (FFS) contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice. For additional information, please check the following Medicare Learning Network (MLN) article # MM5584: [http://www.cms.hhs.gov](http://www.cms.hhs.gov) and search for: MM5584

A Medicare provider number may be obtained by calling 1-877-567-7173. Provider enrollment applications may be obtained at: [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html) or by contacting CMS.

**National Provider Identifier (NPI)**

Beginning March 1, 2008, Medicare Fee-For-Service 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering
fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. For more information call The National Plan and Provider Enumeration System (NPPES): 1-800-465-3203.

Effective January 1, 2008, Medicare requires NPIs to identify the primary providers (the Billing and Pay-To Providers) in Medicare electronic and paper institutional claims (i.e. 8371 and UB-04 claims). You may continue to use the legacy identifier as long as you also use the NPI in these fields.

Overview

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. Beginning May 23, 2007 (May 2008 for small health plans), the NPI has been used in lieu of legacy provider identifiers in the HIPAA standards transactions. Covered entities may invoke contingency plans after May 23, 2007.

If you are a health care provider who bills for services, you probably need an NPI. If you bill Medicare for services, you definitely need an NPI.

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

There are three ways that you can obtain your NPI:

1. Complete the on-line application at the NPPES website: https://nppes.cms.hhs.gov/NPPES/Welcome.do

2. Download the paper application form at http://www.cms.gov/ and search for NPI application form and mail it to the address on the form; or

3. After asking you for your permission, authorize an employer or trusted organization to obtain an NPI for you through bulk enumerations, or Electronic File Interchange (EFI).
Regardless of how you obtain your NPI, it is important that you retain the notification document that NPPES sends to you that contains your NPI. You may need to share this information with other health care partners.

**Reimbursement Rates**

NPs are reimbursed at the lessor of 80% of the actual charge or 85% of the fee schedule amount for physicians (Social Security Act, Section 1848). In the case of assistant at surgery, the reimbursement is the lessor of the actual charge or 85% of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant to surgery. These rates are the same rates that are being paid to rural NPs and NPs providing services in long term care facilities. NPs cannot collect fees if their services have been billed through some other mechanism; i.e. payment twice for the same service is prohibited.

**Medicare Billing Requirements**

As a means of preventing double billing, NPs are now required to submit their own billing number for all professional services “furnished in a facility or other provider settings.” This requirement is obviated only when NPs are performing “facility services and the NPs costs are included in the intermediary payment to the facility.”

**Federal Regulations**

*Published November 2, 1998*

The rule states, “For purposes of Medicare coverage, the collaboration requirement will state that these non-physician practitioners must meet the standards for a collaborative relationship as established by the State in which they are practicing. In the absence of state law or regulation governing collaborative relationships, these non-physician practitioners must document their scope of practice and indicate the relationships that they have with physicians to deal with issues outside their expertise.”

*NYS Department of Health – Emergency Rulemaking (Amendment of Section 86-2.30 of Title 10 NYCRR) Authorizes NPs for Medicaid Reimbursement Equal to MD for conducting the Patient Review Instrument (PRI) in Nursing Home Facilities.*

On July 1, 1999, NPs were authorized to be new admission qualifiers in claiming medical treatments and performing physicals. The PRI is a patient assessment form nursing homes are required to complete. The completed PRI form provides the basis for adjusting each facility’s Medicaid reimbursement rate to appropriately reflect the clinical complexity of its patients and the associated cost of providing services. The PRI assigns higher acuity when patients receive physician-ordered physical and occupational therapy; physician visits for unstable conditions; and certain medical treatments ordered by a physician.
Independent Diagnostic Testing

Federal Requirements
Effective on or after March 15, 1999, carriers will pay for diagnostic procedures under the physician schedule when performed by an NP or CNS when s/he performs a test s/he is authorized by the State to perform.

Team Visits

Effective for services rendered on or after April 1, 1990, a member of a physician/PA/NP team may allow a limited number of visits on a routine basis. As with physician nursing home visits, additional team visits are allowable when the team member adequately substantiates the medical need for more frequent visits to the specific patient. A team consists of physician and a PA acting under the supervision of the physician, or an NP working in collaboration with a physician, or both. A medical group that does not employ a PA or NP cannot be described as a team.

Federal Telehealth Regulations

Nurse Practitioners are authorized as reimbursable referring and consulting providers in the 1999 publication of CMS regulations regarding Medicare reimbursement for telemedicine/telehealth consulting in health professional shortage areas (HPSAs). Under these regulations, referring providers will receive 25% and consulting providers will receive 75% of the allowable Medicare fee for providing telemedicine services to patients. Currently, reimbursement for such activities is limited to when the originating site is either in a rural HPSA or a non-metropolitan statistical area (MSA). In order to obtain their fee, the referring provider must attend the consulting session to present the patient to the consultant. Further information regarding telehealth issues and activities may be obtained from the American Association of Nurse Practitioners, Office of Health Policy.

In cases where telehealth services cross state lines, this may be problematic, depending upon the licensing and scope or practice laws in the state where the patient is located. Therefore, NPs need to be aware of this to ensure that they are legally authorized to practice telehealth in that state.

Federal Regulations Addressing “Split Visits”

CMS transmittal 778 revises the Medicare claims manual publication 100-04, Chapter 12, Section 30.6.10 with the current new CPT codes for follow-up visits and second opinion evaluations beginning January 1, 2006. The revision specifies that shared or split evaluations and management services between a specialist and a Non-Physician Provider (NPP) may not be performed after January 17, 2006. Qualified NPPs may continue to request and/or perform consultation services within the scope of practice and licensure for the NPP in the state where s/he practices.
Medicaid Reimbursement Guidelines

Provider numbers may be obtained by calling New York State Department of Health at: 1-800-541-2831 or by visiting this website for an online application form: http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/06ma025att.pdf

Applications may also be obtained from:
  New York State Department of Health
  Office of Medicaid Management
  Bureau of Enrollment
  99 Washington Avenue
  Suite 3611
  Albany, NY 12210
  Telephone: 518-473-2160

Section 85.43 of Title 10 of the New York State Codes, Rules and Regulations (NYCRR) details the New York Department of Health’s (DOH) requirements that NPs must meet in order to access Medicaid reimbursements.

Section 858.43: Nurse Practitioner Services
  (a) Definitions: (1) NP means a person who is licensed and currently registered as a registered professional nurse in New York State and who is certified as an NP by the New York State Education Department (SED) (see section 6910 of the Education Law and 8 NYCCR section 64.5 and 64.6)

  (b) Scope of care: NPs shall be authorized to provide health care services to eligible medical assistance recipients who fall within the scope of practice for certified NPs as determined by SED (see section 6902 of the Education Law and 8NYCRR sections 52.12, 64.5 and 64.6).

  (c) Medicaid enrollment:
    (1) In order for the NP to provide health care services to eligible medical assistance recipients, s/he must enroll with the New York State Department of Social Services (DSS).

    (2) The licensed physician, in collaboration with the NP, must also enroll with DSS.

    (3) As a condition of enrollment, the NP and the collaborating physician must agree to make their practice agreements and protocols available for inspection by staff of DSS.

Section 505.32 of Title 18 of NYCRR details the DSS requirements that NPs must meet in order to access Medicaid reimbursement. www.health.state.ny.us/nysdoh/phforum/nyccr18.htm
(a) Definitions:

(1) NP means an individual who is licensed and currently registered as a professional nurse in the State and who is certified under section 6910 of the Education Law as a NP.

(2) NP services means the provision of services to a medical assistance (MA) recipient which are in conformity with the provisions of sections 6902 and 6910 of the Education Law, regulations of the Education Department and regulations of the Department of Health.

(3) Collaborating physician means a physician who is not excluded from participation in either the MA or the Medicare programs, with whom the NP maintains practice agreements and practice protocols in accordance with section 6902 of the Education Law.

(4) Practice agreements and practice protocols means written documents meeting the requirements of section 6902 of the Education Law and 8 NYCRR section 64.6 of SED’s regulations.

(b) Written practice agreement and practice protocols required:
Written practice agreements and practice protocols between NPs and their collaborating physicians must contain the provisions required by the Education Law and regulations of SED, including provisions for the collaborating physician’s review of patient records at least every three months. The physician’s review of patients records is not a billable service under the MA program. The NP must make the written practice agreement and practice protocols and evidence that the collaborating physician has reviewed patient records available to the department and its agents for the purpose of conducting audits under the MA programs.

(c) Identification of collaborating physicians required
The NP must submit the name and other identifying information concerning the collaborating physician within the NPs enrollment application.

(d) Payment for NP Services:
Medical Assistance (MA) coverage for NP services is available in accordance with the provisions of this subdivision.

(1) Except as otherwise provided in this subdivision, payment for NP services must be in accordance with the fees established by the DOH and approved by the Director of the Budget.

(2) Payment is available for NPs’ services which are part of the development of, or furnished pursuant to an individualized education program and which are provided by an NP employed by, or under contract to, a school district, an
approved preschool or a County in the State or the City of New York. Reimbursement for such services must be made in accordance with the provider agreement.

(3) Payment is available for NPs’ services which are part of the development of, or furnished pursuant to, an interim or final individualized family services plan and are provided by an NP employed by, or under contact to, an approved early intervention program, or a municipality in the State. Reimbursement for such services must be made in accordance with the provider agreement.

(4) Payment for NP services provided by an NP who is paid a salary by a medical facility which is reimbursed under the MA program for its services on a rate basis will be made on a fee for service basis only if the cost of the NP service is not included in the facility’s cost-based rate.

(5) Payment will be made for medically necessary ancillary services which are covered under the MA program and which the NP orders for an MA recipient. Payment will only be made for prescription drugs when prescribed by an NP who has the authority to write prescriptions under the provisions of the Education Law and regulations of the Education Department.

(e) This section is effective for services provided by NPs on and after July 1, 1990.

(f) Preferred Physicians and Children Program

(1) Scope. The Preferred Physicians and Children Program (PPAC) is a program under which a written agreement is entered into by a provider and the department pursuant to which the department pays enhanced fees for certain medical services provided to children under the age of 21 who are eligible for Medical Assistance (MA). Only qualified nurse practitioners meeting the requirements of this section are eligible to participate in PPAC. Nurse practitioners who wish to participate in PPAC must apply in writing on forms provided by the department. Applications for participation will be reviewed by and must receive approval of the department and the Department of Health. Participating nurse practitioners may obtain payment at the enhanced fees for medical services by using special PPAC procedure codes on their MA claims.

There are additional sub paragraphs in this section that are not included here. To review those sub-paragraphs please see 18 NYCRR 5085.32 (f) et. seq. at: http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm
Preceptorship, Collaboration and Supervision versus Collegiality

Precepting a NP student is a supervisory position, rather than a collegial one. The word supervise is defined in the American Heritage Dictionary of the English Language as “to direct and inspect the performance of workers or work; oversee”. Supervision entails the NP preceptor also seeing the patient and confirming the student’s findings, assessment and plan of care, and assuming full responsibility for the care of the patient as administered by the student. Supervision denotes a vertical relationship, where collegial infers a horizontal relationship between the individuals; this is signified by the requirement that “student” notes must be co-signed by the supervising NP. Faculty at Syracuse University, SUNY Stony Brook and Community General Hospital have confirmed this interpretation of supervision.

The precepting NP must follow the appropriate rules and regulations pertaining to her/his practice. Therefore, precepting may only be done in the specialty area in which the NP is certified.

Precepting a NP Student from an Out-of-State Program
The NP being asked to precept a NP student attending an out-of-state NP program is advised to proceed carefully before agreeing to do so.

The NP in this situation is strongly advised to verify with the State Education Department (SED) whether the out-of-state NP program is registered to operate in New York. This may be done by consulting the “Inventory of Registered Programs” maintained by SED at this link: http://www.nysed.gov/heds/IRPSL1.html or by contacting the Office of Professional Education at 518-474-3817 x 360. If the institution you are looking for does not appear in your search call the above phone number for verification of registered status.

SED has provided guidance regarding serving as a preceptor as well as guidance regarding out-of-state institutions seeking to have their NP students complete clinical education coursework within New York.

Per SED:

- **NOTICE:** An out-of-state institution seeking to offer credit-bearing courses or portions of college programs in New York State must secure prior consent of the Board of Regents in accordance with Section 224 of State Education Law and Section 3.56 of the Rules of the Board of Regents. Permission to operate is required even if the institution is approved in another state, and regardless of the fact that the institution may be accredited. Furthermore, Section 6908 of the Education Law restricts the practice of nursing to licensed persons or students enrolled in educational programs registered by the State Education Department. This law protects the title of nursing and is applicable to programs that lead to the
The title of Registered Professional Nursing (RN), Nurse Practitioner (NP) and Certified Nurse Midwifery (CNM) and Clinical Nurse Specialist (CNS).

IF: The student is:
- Enrolled in a pre-licensure RN program or a program that results in a new certification such as a Nurse Practitioner or Nurse Midwife or Clinical Nurse Specialist;

THEN: The student:
- May not be assigned to clinical in NYS under any circumstance unless the college has applied for ‘permission to operate’ through this department and received authorization from the Board of Regents.

The typical student in this scenario is a student enrolled in a program that leads to a Master’s degree as an NP, CNM, or CNS or a post-B.S. DNP or a pre-licensure RN program.

It is important to note that a NP student from an unregistered program that performs clinical functions in New York does not have authority to practice and the NP who precepts a student in such a situation could be found to have committed professional misconduct.

While precepting NP students is greatly encouraged the NP preceptor must be sure to avoid the above situation.

The term “collaboration” is defined as a process whereby an NP works with a MD or DO to deliver health care services within the scope of the practitioner’s professional expertise.

Practice Questions

Certification Questions

1. What is the acceptable scope of practice for the NP in New York State?

Title VIII of the NYS Education Law, Article 139 (Nursing), Section 6902 (3) identifies the NP’s scope of practice. This document may be found in Appendix A of this document. NOTE: NYSED no longer prints or provides paper or hard copies of information. The current Complete Application Packet for Nurse Practitioners may be obtained from the NYSED website located at http://www.op.nysed.gov/prof/nurse/

To contact the NYSED directly you may use the information below.

The University of the State of New York
State Education Department

Telephone: 518-474-3817
Fax: 518-402-5354
2. How does one apply for a certificate from the State of New York to practice as an NP?

While in many instances the term “NP license” is used by NYSED and others, the proper reference for NPs in New York State is “certified NP”. This is not to be confused with National Certification by a national certification body such as AANP or ANCC or the requirement of federal insurance programs such as Medicare/Medicaid.

Part 64, Section 64.4 (a) and (b) of the Regulations of the Commissioner of Education specify the requirements to obtain nurse practitioner certification in the State of New York. This information may be found in Appendix B of this document or is available from http://www.op.nysed.gov/prof/nurse/ and then looking at the nurse practitioner link under the "application forms" tab on that page.

3. Is there any other way in which a person may be certified in New York State as an NP?

No. All persons wishing to practice as an NP in New York State must receive certification by the New York State Education Department.

4. If a certified NP wishes to change or expand her/his specialty area, must s/he complete another nurse practitioner program in the additional specialty area?

Yes. An NP may expand her/his specialty area by completing an NP program in one or more specialty areas.

The following is a summary of nurse practitioner specialty titles recognized in New York State.

*Acute Care
Adult Health
College Health
*Community Health
Family Health
Gerontology

*Holistic Care
Neonatology
OB/GYN
*Oncology
*Palliative Care
Pediatrics

Perinatology
Psychiatry
School Health
Women’s Health

*No age restriction

Additional information may be obtained by contacting the SED Office of the Professions at 518-474-3817.
5. Is there a state requirement specifying the number of hours an NP must work per calendar year in order to maintain her/his license?

No. There is not a state requirement regarding the number of hours that an NP must work in order to maintain her/his license.

6. May new NP graduates who are waiting for their NP certification number see patients?

No. NPs may not independently see patients until their certification number is known. A candidate may check online using the search tool at the “Online Services” tab of the Office of the Professions website [http://www.op.nysed.gov/](http://www.op.nysed.gov/) or call the NP Processing Unit of the New York State Education Department (SED) at 518-474-3817 ext. 270 to ascertain if their certification number has been assigned. If their certification number has been assigned, NPs will be given the number and they may begin seeing patients prior to receiving written confirmation. NPs may also obtain their certification number by looking at the NYSED website at [http://www.op.nysed.gov/prof/nurse/](http://www.op.nysed.gov/prof/nurse/) and selecting the “Online Services” tab at the top of the page. This will bring you to the “Verification Searches” and from here you select “Nurse Practitioner – All Specialties”, type your name in the box below and select “Search”. Your “license” number will be found here.

7. Changes in licensee’s address and name.

The Education Law requires that a licensee must notify the Department within 30 days of a change in mailing address or in name. You could be charged with unprofessional conduct for willful failure if you fail to notify the Department of an address or name change. Your notification must include your name, profession, license number, social security number, date of birth, and both your old and new address.

For address changes you may notify the Department in one of three ways.

1. Email your information: [oparchive@mail.nysed.gov](mailto:oparchive@mail.nysed.gov)

2. Call the automated phone attendant (available 24 hours a day, 7 days a week) at 518-474-3817. Operators are available to assist you Monday – Friday, 8:30 am – 4:45 pm (EST).

3. Write to: Division of Professional Licensing Services, Office of the Professions, State Education Building, 2nd Floor, 89 Washington Avenue, Albany, NY 12234-1000.

A name change must be submitted in writing using form AD/NAME. You can access a form for name and address change at the Office of Professions website [www.op.nysed.gov/prof/nurse](http://www.op.nysed.gov/prof/nurse) and then looking at the nurse practitioner link under the “Application Forms” tab on that page.

Form AD/Name is available in Appendix F of this guide.

**Collaborative Practice Agreement**

1. What should be included in a collaborative practice agreement?
Title VIII of the Education Law, Article 139, Sections 6902.3 (a), (b), (c) and (e) found in Appendix A of this document or at www.op.nysed.gov identifies specific areas to be addressed in the practice agreement. Part 64, Section 64.5 (a) and (b) of the Regulations of the Commissioner of Education identifies these areas further. This information may be found in Appendix B of this document or at www.op.nysed.gov. You can also refer to Appendix C: Collaborative Agreements and Practice Protocol for more information.

Each collaborative practice agreement will include provisions for referral and consultation, coverage for emergency absence of either the NP or the collaborating physician, resolution of disagreements concerning diagnosis and treatment, review of patient records, and other such provisions determined to be relevant by the NP and collaborating physician. A sample collaborative practice agreement is a benefit of your membership in The NPA. A copy may be found in Appendix C. A sample collaborative practice agreement is also available from The New York State Board for Nursing at www.op.nysed.gov/prof/nurse/ and then selecting Nurse Practitioner under “License Requirements” on that page and scrolling to the bottom of the next page to find a link in the paragraph titled “Collaborative Agreements”.

2. Is there a limit to the number of collaborative physicians, and therefore practice agreements, the NP may have at one time?

Title VIII of the New York State Education Law, Article 139 (Nursing) section 6902 does not set forth any limit of the number of practice agreements a NP may have with physicians. However, there is a limit to the number of offsite nurse practitioners a physician may have collaborative agreements with. Section 6902.3(e) states “no physician shall enter into practice agreements with more than four nurse practitioners who are not located on the same physical premises as the collaborating physician.” As stated above, the law does not address the number of agreements the NP may establish.

3. May an NP have a collaborative agreement with a physician who is part-time or even retired or inactive?

Yes, so long as the physician maintains her/his license in good standing. In such instances, it is advisable that the practice agreement states that patients will be referred to another designated physician in the area when it is beyond the NP’s scope of practice.

4. What is done with the collaborative practice agreement once it is written and signed?

NPs are required to submit only their initial practice agreement(s) to the State Education Department (SED). The collaborative practice agreement is to be maintained in the practice setting of the nurse practitioner. The practice agreement shall be available to the Department of Education for inspection. It is suggested that the NP also retain a copy of the practice agreement separate from the practice site.

5. May a psychologist or podiatrist serve as an NP’s collaborator?

No. Only a physician may serve as the NP’s collaborator. NPs may, however, work in a podiatrist’s office but must have a collaborator other than a podiatrist.
Note: The Office of Health Insurance Policy must be notified when there is a change of name and/or address. The required forms may be accessed by going to: https://www.emedny.org/

- Place your cursor on “Information”
- Click on “provider enrollment forms”
- Click on “nurse practitioner” from the list of professions on that page
- Click on the option that applies to you (option 1 or 2)
- Click on the link in the box on the next page and download both the instructions and the application form
- Send the completed form(s) to the address listed on the application form that you downloaded

6. What may a NP do without a written collaborative practice agreement?

A written collaborative practice agreement is required before a NP may perform or do any act as an NP. This includes signing any form where the signature is being affixed as a NP. Without a written collaborative practice agreement a NP may work as a registered nurse.

Practice Protocol

1. What are practice protocol texts?

Title VIII of New York State Education Law, Article 139 (Nursing), Sections 6902.3 (a), (b) and (d) which may be found in Appendix A of this document, all relate to practice protocols. Part 64, Sections 64.5 (a), (c), (d) and (e) of the Regulations of the Commissioner of Education, found in Appendix B of this document, also relate to practice protocols. The State Education Department revises practice protocols every three to four years.

The texts presently accepted by the State Department of Education for use as practice protocols may be found on the New York State Education Department’s Office of the Professions website at http://www.op.nysed.gov/ and in Appendix C of this document. We strongly encourage checking the NYSED website for the most up to date listings.

2. What may a NP do if s/he is unsure if the practice protocol being used is currently accepted by The State Education Department?

Part 64.5 (d) of the commissioners rules state: The department in its discretion or upon request of a nurse practitioner or collaborating physician may review practice protocols for the purpose of insuring that they are in conformance with accepted medical and nursing practice and with the statutes and regulations governing the practice of medicine, nursing, and, the prescribing of drugs and may render an opinion which shall be binding upon the parties to the protocol.
If the department determines that a protocol is inadequate or contrary to current accepted medical and nursing practice it shall communicate that determination and the reasons therefore, to the nurse practitioner and to the collaborating physician in writing. The nurse practitioner and collaborating physician shall conform to accepted medical and nursing practice immediately, and shall submit a revised protocol within 30 days of receipt of the department’s determination, unless an extension of time is requested and granted by the department. Continuation of practice in violation of the determination shall constitute unprofessional conduct by either or both licensees.

Part 64.5 (e) of the commissioner's rules set forth that an appeals process exists if the NP and physician disagree with the determination of the department. Such an appeal may be taken within 30 days after the receipt of the notice of the determination by a petition setting forth the reasons for the appeal, and signed by both the nurse practitioner and the collaborating physician. Such joint appeal shall be filed with the Division of Professional Licensing Services and determined by the Committee of the Professions whose determination shall be final.

**Record Chart Review**

1. **How often must chart/patient record review be done?**

Title VIII of the NYS Education Law, Article 139 (Nursing), Section 6902 (c) states that patient records are to be reviewed by the collaborating physician “in a timely fashion but in no event less than every three months”. Part 64 (Nursing) of the Regulations of the NYS Commissioner of Education, Section 64.5 (b) further clarifies that provision for this review is to be included in the practice agreement between the NP and the collaborating physician. It restates that this review of patient records is to take place at least every three months.

Copies of Title VIII Article 139 may be found in Appendix A of this document. Copies of Part 64 of the Regulations of the Commissioner of Education may be found in Appendix B of this document.

2. **Must all charts/patient records be reviewed by the collaborating physician?**

No. A memo dated July 1998, from Johanna Duncan Poitier, Deputy Commissioner for the Professions, NYS Education Department, clarifies the essentials of record review. A further clarification is made by Assemblyman Richard Gottfried, Assembly Committee on Health, in a letter dated October 22, 2002 to the Deputy Commissioner for the Professions, Johanna Duncan Poitier.

Effective October 2002, the New York State Education Department announced that the requirements for the specific percentage record review will not be set by the New York State Education Department. Rather, the number of records to be reviewed by the NP’s collaborating physician is to be determined by the NP and collaborator given that “at least once every three months there is some exchange with the collaborating physician on the course of actions that have taken place.”
3. Must charts/patient records be co-signed by the collaborating physician?

No. Neither Education law nor the Regulations of the Commissioner of Education state that NP notes in a patient's record/chart must be co-signed by the collaborating physician. However, documentation of dates that records were reviewed by the NP and collaborating physician may be used as a tool to validate that chart review has been done.

4. May third party payers require that charts/patient records be co-signed by the collaborating physician?

Yes. If a third party payer has indicated that this is the only proof of chart review or physician involvement in the patient's care they will accept, and the appropriate representative of the practice has signed an agreement to do so in order to be eligible for reimbursement, the physician must co-sign records. Although not required by law, all members of that practice must abide by the contractual agreement.

5. Must in-patient charts be co-signed by the collaborating physician?

The New York State Education Department does not require that charts be co-signed by the collaborating physician. However, The Joint Commission for Accreditation of Hospitals has made general recommendation that the charts be co-signed. Each hospital has a Credentialing Committee that sets the specific guidelines for that facility. Clarifying information for the nurse practitioner and collaborating physician about patient record reviews may be found in Appendix C of this document.

Pharmacology

1. How does an NP in New York State qualify for prescriptive privileges?

Part 64, Section 64.4 (f) of the Regulations of the Commissioner of Education of the State of New York specifies the process. Section 64.4 (f) of the Regulations may be found in Appendix B of this document or by visiting the New York State Department's website at http://www.op.nysed.gov/

2. What classes of drugs may an NP, who has her/his DEA number, prescribe?

NPs who have their DEA number may prescribe drugs in schedules or classes 2, 3, 4, and 5. She/he may not prescribe schedule or class 1, or research drugs. Drugs that are prescribed by the NP must be pertinent to her/his specialty area and be in accordance with her/his practice agreements and protocols.

3. What drugs may an NP who does not have a DEA number prescribe?

A certified NP without a DEA number may prescribe any of the legend drugs, such as antibiotics, heart remedies, NSAIDS, etc., that are within her/his specialty and in accordance with her/his protocols and practice agreements. An NP without a DEA number may not prescribe any scheduled or classed drugs. She/he may not prescribe benzodiazepines, narcotics, antibiotic steroids, or combination drugs. It makes no difference whether the prescription is a renewal of an original Rx; if it fits into any of the schedules or classes of medications, it may not be prescribed. Some pharmacies will not
accept a prescription from NPs without DEA numbers even for prescriptions other than those requiring DEA numbers (e.g. Antibiotic).

4. May NPs administer medications?

Yes. NPs may administer medications.

5. May an NP receive samples of medications from representative of pharmaceutical companies for distributing to patients?

Yes. NPs may receive and distribute sample medications if currently licensed and certified in New York State, in the case of schedules drugs the NP has a DEA number and as long as the medications are pertinent to his/her specialty area. The information contained on Form 4NP, Verification of Practice Protocol, filed with the state, in combination with the Office of the Professions, New York State Education Department website data is sufficient for verification of current NP licensure.

6. Is a NP required to participate in the I-STOP Prescription Monitoring Program (PMP) when prescribing medications?

Yes. The I-STOP Act signed into law on August 17, 2012 as Chapter 447 of the Laws of 2012 among its other provisions includes a “real time” electronic prescription tracking system that provides prescribers and pharmacists with enhanced information about prescriptions for controlled substances obtained by patients. This is known as the Prescription Monitoring Program or PMP.

The benefits of PMP are:
- The program allows for better understanding of a patient’s controlled substance utilization based on recent controlled substance prescription history
- Provides a quick, confidential online report to the practitioner and the pharmacist
- Available 24 hours a day, 7 days a week
- Information is based on controlled substance prescription data from nearly 5,000 pharmacies
- No cost to the practitioner or pharmacist

The information about dispensed controlled substances as reported by pharmacies is available to prescribers who, in addition to pharmacies have a duty to consult the I-STOP database (PMP) prior to prescribing schedule II - IV medications. A prescriber may designate the consultation duty to a member of their office staff but each prescriber is ultimately responsible for the confidentiality of the information. Any NYS licensed prescriber, excluding Veterinarians, may access the PMP registry.

To access the PMP a practitioner must establish a Health Commerce System Account (HCS). Instructions for establishing a HCS account are available at the Bureau of Narcotic Enforcement website: http://www.health.ny.gov/professionals/narcotic/
The complete requirements and regulations of the I-STOP/PMP are also published at the NYS Department of Health Bureau of Narcotics Enforcement website. It is most important to note that with limited exceptions, every prescriber and pharmacy in New York is required to participate in I-STOP/PMP. The prescriber must consult the PMP (with very limited exceptions) no more than 24 hours prior to issuing the prescription or dispensing the controlled substance. To learn about the PMP and to register to participate in the PMP consult the NYS DOH Bureau of Narcotic Enforcement at http://www.health.ny.gov/professionals/narcotic/ and click on the I-STOP link on the left side of the page. Then follow the instructions located there. Failure to comply with the required participation in the I-STOP/PMP can result in the prescriber being subject to charges of professional misconduct, substantial fines and potential criminal prosecution. (New York PHL Article 1 section 12b)

Nurse Practitioners must be sure that they stay up to date on these requirements and any changes in the system.

7. May NPs dispense medications?

Yes. In 1992 The Nurse Practitioner Association New York State promulgated an amendment to Pharmacy Law that secured the right of NPs to dispense medications under the same guidelines as other authorized prescribers and dispensers of medicines and medical devices. Medications dispensed must indicate the name and strength of the medication and clearly indicate dosing instructions. The patient’s name, the date and the number of tablets dispensed also must be clearly stated. New York State Health Department regulations require that all this information be included in the patient’s record or a separate log.

8. How may a NP obtain the course on federal and state laws, rules, and regulations required to obtain a DEA number?

The NPA has a self-study course that meets these requirements. You will find the course on our website.

9. May a NP prescribe “simple” drugs for family and friends (i.e. cough/cold remedies, antibiotics, antifungals, etc.)?

It is recommended that NPs not prescribe medications for family or friends unless they are the NP’s patients of record. Drugs should not be prescribed for anyone unless the patient has been examined, findings documented, prescriptions and other Rxs recorded, and effect documented. This record should be readily available for review at all times.

10. May NPs prescribe to themselves?

No. NPs (or any other prescriber) should not prescribe for themselves.

11. Where does a NP obtain a DEA number?

A NP obtains a “DEA Number” from the U.S. Department of Justice Drug Enforcement Administration. This can be done online with a credit card to pay the fees at: http://www.deadiversion.usdoj.gov/ select: New Applications".
Or if paying by check you may print a PDF version of the form as the site above and then mail it to the address on the form.

Request for an application for a DEA registration may be made by calling or writing to:

Drug Enforcement Administration
Attn: ODR
PO Box 2639
Springfield, VA 22152-2639
1-800-882-9539

If the DEA number is not received within approximately 8 weeks, you may contact the DEA at the telephone number listed above or at the appropriate DEA field office as identified at this web page: http://www.deadiversion.usdoj.gov/offices_n_dirs/fielddiv/newyork.htm

Title of the Code of Federal Regulations [21 CFR 1301.12 (a)] requires that an NP obtain registration (DEA #) for each principal place of business/professional practice where the NP distributes or dispenses controlled substances. An NP may prescribe at multiple locations within one state as long as s/he is registered at her/his principal place of business or professional practice [21CFR 1301.1.12 (b)].

12. Where does a NP obtain prescription pads?

Nurse Practitioners may obtain a monthly supply of up to 20 prescription pads from the New York State Department of Health, Bureau of Narcotic Enforcement. Prescription pads may be ordered through a Health Commerce System account (HCS) or using form DOH 250 but form DOH 250 may only be used to order if you are prescribing non-narcotics. Prescribers of narcotics MUST obtain their official prescription pads via a HCS account. A HCS account can be established via the NYS DOH Bureau of Narcotic Enforcement at https://apps.health.ny.gov/pub/top.html

Nurse Practitioners my obtain answers to questions concerning narcotics; prescription pads etc. by calling the New York State Department of Health, Bureau of Narcotic Enforcement 1-866-811-7957 and following the prompts.

13. May a NP order and administer medication to induce conscious sedation?

Medication may be ordered and administered for the purposes of conscious sedation for patients undergoing procedures, which require conscious sedation as long as the medications are appropriate to the NP specialty, and addressed in the written practice agreement and practice protocols. Ordering and administering such drugs would be in accord with the diagnosis and treatment of physical illness and physical conditions as permitted in Article 139, Section 6902.3 (a) of Title VII Education Law. If the sedation is to be administered in a hospital setting, the facility may prohibit such order and administration by the NP.
14. How much time should a NP allow to lapse between pharmacology updates in order to maintain safety and currency?

It is recommended that a NP remain current in pharmacology on at least an annual basis. If a NP has been totally out of the clinical practice for more than two years, it would be appropriate to take a refresher course or several classes about newer drugs on the market. If the NP has been totally out of the clinical area more than three years, a regular pharmacy course or refresher course as well as product updates would be more appropriate to keep up with the extremely rapid changes occurring in the field.

15. May a NP order medication for a patient who resides in New York State but who has the prescriptions filled through a mail-order pharmaceutical company?

Yes. According to the New York State Board of Pharmacy, a NP in New York State may order medications out of state; however, prescriptions may not be filled in states in which NPs do not yet have prescriptive privileges.

16. Is a NP required to obtain a new DEA # when s/he changes position?

No. NPs are only required to submit a change of address notification. The forms may be obtained either at [http://www.deadiversion.usdoj.gov/](http://www.deadiversion.usdoj.gov/) or by calling 212-337-1593.

17. Being Denied Prescriptive Privilege – Sometimes a NP is denied prescription privileges by a pharmacy or pharmaceutical company. When this happens it is often because there either exists disciplinary action or legal action that has put them on a “list” or there is a mistake.

Resources:

- **NYS Medicaid Inspector General List**
  Available online at [http://www.omig.ny.gov/](http://www.omig.ny.gov/) click on the RED “X” in the box on the left side of the page and then follow the instructions. Additional resources for provider information are listed at the bottom of the web page. Questions may be emailed to: information@omig.ny.gov

- **Federal List: Centers for Medicare and Medicaid Exclusion List**

  There are several possible reasons a person’s name may be on this list, from disciplinary action to non-payment of scholarships/loans. Being on this list can and does prevent a script from being honored.


18. May a NP prescribe medications without a collaborative practice agreement?

No. A collaborative practice agreement is required for a NP to perform or do any act as a NP including writing prescriptions for any medication.
Liability

1. If the collaborating physician states that the NP does not need separate professional liability insurance, as the collaborator’s insurance will cover the NP, should the NP drop her/his own professional liability insurance?

No. The person who “owns” the policy is the person who “controls” the policy. Nurse Practitioners need to be very careful about whom they will give “control” to relative to their professional liability insurance.

Questions NPs should ask themselves include:

- Is the physician adding the NP as a named insured or as an additional insured? A named insured affords the NP primary coverage. Being an additional insured typically limits the coverage available to the NP.
- Are there limitations in the MDs policy that might impose limitations to the services the NP can provide?
- Will the MDs policy respond to allegations made against the NP for services s/he may provide outside the practice?
- Will the NP have his/her own limits of liability or will they be sharing coverage with the MD? This could result in policy limits being exhausted.
- What happens to this coverage if the MD and the NP terminate their collaborative relationship? In some instances NPs could find themselves without coverage for the time they were insured under their collaborating MDs policy.

The reality is that the collaborating physician’s professional liability insurance covers the physician for his or her own actions and may have the ability to extend coverage to the NP for acts of omission or commission. It may not protect the NP from the consequences of her/his own acts of omission or commission. Because of these uncertainties, the NP should always have her/his own professional liability policy.

Note: Some companies providing physicians with professional liability insurance will refuse to protect the physicians from acts performed by the NP, unless the NP also has a policy with the same company. In these situations, we strongly recommend the NP ask for a copy of the professional liability insurance policy of the collaborator to ensure coverage is appropriately afforded to the NP and that they are aware of any potential limitations of coverage. **It is strongly recommended that NPs always carry their own professional liability insurance policy.**

2. Why are premiums for professional liability so varied, even within the same company?

Every insurance company ‘rates’ or develops premiums for NPs using their own rating models. Those characteristics that tend to drive ‘rates’ for NPs include: area of specialty, where services are being provided, patient population and more. It is also important to note that many companies will afford premium credits or debits that can reduce or increase the cost of the insurance for that risk based on any number of unique risk
characteristics including; recent claims experience versus a long-term claim free policy, commitment to risk management, recent graduates and more. These credits/debits can impact an individual policy by + or – 25%.

It’s also important, when comparing price, to ensure you are comparing apples to apples policies and coverage: For example:

- A claims-made policy will be less expensive than an occurrence policy for the first (typically) four years of the policy. However, when cancelling a claims-made policy the insured will need to consider the purchase of tail coverage. This additional consideration and expense is not required for those who have an occurrence policy form.

- The limits of liability that someone elects to carry will also impact the cost of insurance.

- It’s also important to note that not all companies charge the same rates for NP coverage. Companies who have been providing coverage to NPs for years (10+) have mature programs; understand the risks associated with NP practice and generally charge rates that are commensurate with the NP risk. They have the actuarial resources and historical data that enable them to predict frequency and severity of claims for the class and at the specialty level. They are then able to take this data and develop premiums by specialty. The premiums charged are intended to ensure the company develops sufficient premiums to cover the future claims anticipated for the profession. Look to these companies to be able to provide documentation on risk/exposure associated with NP practice. And, as importantly, look to them to provide NPs with recommendations on how to improve risk and to help create a safer health care environment for the NP and his/her patients. Companies who are “new” to providing coverage to NPs will typically enter the market with lower rates to try and attract insured’s to their programs. Their ability to maintain this rate advantages long-term is suspect. Moreover, the question that needs to be asked is once these companies start to experience expected losses specific to NP exposure will they maintain their appetite/desire to insure NPs?

Based on these factors, it is essential that NPs do their homework on the companies they choose to partner with and to whom they will entrust their professional livelihood.

3. May NPs testify in court on behalf of their patients?

Yes. Nurse Practitioners may testify on behalf of their patients, except in worker’s compensation cases and some other limited circumstances where NYS law specifies.

4. What should NPs do if they receive a complaint from the NYSED Office of the Professions?

If a NP receives a complaint (or any communication) from Office of the Professions it must be reviewed and responded to. Do not ignore it! Ignoring it will not be in the NPs interest or benefit. The NP should contact their personal professional liability insurance company (malpractice insurance company) as many policies cover this type of event. If necessary seek legal advice/assistance to protect the NP’s license.
5. What should NPs do if they receive a notice of a malpractice claim?

The NP should immediately contact their professional liability insurance company (malpractice insurance company) and inform them of the claim. The insurance company will instruct the NP on further steps they deem necessary. Failure to notify the company within the appropriate amount of time can raise issues concerning coverage of the claim. Do not delay notifying your insurance company.

Skilled Nursing Facilities

1. Coverage of NP services in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)

NPs, with an appropriate written collaborative practice agreement, may practice in SNFs as employees to provide medically-related services within their scope of practice. Such employment need not be made through a contractual arrangement with a physician or physician practice.

Effective April 1, 1990 the services performed by a NP working, in collaboration with a physician, in a SNF or nursing facility that meet the definition on 1919(a) of the Social Security Act are covered as medical and other health services.

2. May NPs write orders and sign certification and recertification in SNFs and NFs?

No. The NYS Education Department takes their current position as stated in a memo dated October 2008. (See Appendix F) “A nurse practitioner certified in a specialty other than psychiatry, may within their individual discretion and competence, determine and treat presenting symptoms and signs that may lead to the necessity of a referral to a qualified health care professional for psychiatric intervention. Failure to provide such referral may constitute grounds for a charge of professional misconduct.”

“The following table summarizes the requirements for physician extenders to write orders, when this function is permitted under the scope of practice for the State. In addition, section 424.20(e)(2) of the Codes of Federal Regulations states that NPs and CNSs who are not employed by the facility and are working in collaboration with a physician, when permitted under the scope of practice for the State, may sign the initial certification and the required SNF recertification.” (Center for Medicare and Medicaid Services, April 10, 2003)

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<td>Subsequent Orders</td>
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Psychiatry

1. May Family Nurse Practitioners (FNP) manage psychiatric patients?
No. The NYS Education Department takes their current position as stated in a memo dated October 2008. (see Appendix D) “A nurse practitioner certified in a specialty other than psychiatry, may within their individual discretion and competency, determine and treat presenting symptoms and signs that my lead to the necessity of a referral to a qualified health care professional for psychiatric intervention. Failure to provide such a referral may constitute grounds for a charge of professional misconduct.”

2. May Psychiatric Nurse Practitioners (NPP) sign treatment plans in licensed psychiatric outpatient programs?
No. 14 NYCRR, Part 587, section 587.16(e) (1), requires in part, the signature of a physician involved in the treatment of the patient. This requirement is consistent with the Federal Medicaid Regulations (42 CFR 440.90) (a).

3. May NPPs sign orders in psychiatric inpatient units of general hospitals licensed by the Office of Mental Health?
No. 14 NYCRR, Part 580, Section 580.5(a) (8) specifies that “…ongoing direction and control of the program shall be delegated to a physician.” This requirement is consistent with Federal Regulations.

4. May NPPs order the involuntary admission to a hospital of a psychiatric patient?
No. The New York Mental Hygiene Law specifies that a physician signature is required for an order to involuntarily admit a psychiatric patient to a hospital or treat over the objection of a psychiatric patient.

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Pediatric Practice

1. If a NP is prepared in the specialty of pediatrics, to what age may s/he see patients?

“The pediatric NP may manage patients up to 18 years of age and in some circumstances up to 21 years of age. In certain circumstances as are determined by the nurse practitioner and the collaborating physician, a pediatric nurse practitioner may treat an individual beyond that age limit, while an adult nurse practitioner may treat an individual younger than that age limit. These special circumstances should be stated in the collaborative practice agreement and protocols on file in the practice.” [Dr. Barbara Zittel, New York State Education Department of the Professions.] (See Appendix F, December 21, 2001).

2. If a NP is prepared in neonatology, to what age may s/he see patients?

In a memo from the NYS Education Department (see Appendix F) the appropriate age range for NPs certified in neonatology is described as from birth to one year. This is notwithstanding that “Neonatology” usually refers to the first 28 days of life. However, if a child is 6 to 8 weeks premature delivery, the patient may be in a neonatal intensive care unit for more than 28 days. It is not reasonable for the NP to refuse to continue care for that patient just based on the chronological age; developmental age may be quite different. Also, some neonatologists care for people with chronic conditions such as Cystic Fibrosis. Again, the standard is that if the neonatologist who is the collaborating physician cares for the individual patient, it would be appropriate for the NP to do so as well, as long as s/he is competent and the situation has been addressed in the written practice agreement and the practice protocols.

3. May NPs prepared in neonatology see patients on the pediatric unit?

Yes. As long as the patient has been followed, and is currently being followed, by the NP and the collaborating neonatologist. However, the NP prepared in neonatology may not see general pediatric patients, as s/he would then by practicing out of scope.

4. May Pediatric NPs care for adults, especially the parents of the patients?

No. The NP’s specialty is pediatric and, except as noted above, s/he must practice within her/his specialty.

5. May Adult Nurse Practitioners (ANP) see pediatric patients?

No. An NP must practice with his/her specialty. Patients may be seen who are less than 18 years of age if the patient is an emancipated minor or is usually seen by the collaborating physician for “adult” problems (i.e. reproductive health). The NP may also see these patients as long as s/he is competent and the situation is addressed in the written practice agreement as well as the written practice protocols.

Generally, an ANP providing care to the pediatric patients is practicing out of scope of practice, as the educational qualifications have not been met. The Adult NP may achieve additional certification in Family or Pediatrics, but care given during clinical hours prior to
additional certification must be under direct supervision. Under no circumstances is it acceptable to write prescriptions for pediatric patients without proper certifications.

6. May a Pediatric NP sign the Childhood Medical Disability Report (CMDR)?

No. 20 CFR Section 404.1513 and 18 NYCRR Section 360.5.3 specifies in part that the CMDR must be signed by a physician.

Rehabilitation Services

1. May Respiratory Therapists accept orders from Nurse Practitioners?

Yes. Chapter 583 of the Laws of 2003 states that, “Respiratory therapy services may be performed pursuant to a prescription of a licensed physician or certified nurse practitioner.”

2. May NPs order speech pathology?

Yes. NPs may order speech pathology. Federal regulations do not address this issue and there is no state requirement requiring an order for speech pathology.

3. May NPs order physical therapy services, when medically necessary in?

- **Hospitals:** Yes. NPs may order physical therapy for patients in hospitals as governed by State law and hospital policy.

- **Skilled Nursing Facilities:** No. NPs may not order physical therapy for patients in SNFs. The physician must date and sign all orders as specified in 483.40(b) and 483.10(b) (3) of Title 10, New York Code of Rules and Regulations.

- **Certified Home Health Agencies (CHHA) and Hospices:** No. NPs are prohibited by Federal regulations from ordering physical therapy in CHHAs and hospices.

- **Licensed Home Care Service Agencies (LHCSA):** Yes. NPs may order physical therapy services for patients in LHCSAs as governed by State law.

First Assistant

1. Can a NP without additional educational and training act as a first assistant at surgery?

No. Without RNFA training it is not within the scope of practice for an NP to act as a first assistant at surgery. Where the NP has completed appropriate formal education for the role of an RN to function as a first assistant at surgery (RNFA) the NP may function as a first assistant. The New York State Board for Nursing can provide you with further information regarding resources for RN first assistant education. You may contact the State Board for Nursing by email: nursebd@mail.nysed.gov or by phone: 518-474-3817 ext.120.
2. Can a NP bill and receive reimbursement for first assistant at surgery services?

Yes, as long as the NP has completed the scope of practice requirements for functioning as a first assistant at surgery, (appropriate education as stated above) Medicare will reimburse the NP for assistant at surgery service. One must be aware that only certain surgical procedures are recognized as being eligible for reimbursement for assistant at surgery services. Other 3rd party payers may also reimburse an NP for first assistant at surgery services. Insurance companies vary with respect to which procedures they will reimburse a first assistant. Some companies may only reimburse MDs as first assistants. The billing process itself requires an understanding of the Current Procedural Terminology (CPT) and modifier coding. Most physician office managers are familiar with this process. The NP who works privately with a physician may be able to have the office manager handle this process. The NP who works with many physicians can hire a billing company to perform this process or may choose to do the billing him/her.

3. How does a NP establish privileges to function as a first assistant at surgery in hospitals/ambulatory surgery centers?

The process for establishing privileges to first at surgery is similar to obtaining privileges for practice as an NP. It requires contacting the Medical Staff Office credentialing/privileging department of the facility. Generic privileges as an NP do not usually include first assistant as surgery privileges. First assisting privileges should be a separately defined area in the privileging process, identifying the surgeons and/or the surgical services you will be assisting. The first assistant privileges should also document your educational preparation (as described above) for the first assistant role.

4. Can a NP work independently as an NP first assistant at surgery?

No. While NPs have a scope of practice that allows them to function in an independent manner, functioning as a first assistant at surgery is not within the independent scope of practice of an NP. First assisting at surgery is, by definition, assisting a physician in the performance of surgery. First assisting is a dependent function of the RNFA prepared NP. A RNFA prepared NP can affiliate with various surgeons to function as a first assistant at surgery, providing of course that appropriate educational preparation has been completed (as stated above) and that first assistant privileges have been obtained at the appropriate facilities. (Marlene Craden, RN, BSN, CNOR, CRNFA)

5. Where can NPs obtain additional information on the role of an RN who practices as first assistant at surgery in New York State?

1. New York State Board for Nursing: nursebd@mail.nysed.gov

Independent Practice

1. What is the first step in an independent practice?

In order to consider opening an independent practice, the NP needs to:

- Develop a vision of the service to be provided
- Review state and federal regulations governing the service
- Explore the community available of the service
- Determine the level of competition for the service in the community
- Speak with other providers in the same specialty to discuss successes and failures

2. What professional services are recommended?

The following are necessary services:

- A good attorney and accountant are essential no matter what business form the NP is considering, Corporation, Limited Liability Company, Partnership or Sole ownership.

- Billing company - the NP should consult with other providers in the immediate area. The practitioner should explore the various programs and consider the options for billing on his/her own. The NP should be warned, however, that doing his/her own billing can be time-consuming especially at the beginning when the practice is being credentialed with the insurance companies.

- The development of a business plan – establishing a business plan is essential. Free assistance can be obtained from the Small Business Administration. Some of these offices have a “SCORE” group that is a group of retired business executives who offer assistance to individuals starting out in a small business.

- The bank – it is essential to develop a good relationship with a local bank and executive officer.

3. What are the major pitfalls for NPs staring their own practice?

Finding a collaborating physician who will agree to be an independent contractor

- Some HMOs still do not recognize NPs as primary care providers. A HMO may agree to directly reimburse your practice versus reimbursement through a physician. Each practice is decided on an individual basis at the time of application. Obtaining provider status with Medicare may take three to six months and that will delay reimbursement. Other third party payers may respond in a timelier manner.

4. Can NPs directly employ an MD to work in his or her own private practice?

No. The State Education Department would consider this an unlicensed expansion into the practice of medicine by the Nurse Practitioner. As an employer, the NP is placed in a supervisory capacity with implicit responsibility and authority to direct the management and care of the physician’s patient.

5. Develop a business plan.

A business plan is a written document that a potential business owner develops after deciding to open a business and before incurring debt, renting space, hiring staff or signing contracts. To learn more about business plans see the US Small Business Administration “Create Your Business Plan” at http://www.sba.gov/ from the “Starting and Managing” menu select “Create your Business Plan”.

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General Practice Questions

No Fault Insurance Forms

May NPs sign No Fault Insurance forms?

The NYS Insurance Department’s Office of General counsel has verbally confirmed that there is no prohibition against NPs billing a No Fault insurance carrier for services s/he provides as long as the NP practices within her/his area of specialization. However, some insurance companies do not accept NP signatures claiming No-Fault follows all worker compensation rules not just the fee schedule.

Worker’s Compensation

May NPs sign Worker’s Compensation forms?

No. NPs may not sign Worker’s Compensation forms. Worker’s Compensation Law (WCL) Section 13-b (1) (c) requires that NPs render care under the active, direct and personal supervision of an authorized physician.

May NPs testify at a hearing regarding eligibility of an employee to receive worker’s compensation benefits?

No. New York State Worker’s Compensation Law presently does not recognize the NP as an acceptable evaluator or examiner. Therefore, NPs may not testify at worker’s compensation hearings.

Death Certificate

May NPs pronounce death and sign the death certificate?

Yes. A NP may pronounce death and, effective January 16, 2012 may also complete and sign a death certificate. Instructional materials are available in Appendix G.

DNR Orders

May NPs sign a Do Not Resuscitate (DNR) form as the “secondary physician”?

Yes. The DNR Law passed in 2017 authorizes nurse practitioners to executive orders not to resuscitate and orders relating to life sustaining treatments. The bill was passed and signed into law on November 29, 2017 and will be effective May 2018.

MOLST

May NPs sign the Medical Orders for Life Sustaining Treatment (MOLST) form?

1. NPs have always been able to counsel their patients on end-of-life issues.
2. As of May 2018, the new law allows NPs to sign and execute DNR’s and other end of life orders, on behalf of their patients, with very limited exceptions.
   a. Specifically, the new law DOES NOT impact the existing statue of health care proxies, with only authorizes a physician to sign.
   b. And the new law DOES NOT impact the existing Surrogate Court Procedures Act with only authorizes a court action.

3. NYS Law defers to Department of Health (DOH) on how to prepare a MOLST form.
   a. We expect that DOH will update the form to acknowledge the new statutory authority afforded to NPs. The NPA has already begun the conversation with DOH.
      i. DOH would again in the future revise the MOLST form if the laws pertaining to health care proxies and those acting on behalf of individuals with intellectual developmental disabilities were amended to conform with the recent changes regarding NP authority.

X-Rays and Mobile Imaging

May NPs may order X-rays from mobile imaging units for nursing home patients?

Yes. NPs may order X-rays from mobile imaging units for nursing home patients.

Nursing Homes

May NPs sign their collaborative physician’s verbal orders for patients in nursing homes?

No. A NP may not sign his/her collaborative physician’s verbal orders for patients residing in nursing homes. Fax orders are permissible.

May NPs working in nursing homes countersign physician’s orders?

No. According to Section 415.18 of Title 10 of the New York State Code of Rules and Regulations, all orders for patients in nursing homes must be signed within 48 hours by the physician or alternate physician.

Home Health Care Services

May NPs write orders for patients receiving home health care services?

It depends on the type of home health care services. According to Federal regulations, NPs may not write or give verbal orders for patients receiving services from certified home health agencies (CHHA), long term health care agencies and hospices. NPs may write orders for patients receiving services from licensed home health care services agency (LHHCSA) because these agencies are only required to meet New York State regulations. However, NPs are prohibited from writing orders for Medicare patients that are provided service through a LHHCSA if that agency is under contract with a CHHA.
Hospice Patients

May NPs write orders for hospice patients?

Although Federal regulations permitting NPs to act as the patient’s attending physician became effective September 24, 2004, the NYSDOH’s hospice regulations have not yet been amended to be consistent with the Federal regulations. Since the Federal statute has not yet been changed to permit NPs to write orders for Medicare patients in hospices, NPs may not certify or rectify that a beneficiary has a terminal diagnosis with a prognosis of 6 months or less if the illness runs its usual course. NPs may not take the place of the physician of the interdisciplinary team. NPs may not bill Medicare separately, unless they are the chosen attending physician of the patients, because the hospice benefit is a prospective payment system with an all-inclusive rate.

Durable Medical Equipment

May NPs bill for durable medical equipment?

Under current law, CMS has been tasked with enforcing a rule that would require an NP to obtain a physician's documentation certifying that a face-to-face encounter with that patient has taken place when ordering certain DME. According to CMS (2014), “The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient.” CMS’s most recent statement on September 9, 2013, explained that they “will start actively enforcing and will expect full compliance with the DME face-to-face requirements beginning on a date that will be announced in Calendar Year 2014.” In short, the delay is still in effect. A link to the full statement released by CMS on the DME face-to-face requirement rule can be found here.

Should you encounter a supplier who will not fill your DME order, provide them with the full CMS announcement, ensure that you have provided all of the information required on the detailed written order and ask that they fill your order.

Out-of-State NP Procedures for Practicing in New York State

What procedures must an out-of-state NP follow in order to practice in NY?

NPs desiring to practice in New York State must complete an application that may be obtained at http://www.op.nysed.gov/ and click on “list of Professions; Nursing: Application Forms for NPs to Complete”. A complete listing of application forms and instructions can be found in Appendix F.

Women’s Health NPs Treating Male Patients

May NPs prepared in women’s health see male patients?

NPs certified in women’s health may treat all males as well as female patients for sexually transmitted diseases.
Pregnancy Termination

May NPs administer drug(s) to terminate a pregnancy?

Yes. While the New York Penal Law Section 125.05(3) indicates that termination of pregnancy may only be performed by a physician, a letter from the NYS Attorney General dated June 29, 2001 examining the question of whether a NP may perform medical abortions (i.e. Intentional, drug-induced abortion) indicates that “those in the mid-level medical professions, i.e. physicians assistants, nurse practitioners, certified nurse midwives and certified midwives” may do so. Practitioners who wish to receive a copy of this letter may request one from The NPA by writing to info@TheNPA.org.

NPs Employed by a Chiropractor

May NPs be employed by a chiropractor?

No. NPs and physical therapists may not be employed by a chiropractor.

NPs Administering Chemotherapy

May NPs administer chemotherapy?

Yes. CMS confirmed that NPs may bill Medicare using their provider number without a physician on-site at the time of administration.

Homeopathy and Alternative Therapies

May NPs incorporate homeopathy and/or other complementary and alternative therapies into her/his practice?

Yes. The NP must be able to verify that s/he has been educated/trained in the alternative therapy, has demonstrated competence to perform such therapy, and has incorporated such therapy into the written practice agreement and practice protocols.

High Tech Procedures

May a NP perform high tech procedures?

Yes. The New York State Education Department’s position is that an NP must demonstrate competence in the performance of the procedure after completing a course of study and a period of supervised clinical experience. S/he must also incorporate the procedure into the collaborative agreement and practice protocols as well as confirm that the procedure is covered by her/his insurance carrier.
Scope of Practice

May an individual institution restrict NP scope of practice?

Yes. Institutions may set higher standards and, therefore restrict NP scope of practice because institutions are required to follow their procedures that may prohibit specific NP tasks.

When filling a lesser position (ex. a NP working as a RN), and if for any reason concerns arise about scope of practice in an emergency, should the NP follow scope of practice of licensure or scope of employment?

According to the SBN, NPs working in NYS as RNs are held to the RN standard.

May a FNP work in an acute care setting?

Yes, as long as the FNP has the education and competency. NPs certified in acute care may only work in acute care settings.

Informed Consent

May NPs obtain a patient’s informed consent?

Yes. Obtaining informed consent is a non-delegable responsibility and is the sole responsibility of the treating provider. However, see consent for surgery below.

May NPs obtain a patient’s informed consent for surgery?

No. Obtaining a patient’s informed consent prior to surgery is a non-delegable responsibility. The treating physician is in the best position to assume responsibility for answering patient’s questions and informing patients of risks and benefits of surgical procedures.

NPs Reporting Incapacitated Driver to NYS DMV

Are NPs required to report incapacitated driver to the Department of Motor Vehicles (DMV)?

Yes. NPs must complete form DS6 to report such patients to the DMV. That form may be accessed on the DMV website: http://dmv.ny.gov/ select: Forms and enter DS6 in the “search for a specific term” area.

Assisted Living Programs and Adult Care Facilities

May NPs conduct pre-admission and annual resident medical evaluations for Assisted Living Programs (ALP) and Adult Care Facilities (ACF)?

Yes. By consensus rule proposed November 20, 2013 and effective January 4, 2014 section 487.4 and 488.4 of title 18 NYCRR and section 1001.7 of the title 10 NYCRR were amended to permit Physician Assistants and Nurse Practitioners to perform these evaluations.
Automated External Defibrillators (AED)

Can nurse practitioners order Automated External Defibrillators?

Yes, NPs may order Automated External Defibrillators (AED). The law was passed on July 25, 2017.

Tips to Avoid Scope of Licensure versus Scope of Employment Liabilities

1. Inform employers and collaborating and/or supervising physicians that you are a NP working beneath your licensure.

2. Carry private insurance. Notify the carrier that you are working in a health care role other than that for which you are licensed (e.g. NP working as a RN). Request a written document stating that the carrier was notified, is aware of your employment, and will cover you.

3. Avoid settings where you have clinical privileges or are also employed as a NP. This minimizes your chances of being asked to do something beyond your scope of employment. Also avoid working in non-NP roles where your collaborating and/or supervising physicians (as well as other physician colleagues) work or have clinical privileges.

4. Seek settings outside your NP specialty or area of expertise. A pediatric NP working as RN in a senior center would not likely be called upon regarding advanced scope of licensure.

5. Look for settings and shifts with physicians or other advanced clinicians on site; that is, avoid being the only advanced-level clinician on duty. Be certain of ready access to advanced clinicians and/or physicians in case of problems.

6. Know your state’s practice act. States with a more independent practice act are less restrictive than are collaborating acts (especially for NPs) regarding exercising your scope of licensure.

7. Meticulously document all actions, no matter how routine. This will be useful if any liability issues arise.

(Clinicians News, November 12, 2002)
Appendix A
Scope of Practice

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Title VIII, Article 139 of New York State Education Law

Scope of Nurse Practitioner Practice in New York State

§6900. Introduction.

This article applies to the profession of nursing. The general provisions for all professions contained in article one hundred thirty of this title apply to this article.

§6901. Definitions.

As used in section sixty-nine hundred two:

1. "Diagnosing" in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis.

2. "Treating" means selection and performance of those therapeutic measures essential to the effective execution and management of the nursing regimen, and execution of any prescribed medical regimen.

3. "Human Responses" means those signs, symptoms and processes which denote the individual's interaction with an actual or potential health problem.

§6902. Definition of practice of nursing.

1. The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations. A nursing regimen shall be consistent with and shall not vary any existing medical regimen.

2. The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations.

3. a. The practice of registered professional nursing by a nurse practitioner, certified under section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols. The written practice agreement shall include explicit provisions for the resolution of any disagreement between the collaborating physician and the nurse practitioner regarding a matter of diagnosis or treatment that is within the scope of practice of both. To the extent the practice agreement does not so provide, then the collaborating physician's diagnosis or treatment shall prevail.

b. Prescriptions for drugs, devices and immunizing agents may be issued by a nurse practitioner, under this subdivision and section six thousand nine hundred ten of this...
article, in accordance with the practice agreement and practice protocols. The nurse practitioner shall obtain a certificate from the department upon successfully completing a program including an appropriate pharmacology component, or its equivalent, as established by the commissioner's regulations, prior to prescribing under this subdivision. The certificate issued under section six thousand nine hundred ten of this article shall state whether the nurse practitioner has successfully completed such a program or equivalent and is authorized to prescribe under this subdivision.

c. Each practice agreement shall provide for patient records review by the collaborating physician in a timely fashion but in no event less often than every three months. The names of the nurse practitioner and the collaborating physician shall be clearly posted in the practice setting of the nurse practitioner.

d. The practice protocol shall reflect current accepted medical and nursing practice. The protocols shall be filed with the department within ninety days of the commencement of the practice and may be updated periodically. The commissioner shall make regulations establishing the procedure for the review of protocols and the disposition of any issues arising from such review.

e. No physician shall enter into practice agreements with more than four nurse practitioners who are not located on the same physical premises as the collaborating physician.

f. Nothing in this subdivision shall be deemed to limit or diminish the practice of the profession of nursing as a registered professional nurse under this article or any other law, rule, regulation or certification, nor to deny any registered professional nurse the right to do any act or engage in any practice authorized by this article or any other law, rule, regulation or certification.

g. The provisions of this subdivision shall not apply to any activity authorized, pursuant to statute, rule or regulation, to be performed by a registered professional nurse in a hospital as defined in article twenty-eight of the public health law.

§6903. Practice of nursing and use of title "registered professional nurse" or "licensed practical nurse".

Only a person licensed or otherwise authorized under this article shall practice nursing and only a person licensed under section sixty-nine hundred four shall use the title "registered professional nurse" and only a person licensed under section sixty-nine hundred five of this article shall use the title "licensed practical nurse". No person shall use the title "nurse" or any other title or abbreviation that would represent to the public that the person is authorized to practice nursing unless the person is licensed or otherwise authorized under this article.

§6904. State board for nursing.

A state board for nursing shall be appointed by the board of regents on recommendation of the commissioner for the purpose of assisting the board of regents and the department on matters of professional licensing and professional conduct in accordance with section sixty-five hundred eight of this title. The board shall be composed of not less than fifteen members, eleven of whom shall be registered professional nurses and four of whom shall be licensed practical nurses all licensed and practicing in this state for at least five years. An executive secretary to the board shall be appointed by the board of regents on recommendation of the commissioner and shall be a registered professional nurse registered in this state.
Appendix A – Scope of Practice

§6905. Requirements for a license as a registered professional nurse.

To qualify for a license as a registered professional nurse, an applicant shall fulfill the following requirements:

1. Application: file an application with the department;
2. Education: have received an education, and a diploma or degree in professional nursing, in accordance with the commissioner's regulations;
3. Experience: meet no requirement as to experience;
4. Examination: pass an examination satisfactory to the board and in accordance with the commissioner's regulations;
5. Age: be at least eighteen years of age;
6. Citizenship: meet no requirement as to United States citizenship;
7. Character: be of good moral character as determined by the department; and
8. Fees: pay a fee of one hundred fifteen dollars to the department for admission to a department conducted examination and for an initial license, a fee of forty-five dollars for each reexamination, a fee of seventy dollars for an initial license for persons not requiring admission to a department conducted examination, and a fee of fifty dollars for each triennial registration period.

§6906. Requirements for a license as a licensed practical nurse.

To qualify for a license as a licensed practical nurse, an applicant shall fulfill these requirements:

1. Application: file an application with the department;
2. Education: have received an education including completion of high school or its equivalent, and have completed a program in practical nursing, in accordance with the commissioner's regulations, or completion of equivalent study satisfactory to the department in a program conducted by the armed forces of the United States or in an approved program in professional nursing;
3. Experience: meet no requirement as to experience;
4. Examination: pass an examination satisfactory to the board and in accordance with the commissioner's regulations, provided, however, that the educational requirements set forth in subdivision two of this section are met prior to admission for the licensing examination;
5. Age: be at least seventeen years of age;
6. Citizenship: meet no requirements as to United States citizenship;
7. Character: be of good moral character as determined by the department; and
8. Fees: pay a fee of one hundred fifteen dollars to the department for admission to a department conducted examination and for an initial license, a fee of forty-five dollars for each reexamination, a fee of seventy dollars for an initial license for persons not requiring admission to a department conducted examination, and a fee of fifty dollars for each triennial registration period.

§6907. Limited permits.

1. A permit to practice as a registered professional nurse or a permit to practice as a licensed practical nurse may be issued by the department upon the filing of an application for a license as a registered professional nurse or as a licensed practical nurse and submission of such other information as the department may require to
   i. graduates of schools of nursing registered by the department,
   ii. graduates of schools of nursing approved in another state, province, or country or
iii. applicants for a license in practical nursing whose preparation is determined by the
department to be the equivalent of that required in this state.

2. Such limited permit shall expire one year from the date of issuance or upon notice to the
applicant by the department that the application for license has been denied, or ten days after
notification to the applicant of failure on the professional licensing examination, whichever
shall first occur. Notwithstanding the foregoing provisions of this subdivision, if the applicant is
waiting the result of a licensing examination at the time such limited permit expires, such
permit shall continue to be valid until ten days after notification to the applicant of the results
of such examination.

3. A limited permit shall entitle the holder to practice nursing only under the supervision of a
nurse currently registered in this state and with the endorsement of the employing agency.

4. Fees. The fee for each limited permit shall be thirty-five dollars.

5. Graduates of schools of nursing registered by the department may be employed to practice
nursing under supervision of a professional nurse currently registered in this state and with
the endorsement of the employing agency for ninety days immediately following graduation
from a program in nursing and pending receipt of a limited permit for which an application has
been filed as provided in this section.

§6908. Exempt persons.

1. This article shall not be construed:

a. As prohibiting
   i. the domestic care of the sick, disabled or injured by any family member, household
   member or friend, or person employed primarily in a domestic capacity who does not
   hold himself or herself out, or accept employment as a person licensed to practice
   nursing under the provision of this article; provided that if such person is
   remunerated, the person does not hold himself or herself out as one who accepts
   employment for performing such care; or the administration of medications or
   treatment by child day care providers or employees or caregivers of child day care
   programs where such providers, employees or caregivers are acting under the
direction and authority of a parent of a child, legal guardian, legal custodian, or an
adult in whose care a child has been entrusted and who has been authorized by the
parent to consent to any health care for the child and in compliance with the
regulations of the office of children and family services pertaining to the administration
of medications and treatment; or
   ii. any person from the domestic administration of family remedies; or
   iii. the providing of care by a person acting in the place of a person exempt under clause
   (i) of this paragraph, but who does hold himself or herself out as one who accepts
   employment for performing such care, where nursing services are under the
   instruction of a licensed nurse, or under the instruction of a patient or family or
   household member determined by a registered professional nurse to be self-directing
   and capable of providing such instruction, and any remuneration is provided under
   section thirty-six hundred twenty-two of the public health law or section three hundred
   sixty-five-f of the social service law; or
   iv. the furnishing of nursing assistance in case of an emergency;

b. As including services given by attendants in institutions under the jurisdiction of or subject to
the visitation of the state department of mental hygiene if adequate medical and nursing
supervision is provided;

c. As prohibiting such performance of nursing service by students enrolled in registered schools
or programs as may be incidental to their course of study;
d. As prohibiting or preventing the practice of nursing in this state by any legally qualified nurse or practical nurse of another state, province, or country whose engagement requires him or her to accompany and care for a patient temporarily residing in this state during the period of such engagement provided such person does not represent or hold himself or herself out as a nurse or practical nurse registered to practice in this state;

e. As prohibiting or preventing the practice of nursing in this state during an emergency or disaster by any legally qualified nurse or practical nurse of another state, province, or country who may be recruited by the American National Red Cross or pursuant to authority vested in the state civil defense commission for such emergency or disaster service, provided such person does not represent or hold himself or herself out as a nurse or practical nurse registered to practice in this state;

f. As prohibiting or preventing the practice of nursing in this state, in obedience to the requirements of the laws of the United States, by any commissioned nurse officer in the armed forces of the United States or by any nurse employed in the United States veterans administration or United States public health service while engaged in the performance of the actual duties prescribed for him or her under the United States statutes, provided such person does not represent or hold himself or herself out as a nurse registered to practice in this state;

g. As prohibiting the care of the sick when done in connection with the practice of the religious tenets of any church.

h. As prohibiting the provision of psychotherapy as defined in subdivision two of section eighty-four hundred one of this title to the extent permissible within the scope of practice of nursing as defined in this title, by any not-for-profit corporation or education corporation providing services within the state and operating under a waiver pursuant to section sixty-five hundred three-a of this title, provided that such entities offering such psychotherapy services shall only provide such services through an individual appropriately licensed or otherwise authorized to provide such services or a professional entity authorized by law to provide such services.

§6909. Special provision.

1. Notwithstanding any inconsistent provision of any general, special, or local law, any licensed registered professional nurse or licensed practical nurse who voluntarily and without the expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or other emergency, outside a hospital, doctor's office or any other place having proper and necessary medical equipment, to a person who is unconscious, ill or injured shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such first aid or emergency treatment unless it is established that such injuries were or such death was caused by gross negligence on the part of such registered professional nurse or licensed practical nurse. Nothing in this subdivision shall be deemed or construed to relieve a licensed registered professional nurse or licensed practical nurse from liability for damages for injuries or death caused by an act or omission on the part of such nurse while rendering professional services in the normal and ordinary course of her practice.

2. Nothing in this article shall be construed to confer the authority to practice medicine or dentistry.

3. An applicant for a license as a registered professional nurse or licensed practical nurse by endorsement of a license of another state, province or country whose application was filed with the department under the laws in effect prior to August thirty-first, nineteen hundred seventy-one shall be licensed only upon successful completion of the appropriate licensing examination unless satisfactory evidence of the completion of all educational requirements is submitted to the department prior to September one, nineteen hundred seventy-seven.
4. A certified nurse practitioner may prescribe and order a non-patient specific regimen to a registered professional nurse, pursuant to regulations promulgated by the commissioner, consistent with subdivision three of section six thousand nine hundred two of this article, and consistent with the public health law, for:
   a. administrating immunizations.
   b. the emergency treatment of anaphylaxis.
   c. administering purified protein derivative (PPD) tests.
   d. administering tests to determine the presence of the human immunodeficiency virus.

5. A registered professional nurse may execute a non-patient specific regimen prescribed or ordered by a licensed physician or certified nurse practitioner, pursuant to regulations promulgated by the commissioner.

6. A registered professional nurse defined under subdivision one of section sixty-nine hundred two of this article may use accepted classifications of signs, symptoms, dysfunctions and disorders, including, but not limited to, classifications used in the practice setting for the purpose of providing mental health services.

7. * A certified nurse practitioner may prescribe and order a non-patient specific regimen to a licensed pharmacist, pursuant to regulations promulgated by the commissioner, and consistent with the public health law, for administering immunizations. Nothing in this subdivision shall authorize unlicensed persons to administer immunizations, vaccines or other drugs. * NB Repealed March 31, 2012

§6910. Certificates for nurse practitioner practice.

1. For issuance of a certificate to practice as a nurse practitioner under subdivision three of section six thousand nine hundred two of this article, the applicant shall fulfill the following requirements:
   a. Application: file an application with the department;
   b. License: be licensed as a registered professional nurse in the state;
   c. Education:
      i. have satisfactorily completed educational preparation for provision of these services in a program registered by the department or in a program determined by the department to be the equivalent; or
      ii. submit evidence of current certification by a national certifying body, recognized by the department; or
      iii. meet such alternative criteria as established by the commissioner's regulations;
   d. Fees: pay a fee to the department of fifty dollars for each initial certificate authorizing nurse practitioner practice in a specialty area and a triennial registration fee of thirty dollars. Registration under this section shall be coterminous with the nurse practitioner's registration as a professional nurse.

2. Only a person certified under this section shall use the title "nurse practitioner".

3. The provisions of this section shall not apply to any act or practice authorized by any other law, rule, regulation or certification.

4. The provisions of this section shall not apply to any activity authorized, pursuant to statute, rule or regulation, to be performed by a registered professional nurse in a hospital as defined in article twenty-eight of the public health law.

5. The commissioner is authorized to promulgate regulations to implement the provisions of this section.

Source: [http://www.op.nysed.gov/prof/nurse/article139.htm#sect6900](http://www.op.nysed.gov/prof/nurse/article139.htm#sect6900)
Appendix B

Nurse Practitioner Education

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Part 52.12, Registration of Curricula

New York State Education Department

Programs which prepare for admission to licensing examinations

1. The curriculum for a program preparing for admission to the licensing examination for registered professional nurse shall meet the following standards:
   i. The program leading to the diploma in nursing shall include a minimum of the equivalent of 30 semester hours in nursing and shall be at least two years in length.
   ii. The program leading to an associate degree with a major in nursing shall include a minimum of 30 semester hours or the equivalent in nursing.
   iii. The program leading to a baccalaureate or higher degree with a major in nursing shall include a minimum or 40 semester hours or the equivalent in nursing.

2. The curriculum for a program preparing for admission to the licensing examination for licensed practical nurse shall meet the following standards:
   i. The curriculum offered by an agency or institution other than a college shall be a minimum or nine months in length.
   ii. The curriculum offered by a college shall be a minimum or two semesters or the equivalent in length.

3. Clinical facilities. A written contract or agreement shall be executed between the institution conducting the nursing program and the cooperating clinical facility or agency, shall be signed by the responsible officer or each party, and shall set forth the responsibilities or each party.

b. Programs and courses in nursing other than those that prepare for admission to a licensing examination.

Nurse practitioner programs

i. Definitions of terms.
   a. For purposes of this paragraph, the term nurse practitioner program means an educational program which meets the requirements of this paragraph and which has as its objective the education of nurses who will, upon completion of their studies in such programs, be qualified to provide services,
within the scope of practice permitted by section 6910 of the Education Law.

ii. Registration. No nurse practitioner program shall be offered until such program has been registered by the department.

iii. Admission. Licensure as a registered nurse in New York or another jurisdiction of the United States shall be required for admission to a registered program, except that in a combined program of education as a registered professional nurse and as a nurse practitioner, registered by the department or accredited by an accrediting agency acceptable to the department, the nurse practitioner component may be taken upon successful completion of the registered nurse component.

iv. Curriculum. The curriculum shall include, in addition to the requirements of section 52.2 (c) of this Title:

a. classroom and supervised clinical designed to prepare nurse practitioners in the areas of diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice;

b. a pharmacology component of not less than three semester hours or the equivalent; to include instruction in drug management of clients in the nurse practitioner specialty area and instruction in New York State and Federal laws and regulations relating to prescriptions and recordkeeping; and

c. a preceptorship experience, supervised by a nurse practitioner or physician practicing in the specialty area of the program, of at least one semester in length or its equivalent.

v. Credential. Upon satisfactory completion of all components of the program including class, supervised clinical nursing practice, and preceptorship, a certificate of completion indicating the specialty area shall be issued to each individual by the sponsoring institution/agency.

2. Other courses. No institution may offer courses in clinical nursing for students enrolled in basic nursing programs, or for graduates of State-approved nursing education programs who are not licensed and currently registered to practice nursing in New York, unless such courses have been registered by the department.
§64.1 Professional study of nursing.

a. Registered professional nursing. To meet the professional education requirement, the applicant shall have graduated from:

1. a program in nursing registered by the department as preparation for practice as a registered professional nurse;

2. a program in nursing approved by the licensing authority in another state, territory or possession of the United States as preparation for practice as a registered professional nurse; or

3. a general nursing course of at least two academic years in a country outside the United States and its territories or possessions that is satisfactory to the department and that the licensing authority or appropriate governmental agency of said country certifies to the department as being preparation for practice as a registered professional nurse. For issuance of a limited permit, an applicant shall obtain a score satisfactory to the department on a proficiency examination selected by the department as evidence of equivalent training, if the applicant's nursing education was obtained in a school of nursing outside the United States and its territories and has not been determined by the department to be equivalent in quality and scope to a program of nursing education registered by the department.

b. Licensed practical nursing. To meet the education requirements, the applicant shall have graduated from high school or its equivalent, and shall have:

1. graduated from a program in nursing registered by the department or approved by the licensing authority in another state, territory, or possession of the United States as preparation for practice as a licensed practical nurse;

2. completed preparation in a program determined by the department to be equivalent to the programs described in paragraph (1) of this subdivision;

3. graduated from a program in practical nursing of at least nine months in a country outside the United States and its territories or possessions, which program is satisfactory to the department and which program the licensing authority of said country certifies to the department as being preparation for practice as a licensed practical nurse; or

4. graduated from a general nursing course in a country outside the United States and its territories that is satisfactory to the department and that the licensing authority of said country certifies to the department as being preparation for practice as a professional nurse.
§64.2 Licensing examinations.
   a. Registered professional nursing.
      1. All parts of the registered professional nurse licensing examination shall be taken each time the candidate is examined.
      2. Each candidate for licensure as a registered professional nurse examined after November 22, 1961 shall have taken an examination acceptable to the State Board for Nursing. Except as provided in Section 64.3 of this Part, each candidate examined after May 31, 1974 shall have taken the same examination on the same dates such examination was given in this State.
      3. The registered professional nurse licensing examination results shall be reported as a single score. Applicants who have passed a part or parts of the registered professional nurse licensing examination prior to July 1, 1982 may not retain credit for such part or parts beyond that date.
   b. Licensed practical nursing.
      1. A candidate for licensure as a practical nurse shall pass an examination acceptable to the State Board for Nursing. Each candidate examined after September 11, 1974 shall have taken the same examination on the same dates such examination was given in this State.
      2. The passing score as determined by the State Board for Nursing for the licensed practical nurse licensing examination shall be reported as a single score.

§64.3 Limited permits.
A limited permit to practice as a registered professional nurse or licensed practical nurse may be issued after the applicant has met requirements of age, moral character, education and proficiency examination, if applicable, provided that the applicant has not failed the professional licensing examination. Failure on a registered professional nurse licensing examination shall not preclude issuance of a limited permit to practice as a licensed practical nurse.

§64.4 Nurse practitioner certification.
   a. Certificates.
      1. Nurse practitioner certificates issued to a registered professional nurse will reflect the specialty area of nurse practitioner academic preparation.
      2. The certificate will specify the specialty area of practice and, when applicable, that prescriptive privileges have been granted.
3. A nurse practitioner may apply for certification in more than one specialty area of practice. A complete application and fee shall be required for each certificate.

b. Professional study. To meet the professional education requirements for certification in this State, the applicant shall present evidence of:

1. i. completion of an educational program registered by the department, or a program determined by the department to be equivalent to a registered program, which is designed and conducted to prepare graduates to practice as nurse practitioners; or ii. certification as a nurse practitioner by a national certifying body acceptable to the department; and

2. completion of not less than three semester hours or the equivalent in pharmacology either in an acceptable nurse practitioner program or after other educational requirements for certification as nurse practitioner have been satisfied. An acceptable course in pharmacology shall be equivalent in scope and content to that required by Section 52.12 of this Title.

c. Alternative criteria for certification.

1. For applicants whose professional education as a nurse practitioner was completed prior to April 1, 1989, the department may accept as alternative educational criteria the following qualifications:

   i. A program of education preparation for the provision of primary health care services as nurse practitioner of at least four weeks in duration, and completed prior to April 1, 1989; and

   ii. a course of instruction in pharmacotherapeutics management as required by this subdivision; and either:

   iii. two years of experience prior to April 1, 1989, at least one year of which shall be subsequent to April 1, 1986, in the provision of primary health care services in a health care facility licensed pursuant to Article 28 of the Public Health Law or in a school health demonstration project; or

   iv. satisfactory completion of a supplemental educational program culminating in the successful completion of a comprehensive examination or clinical evaluation.

2. the department may accept as alternative criteria for satisfaction of the pharmacotherapeutics requirement set forth in paragraph 2 of subdivision (b) of this section any of the following:

   i. an educational program or a combination of courses which is the substantial equivalent in content and scope to the pharmacotherapeutics component of a registered program; or
ii. satisfactory completion of an examination in pharmacotherapeutics satisfactory to the department; or

iii. satisfactory completion of a nationally recognized examination acceptable for licensure in New York State as a physician assistant or as a midwife.

3. The department may issue a certificate upon the receipt of satisfactory evidence that an applicant licensed or certified in another state or country has met the substantial equivalent of the New York requirements for certification. An applicant who does not have the substantial equivalent of all of the New York requirements may be required to make up specific deficiencies and/or pass a proficiency examination.

d. **Alternative criteria for certification in additional specialty areas of practice.**

1. The alternative requirements of this subdivision are only available to applicants who apply to the department for certification in the additional specialty area of practice on or before September 15, 2006 and who meet all requirements for certification under this subdivision by September 15, 2007. These alternative requirements for certification shall not be available to applicants who do not meet these conditions and shall not be available to applicants who apply for certification after September 15, 2006.

2. An applicant who has been certified as a nurse practitioner may be certified in an additional specialty or specialties upon the submission of evidence satisfactory to the department that the criteria for initial certification in the additional specialty or specialties has been met, or in the alternative, that the applicant has met the following alternative education and experience requirements:

   i. **Alternative education.** The department may accept 60 hours of continuing education obtained in the specialty area of practice in which certification is sought. Such continuing education may be obtained through the completion of any of the following:

      a. academic courses or continuing education programs approved by the department or by a nursing or medical organization or accrediting agency acceptable to the department; or

      b. evidence of preparation for the specialty by service as a presenter or lecturer in an academic or continuing education program, or by the publication in a professional journal of clinical information related to the specialty. Credit for such services or publication may not exceed 30 contact hours;

      c. independent study in an academic course or continuing education program may be accepted but may not exceed 12 contact hours;

      d. for the purposes of this paragraph one contact hour shall include at least 50 minutes of study and one academic semester hour shall equal 15 contact hours and one academic quarter hour shall equal 12.5 contact hours.
ii. Alternative experience. The department may accept either:
   a. one thousand hours of clinical practice after April 1, 1986 in the specialty for which additional certification is sought. Such practice shall be in a health care facility licensed pursuant to article 28 of the Public Health Law or in a school health demonstration project; or
   b. three hundred hours of clinical practice as part of a clinical practicum affiliated with a nurse practitioner program registered by the department, or accredited by an accrediting agency acceptable to the department.

3. Evidence of completion of educational programs, experience and examinations submitted to meet alternative criteria for certification as a nurse practitioner must be satisfactory to the department, and the overall preparation of the applicant must be comparable by assessment and substantially equivalent to the preparation provided by a registered or approved program. The department may require verification of the content and completion of the program or experience and of the satisfactory performance of the applicant by the person or institution conducting the program or in which the experience was acquired.

e. Prescriptive privilege. An applicant who satisfies all requirements for certification as a nurse practitioner may be authorized to issue prescriptions pursuant to Section 6902(3)(b) of the Education Law after completing instruction, satisfactory to the department, in New York State and Federal laws and regulations relating to prescriptions and recordkeeping.

§64.5 Nurse practitioner practice.

a. Practice agreements and practice protocols shall be maintained in the practice setting of the nurse practitioner and collaborating physician and shall be available to the department for inspection.

b. Practice agreements shall include provisions for referral and consultation, coverage for emergency absences of either the nurse practitioner or collaborating physician, resolution of disagreements between the nurse practitioner and collaborating physician regarding matters of diagnosis and treatment, and the review of patient records at least every three months by the collaborating physician; and may include such other provisions as determined by the nurse practitioner and collaborating physician to be appropriate.

c. Protocols shall identify the area of practice to be performed by the nurse practitioner in collaboration with the physician and shall reflect accepted standards of nursing and medical practice. Protocols shall include provisions for case management, including diagnosis, treatment, and appropriate recordkeeping by the nurse practitioner; and may include such other provisions as are determined by the nurse practitioner and collaborating physician to be appropriate. Such protocols may be updated periodically.
d. The department in its discretion or upon request of a nurse practitioner or collaborating physician may review practice protocols for the purpose of ensuring that they are in conformance with accepted medical and nursing practice and with the statutes and regulations governing the practice of medicine, nursing, and the prescribing of drugs, and may render an opinion which shall be binding upon the parties to the protocol. A practice and protocol committee designated by the Deputy Commissioner for the Professions shall review practice protocols and shall recommend findings as to their adequacy and conformity with current accepted medical and nursing practice. If the department determines that a protocol is inadequate or contrary to current accepted medical and nursing practice it shall communicate that determination and the reasons therefor, to the nurse practitioner and to the collaborating physician in writing. The nurse practitioner and collaborating physician shall conform to accepted medical and nursing practice immediately, and shall submit a revised protocol within 30 days of receipt of the department's determination, unless an extension of time is requested and granted by the department. Continuation of practice in violation of the determination shall constitute unprofessional conduct by either or both licensees.

e. An appeal from a determination that a practice protocol is inadequate or contrary to current accepted medical and nursing practice may be taken within 30 days after receipt of the notice of determination by a petition setting forth the reasons for the appeal, and signed by both the nurse practitioner and the collaborating physician. Such joint appeal shall be filed with the Division of Professional Licensing Services and determined by the Committee on the Professions whose determination shall be final.

f. In addition to the requirements of Section 6810 of the Education Law, prescription forms used by nurse practitioners shall be printed with the name, nurse practitioner certificate number, office address, and office telephone number of the nurse practitioner.

§64.6 Prescription and direction of nursing services.

a. Health care providers authorized to prescribe medical regimens to be executed by a registered professional nurse shall include persons licensed or authorized to practice pursuant to a limited permit or statutory exemption from the licensure requirement in the following licensed professions: medicine, including physician's assistant and specialist's assistant; dentistry; podiatry; midwifery; and nurse practitioner.

b. Health care providers authorized to direct the performance of professional services by licensed practical nurses shall include persons licensed or authorized to practice pursuant to a limited permit or statutory exemption from the licensure requirement in the following licensed professions: medicine, including physician's assistant and specialist's assistant; dentistry; podiatry; midwifery; and registered professional nursing, including but not limited to nurse practitioners.
Appendix C

Collaborative Agreement and Practice Protocols

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Sample Collaborative Practice Agreement

You are required to establish a collaborative agreement with one physician prior to beginning practice and maintain that agreement in the practice setting(s) where it will be available for inspection by the State Education Department (SED). New practitioners are also required to submit Form 4NP-Verification of Collaborative Agreement and Practice Protocol only once to the SED’s Office of the Professions no later than 90 days after beginning professional practice.

The collaborative agreement shall include provisions for referral and consultation, coverage for absences of either the nurse practitioner or the collaborating physician, resolution of disagreements between the nurse practitioner and the collaborating physician regarding matters of diagnosis and treatment, the review of a representative sample of patient records every three months by the collaborating physician, record keeping provisions and any other provisions jointly determined by the nurse practitioner and the physician to be appropriate.

Below is a sample practice agreement, it was written with one possible approach being used. There are many other styles and terms that may be used.

(Sample) Collaborative Practice Agreement

This agreement sets forth the terms of the Collaborative Practice Agreement between (nurse practitioner and specialty as listed on the State issued certificate) and (name of collaborating physician and specialty if any) at (name and address of agency or entity where practice takes place). This agreement shall take effect as of (date).

Introduction

(YOUR NAME, RN, NP) meets the qualifications and practice requirements as stated in Chapter 257 of the Laws of 1988 and Article 139 of the Education Law of New York State, holds a New York State license and is currently registered as a registered professional nurse in good standing, holds a certificate as a nurse practitioner pursuant to Sec. 6910 of the Education law and herein meets the requirement of maintaining a collaborative practice agreement with (NAME OF COLLABORATOR, MD/DO) a duly licensed and currently registered physician in good standing under Article 131 of the New York State Education Law.

I. Scope of Practice

The practice of a registered professional nurse as a nurse practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and
corrective measures including prescribing medications for patients whose conditions fall within the authorized scope of the practice as identified on the college certificate. This privilege includes the prescribing of all controlled substances under a DEA number. The nurse practitioner, as a registered nurse, may also diagnose and treat human responses to actual or potential health problems through such services as case finding, health counseling, health teaching, and provision of care supportive to or restorative of life and well-being. This practice will take place at (above identified agency) or in such other facility or location as designated by (name of identified agency) or by the parties of this contract. The following exceptions to the certified scope of practice have been agreed upon by the undersigned parties: (list exception(s)).

II. Practice Protocols

The protocols used in this (identify specialty as listed on State issued certificate) practice are contained in (name approved protocol text with all bibliography citations) and in (cite location of any other protocols which are germane to this particular practice).

III. Physician Consultation

The parties shall be available to each other for consultation either on site or by electronic access including but not limited to telephone, facsimile and email. Each party will cover for the other in the absence of one of them or (names of third parties) who are designated by (YOUR NAME, RN, NP and NAME OF COLLABORATOR MD/DO) as appropriate for coverage in the absence of both parties. In the event that there is an unforeseen lack of coverage, patients will be referred to the appropriate emergency room.

IV. Record Review

A representative sample of patient records shall be reviewed by the collaborating physician every three months to evaluate that (name of NP)'s practice is congruent with the above identified practice protocol documents and texts. Summarized results of this review will be signed by both parties and shall be maintained in the nurse practitioner's practice site for possible regulatory agency review. Consent forms for such review will be obtained from any patient whose primary physician is other than (name of collaborating physician).

V. Resolution of Disagreements

Disagreement between (name of nurse practitioner) and (name of collaborating physician) regarding a patient's health management that falls within the scope of practice of both parties will be resolved by a consensus agreement in accordance with current medical and nursing peer literature consultation. In case of disagreements that cannot be resolved in this manner, (name of collaborative physician's) opinion will
prevail. In disagreements between the nurse practitioner and non-collaborating physicians, the collaborating physician’s opinion will prevail.

VI. Alteration of Agreement

The collaborative practice agreement shall be reviewed at least annually and may be amended in writing in a document signed by both parties and attached to the collaborative practice agreement.

VII. Agreement

Having read and understood the full contents of this document, the parties hereto agree to be bound by its terms.

Nurse Practitioner (Specialty):

Printed Name___________________________________ RN license #_____________
Certificate #_____________________________________
Signature___________________________________________
Date____________________________________________

Collaborating Physician:

Printed Name___________________________________ MD license #_____________
Board Certification_________________________________
Signature___________________________________________
Date____________________________________________

Practice Agreements and Practice Protocols

NYS Dept. of Education Regulations Part 64.6

(a) Practice agreements and practice protocols shall be maintained in the practice setting of the nurse practitioner and collaborating physician and shall be available to the department for inspection.

(b) Practice agreements shall include provisions for referral and consultation, coverage for emergency absences of either the nurse practitioner or collaborating physician, resolution of disagreements between the nurse practitioner and the collaborating physician regarding the matter of diagnosis and treatment, and the review of patient records at least every three months by the collaborating physician, and may include such other provisions as determined by the nurse practitioner and the collaborating physician to be appropriate.

(c) Protocols shall identify the area of practice to be performed by the nurse practitioner in collaboration with the physician and shall reflect accepted standards of nursing and
medical practice. Protocols shall include provisions for case management, including diagnosis, treatment, and appropriate record keeping by the nurse practitioner: and may include such other provisions as are determined by the nurse practitioner and the collaborating physician to be appropriate.

(d) The department In its discretion or upon request of a nurse practitioner or collaborating physician may review practice protocols for the purpose of insuring that they are in conformance with accepted medical and nursing practice and with the statutes and regulations governing the practice of medicine, nursing, and the prescribing of drugs, and may render an opinion which shall be binding upon the parties to the protocol.

(e) In addition to the requirements of section 6810 of the Education Law, prescription forms used by the nurse practitioners shall be printed with the name, nurse practitioner certificate number, office address, and office telephone number of the nurse practitioner.

**What You Should Include in Your Practice Agreement**

1 Briefly define the collaborative model and the purpose of your agreement. A general statement describing the role and scope of the nurse practitioner's practice is often included.

2. Required details are stated in the Education Dept. regulations, part 64.6, subsection (b) above. Co-signing of notes is NOT required, nor is review of all charts. A meaningful review of records is required, sufficient to establish that safe and effective care is given, based on the extent of the physician's knowledge of the nurse practitioner's education, experience, and past performance. The sample of records reviewed must also be sufficient to ensure the safety and quality of care. The mechanism and frequency of chart review should be explained in your practice agreement.

3. In addition, you might explain in your practice agreement the mechanism for reviewing specialty consultation requests, radiographic and nuclear medicine studies, lab tests, and referrals for emergency or urgent clinical situations requiring immediate physician referral. Some agreements identify the protocols you will use. Some institutions specifically limit the tests that may be ordered without physician co-signature (for example, non-contrast radiographic studies may be ordered independently, but contrast studies require co-signature). Obviously, the fewer specific limits spelled out in the agreement, the more flexible your practice can remain. In some situations, you may feel more comfortable having specific limits and responsibilities spelled out, so that you may practice within your scope of competence and are assured of having consultation and support available when needed.

4. In institutional settings, some practice agreements include or attach a job description or clinical privileges listing
Approved Protocol Texts - Updated June 2013

You are also required to identify a protocol text, from the approved list, as your official practice protocol which must reflect the specialty area of practice as identified on your State Education Department issued nurse practitioner certificate. The approved protocol texts include provisions for case management, diagnosis and treatment of pathology in the specialty area. Additional protocols or textbooks which may be appropriate to the practice and/or employment setting may be used but need not be reflected in the collaborative agreement.

Check NYS Education Department website for current listing of approved protocol text. www.nysed.gov and search for “approved protocol text”.

Protocols Commonly Used In Acute Or Tertiary Care Practice


Protocols Commonly Used In Mental Health Practice


Protocols commonly used in Oncology or Palliative Care Practice


Protocols commonly used in Adult Care or Gerontologic Practice


Protocols Commonly Used in Family, Holistic or General Primary Care Practice

Appendix C – Collaborative Agreement


Protocols Commonly Used In OB-GYN, Women’s Health or Perinatal Practice

- Heath, C., & Sulik, S., (Editors) (2010) *Primary Care Procedures In Women’s Health Springer*.
Appendix C – Collaborative Agreement

Protocols Commonly Used in Neonatal or Pediatric Practice

- Centers for Disease Control and Prevention. (2011). *Vaccines And Immunizations* See, [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines/)
Appendix C – Collaborative Agreement


All Approved Protocols Listed

Appendix C – Collaborative Agreement

Clarifying Information for Nurse Practitioners and Collaborating Physicians about Patient Records Review

Nurse Practitioners sometimes request information about the number of patient records that must be reviewed by their collaborating physicians. The New York State Education Department is pleased to provide you with information to help clarify this issue.

Patient records must be reviewed by a nurse practitioner's collaborating physician according to Section 6902 (3)(c) of the Education Law which states that:

Each practice agreement (between a nurse practitioner and physician) shall provide for patient records review by the collaborating physician in a timely fashion but in no even less often than every three months.

The law does not provide specific ratios or numbers of charts that must be reviewed by the collaborating physician. That decision is left to the professional judgment of the nurse practitioner and the collaborating physician and might vary depending on:

- Nurse practitioner's experience
• Collaborating physician's knowledge of the nurse practitioner's abilities and judgment
• Specialty
• Patient mix
• Nature of the practice setting, and
• Other factors

It is important that the nurse practitioner and the physician determine the terms of the collaboration on the matter of patient records review through negotiation and agreement. The appropriateness of the process of patient record review might be considered in professional discipline, malpractice litigation, or in institutional internal reviews, as for example in an Article 28 facility.

If you have additional questions, please contact:

Education Department Building
Nursing Board Office
89 Washington Avenue
Second Floor
Albany, NY 12234

Email: nursebd@mailnysed.gov,
Phone: 518-474-3817 Ext. 120
Fax: 518-474-3706
Appendix D

Memoranda

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To: Interested Parties  
From: Barbara Zittel, RN, Ph.D. Executive Secretary to the NYS Board for Nursing 
Re: Practice Considerations for Providing Psychiatric Care  
Date: October 1, 2008

Article 139, section 6902(3)a of New York State Education Law provides the following legal definition of the practice of a Nurse Practitioner:

> The practice of registered professional nursing by a nurse practitioner, certified under section six thousand nine hundred ten of this article, may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty involved, provided such services are performed in accordance with a written practice agreement and written practice protocols. The written practice agreement shall include explicit provisions for the resolution of any disagreement between the collaborating physician and the nurse practitioner regarding a matter of diagnosis or treatment that is within the scope of practice of both. To the extent the practice agreement does not so provide, then the collaborating physician's diagnosis or treatment shall prevail.

Nurse Practitioners are thus limited to practice in the specialty in which they hold a New York State Education Department certificate. For example, only nurse practitioners registered with the Department in the specialty of psychiatry may engage in the practice of psychiatry.

A nurse practitioner certified in a specialty other than psychiatry, may within their individual discretion and competence, determine and treat presenting symptoms and signs that may lead to the necessity of a referral to a qualified health care professional for psychiatric intervention. Failure to provide such a referral may constitute grounds for a charge of professional misconduct.

If you have additional questions, please contact Dr. Zittel, Executive Secretary to the State Board for Nursing, by mail: Education Department Building, 89 Washington Ave., Nursing Board Office, Second Floor, West Wing, Albany, NY 12234, e-mail: nursebd@mail.nysed.gov, phone: 518-474-3817 Ext. 120, or fax: 518-474-3706.
To: Susan Naccarato  
Francine Angian  
From: Laurene C. O’Brien  
Re: General guidelines for practice under NP specialty certificate  
Date: 2/1/2012

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<td>age 50 and above</td>
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PAYMENT OF COLLABORATING PHYSICIANS BY NURSE PRACTITIONERS

Statement of Issue

In order to practice lawfully, New York State Education Law requires a Nurse Practitioner to enter into a written collaborative agreement with a physician qualified to collaborate in the specialty involved (Title VIII, Article 139). In some situations, collaborating physicians may expect to receive some form of reasonable payment for the services which they render, such as availability for consultation or chart review, or other tasks surrounding fulfillment of their obligations under the collaborative agreement. The purpose of this memorandum is to offer guidance to Nurse Practitioners related to circumstances under which such payment may be provided. Questions regarding physicians’ conduct related to this issue should be directed to the Department of Health’s Office of Professional Medical Conduct.

Regents Rules-Part 29

Part 29 of Regents Rules describes conditions that may be considered professional misconduct. Section 29.1(b)(3) of the Rules states that unprofessional conduct shall include:

"directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services."

Interpretation

The Office of the Professions has interpreted this rule, within the context of Nurse Practitioner practice, to mean that a Nurse Practitioner may pay a collaborating physician for the fair market value of services such as chart review and consultation. However, there is no compulsion for the NP to enter into such an arrangement nor is it appropriate to include such terms within the written collaborative agreement. When a payment agreement does exist, the payment may not influence the nature of the chart review nor result in any exclusive arrangement between the NP and physician for patient referrals in exchange for the services rendered. It is understood that in certain instances Nurse Practitioners may refer patients to their collaborating physicians when medically necessary including situations where a Nurse Practitioner may not be granted hospital privileges. Such instances would not automatically be considered professional misconduct unless NPs bind themselves into an exclusive arrangement for referrals to the collaborating physician(s) or otherwise give or receive compensation for such referrals.

Contact Information

If you have additional questions, please contact Barbara Zittel, Executive Secretary to the State Board for Nursing, by mail: Education Department Building, 89 Washington Ave., Nursing Board Office, Second Floor, West Wing, Albany, NY 12234, e-mail: nursebd@mail.nyssed.gov, phone: 518-474-3817 Ext. 120, or fax: 518-474-3706.

July 2006
TO: Article 19-A Motor Carriers
   Certified Examiners
   School Districts
   Testing and Investigation Units

SUBJECT: Chapter 600 of the Laws of 2002 (Article 19-A Medical Exams)

Effective September 24, 2002, Section 509(g) of the Vehicle and Traffic Law and effective April 16, 2003, the Commissioner's Regulations are amended authorizing nurse practitioners, in addition to physicians, to perform medical examinations for drivers in accordance with Article 19A of the Vehicle Traffic Law. The physician or nurse practitioner performing the medical examination cannot be the personal physician or nurse practitioner of the driver who is being examined.

When the required biennial medical examination is completed, form DS-874, ("Examination to Determine Physical Condition of Driver Under Article 19A"), must be completed and signed by the physician or nurse practitioner that conducts the exam. The carrier or employer is then required to place the original copy of the examination report in the employee's file.

The amended text of Section 509 (g) of the Vehicle and Traffic Law, and the amended parts of Section 6 of the Commissioner's Regulations, is attached for your reference.

Raymond P. Martinez
Commissioner of Motor Vehicles

Attachment
The Board Office has received a number of questions during the last several weeks on the legal age limitations for Adult and Pediatric Nurse Practitioners. After discussion with legal counsel, the following is provided to clarify this issue.

The age of majority in New York State is 18. In developing regulations for the recently enacted law on the administration of immunizations and anaphylactic agents for non-patient specific orders, this age was used to differentiate children and adults and the types of immunizations that can be provided to these two groups.

It is expected that both Pediatric and Adult Nurse Practitioners determine an appropriate age limitation for their practice. The 18 year guideline is legally defensible. However, in certain circumstances as are determined by the Nurse Practitioner and the collaborating physician, a Pediatric Nurse Practitioner may treat an individual beyond that age limit, while an Adult Nurse Practitioner may treat an individual younger than that age limit. These special circumstances shall be stated in the collaborative agreement on file in the practice setting.

It is expected that those individuals who undertake such practice will have education and training to be competent in providing care for this older or younger age-group.
Appendix E

Federal and State Funding for Nurse Practitioner Education

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  Federal and State Funding for Nurse Practitioner Education................................. 1
Federal Funding for Nurse Practitioner Education

Scholarships for physician assistant, nurse practitioner, or midwifery students are available through the National Health Services Corps (NHSC). The National Health Services Corps is part of the Department of Health and Human Services’ Health Resources and Services Administration (HRSA). HRSA improves the Nation’s health by assuring equal access to comprehensive, culturally competent, quality health care for all.

Contact and Information:
HRSA Scholarship web page:  http://nhsc.hrsa.gov/scholarships/index.html
Phone:  800-221-9393
E-Mail:  gethelp@hrsa.gov

State Funding for Nurse Practitioner Education

The New York State Education Department offers scholarships to physician assistant, nurse practitioner, or midwifery students through its Regents Professional Opportunities Scholarships.

Collegiate Development Programs

The Unit’s mission is to coordinate State and federally funded grant programs, Physician Loan Forgiveness, High Needs Nursing, Higher Education Emergency Management, and a variety of processes associated with implementation of the NYS Tuition Assistance Program, that promote and support strategies to:

- Increase retention and graduation rates for underrepresented and/or economically disadvantaged college students in postsecondary education;
- Increase access for underrepresented and economically disadvantaged college students in pre-professional programs of study in the licensed professions;
- Prepare college students to work in technical careers and in the licensed professions; and
- Assist New York State residents with accessing post-secondary educational opportunities.
Contact and Information:


Collegiate Development Programs Information: http://www.highered.nysed.gov/kiap/colldev/

Phone: 518-486-6042

Collegiate Development Programs Unit
New York State Education Department
Room 505W, Education Building
Albany NY 12234

E-Mail: cdpu@mail.nysed.gov
Appendix F

Forms & Instructions for Licensure & Practice

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Instructions for a Certificate as a Nurse Practitioner

INSTRUCTIONS

Please type or print all information and sign all forms in black or blue ink. Original signatures are required on all forms.

FORM 1 - APPLICATION FOR A CERTIFICATE

All applicants for a certificate must complete this form and submit it with the $85 fee for a certificate and initial registration directly to the Office of the Professions at the address at the end of Form 1. Make checks payable to the New York State Education Department. NOTE: Your cancelled check is your receipt.

You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. Your signature on Form 1 must be notarized by a Notary Public.

FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION (For applicants who have completed a program registered by the State Education Department as qualifying for a certificate or a program determined by the Department to be equivalent; see pages 3-4.)

This form must be submitted directly to the Office of the Professions by the professional school you attended. This form will not be accepted if submitted by the applicant or any party other than the school official.

Section I: Complete this section of the form before sending the entire form to your school. Be sure to sign and date item 11.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 2B - VERIFICATION OF INSTRUCTION IN NEW YORK STATE AND FEDERAL LAWS RELATED TO PRESCRIPTIONS AND RECORD KEEPING (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

This form must be submitted directly to the Office of the Professions by the school, institution or professional association where you completed instruction. This form will not be accepted if submitted by the applicant or any party other than the school, institution or professional association official.

Section I: Complete this section of the form before sending the entire form to the school, institution or professional association where you completed instruction in New York State and federal laws relating to prescriptions and record keeping. Be sure to sign and date item 8.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 2C - VERIFICATION OF PHARMACOTHERAPEUTICS COURSE (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)

This form must be submitted directly to the Office of the Professions by the school, institution or professional association where you completed instruction. This form will not be accepted if
submitted by the applicant or any party other than the school, institution or professional association official.

Section I: Complete this section before sending the entire form to the school institution or professional association where you completed a pharmacotherapeutic course, including instruction in drug management of clients in the nurse practitioner’s specialty area. Be sure to sign and date item 8.

Section II: The Registrar must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 3 - VERIFICATION OF NATIONAL NURSE PRACTITIONER EXAMINATION (For applicants seeking a New York State nurse practitioner certificate through a national certifying organization.)

This form must be submitted directly to the Office of the Professions from the national certifying organization that will verify your certification examination. The Office of the Professions will not accept this form if submitted by the applicant or any other party.

Section I: Complete this section before sending the entire form to the national certifying organization to verify that you passed the nurse practitioner certification examination. Be sure to sign and date item 9.

Section II: The national certifying organization must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

FORM 4 - VERIFICATION OF EXPERIENCE (For applicants following pre-1989 alternative requirements for a certificate.)

This form is required within 90 days after commencement of practice.

Section I: Complete this section of the form before sending the entire form to the physician who supervised your experience within the specialty for which you are seeking a certificate. Be sure to sign and date item 7.

Section II: The supervising physician must complete this section and return both pages of the form directly to the Office of the Professions at the address at the end of the form.

A separate Form 4 must be submitted by each physician with whom you worked with while acquiring the required experience.

FORM 4NP - VERIFICATION OF COLLABORATIVE AGREEMENT AND PRACTICE PROTOCOL (All applicants.)

Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required once.

Section I: Complete this section of the form.

Section II & III: You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete these sections and return both pages of the form to the Office of the Professions at the address at the end of the form. Be sure to sign item 4 in Section III.

Completing Additional Forms

FORM AD/NAME - ADDRESS/NAME CHANGE FORM

You are required to notify us within 30 days of any name or address changes. Please read the instructions and complete the appropriate sections of this form.
Applicant Checklist

Please complete and keep this checklist as a reminder of what forms you have filed and when you filed them. This is for your reference and should not be submitted with your application forms. **You should keep a copy of all application forms submitted.**

CHECK (★) AND DATE EACH STEP WHEN COMPLETED.

1. Have you completed and sent the following to the Office of the Professions?
   - FORM 1 - APPLICATION FOR A CERTIFICATE
   - FEE ($85) - FOR A CERTIFICATE AND INITIAL REGISTRATION

2. Have you completed and forwarded the following forms to the appropriate institution(s) or agencies? Keep copies of the requests so that you may check with them to be sure they have submitted the information.
   - FORM 2 - CERTIFICATION OF PROFESSIONAL EDUCATION (For applicants who have completed a program registered by the State Education Department as qualifying for a certificate or a program determined by the Department to be equivalent; see pages 3-4.)
     - Sent to the following educational institutions:
       - Date sent

   - FORM 2B - VERIFICATION OF INSTRUCTION IN NEW YORK STATE AND FEDERAL LAWS RELATED TO PRESCRIPTIONS AND RECORD KEEPING (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)
     - Sent to the following school/institution/professional association:
       - Date sent

   - FORM 2C - VERIFICATION OF PHARMACOTHERAPEUTICS COURSE (For applicants who have completed a program other than a program registered by the New York State Education Department as qualifying for a certificate.)
     - Sent to the following school/institution/professional association:
       - Date sent
D. FORM 3 - VERIFICATION OF NATIONAL NURSE PRACTITIONER EXAMINATION (For applicants seeking a New York State nurse practitioner certificate through a national certifying organization.)

Sent to the following national certifying organization:  

__________________________________________________________  ________________

__________________________________________________________  ________________

E. FORM 4 - VERIFICATION OF EXPERIENCE (For applicants following pre-1989 alternative requirements for a certificate.) This form is required within 90 days after commencement of practice.

Sent to the following supervising physician(s):  

__________________________________________________________  ________________

__________________________________________________________  ________________

F. FORM 4NP - VERIFICATION OF COLLABORATIVE AGREEMENT AND PRACTICE PROTOCOL (all applicants) This form is required within 90 days after commencement of initial practice.

TO SPEED PROCESSING OF YOUR APPLICATION:

- Submit your application for a New York State certificate in plenty of time to allow verifying organizations to send the required independent verifications to the Office of the Professions. This may take eight weeks or more.
- Notify the Office of the Professions promptly of any address or name changes.
- Respond promptly to requests for additional information from the Office of the Professions.
Nurse Practitioner Form 1

Application for a Certificate

Applicants Must Complete All Pages of This Application In Ink

All applicants for a certificate must complete this form and submit it with the $85 fee for a certificate and initial registration directly to the Office of the Professions at the address at the end of this form. You must answer all questions and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. Form 1 must be notarized by a Notary Public.

2 Social Security Number

(Leave this blank if you do not have a U.S. Social Security Number)

3 Birth Date

Month ☐ Day ☐ Year ☐

4 Print Name Exactly as You Wish It to Appear on Your Certificate

(This must be the same name as on your RN license.)

Last ☐ First ☐ Middle ☐

5 Mailing Address

(You must notify the Department promptly of any address or name changes.)

Line 1 ☐ Line 2 ☐ Line 3 ☐

City ☐ State ☐ Country/Province ☐

Zip Code ☐

6 Telephone/E-Mail Address

Daytime phone ☐

Area Code ☐ Phone ☐

E-mail Address (please print clearly) ☐

If we may discuss your certification using this e-mail address, please check this box.

7 New York State Registered Professional Nurse License Number:

Name(s) under which credentialed (if different from above):

8 Name as it appears on degree or other credentials (if different from above):

9 Nurse Practitioner specialty area for which you are applying:

10 Identify the basis on which you are applying for a certificate. NOTE: A Form 1 & fee must be filed for each specialty area.

Name at time of graduation (if different from above):

☐ a. Completion of nurse practitioner educational program registered by the New York State Education Department as qualifying for a certificate. (File Form 2)

Program title (including specialty) ☐ Institution ☐ Date Graduated ☐

☐ b. Completion of nurse practitioner educational program determined to be equivalent to a registered program by the State Education Department as qualifying for a certificate. (File Form 2)

Program title (including specialty) ☐ Institution ☐ Date Graduated ☐

☐ c. Verification of passing a nurse practitioner examination administered by a national certifying organization. (File Form 3)

Examination ☐ Certifying agency ☐ Date Graduated ☐

☐ d. On the basis of alternative requirements for graduates of nurse practitioner programs prior to April 1, 1989

Experience (File Form 4) ☐ Supplemental education program (File Form 2) ☐

Nurse Practitioner Form 1, Page 1 of 4, Rev. 9/09
Please print clearly giving an accurate record of your educational preparation below. YOU MUST COMPLETE ALL INFORMATION FOR ALL SCHOOLS/COLLEGES/UNIVERSITIES ATTENDED AND DIPLOMAS AND/OR DEGREES RECEIVED OR YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE. Attach additional sheets if necessary.

**Basic Nursing Program for R.N. Licensure**

Name of school: ____________________________________________________________

City: __________________________ State/Province: _____________________________ Country: _____________________________

Number of years attended: __________________________

Attendance from: __________/________/________ to __________/________/________

Graduation date: __________/________/________

---

**All Postsecondary Higher Education except Nurse Practitioner Program(s)**

Name of School: ____________________________________________________________

City: __________________________ State/Province: _____________________________ Country: _____________________________

Major/Concentration: ______________________________________________________

Number of years attended: __________________________

Attendance from: __________/________/________ to __________/________/________

Title of Degree/Diploma/Certificate awarded (in the original language): _____________________________________________

Date Degree/Diploma/Certificate awarded: __________/________/________

---

**Nurse Practitioner Program(s)**

Name of School: ____________________________________________________________

City: __________________________ State/Province: _____________________________ Country: _____________________________

Major/Concentration: ______________________________________________________

Number of years attended: __________________________

Attendance from: __________/________/________ to __________/________/________

Title of Degree/Diploma/Certificate awarded (in the original language): _____________________________________________

Date Degree/Diploma/Certificate awarded: __________/________/________

---

**Certification by national certifying organizations or state**

Name of certifying organization or state: _____________________________________________

Date originally certified: __________/________/________

Expiration date of current certification: __________/________/________
12 Gender and Ethnicity: (This item is optional.)

Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning diversity in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

Gender: ☐ Male ☐ Female
Ethnicity: ☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American ☐ Biracial

13 Student Loan Disclosure

The State Education Department is required* to ask these questions about any student loans made or guaranteed by the New York State Higher Education Services Corporation, and to forward any "yes" responses to the New York State Higher Education Services Corporation. Your license application is not complete without this information.

A) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? ☐ Yes ☐ No

B) If you have such a loan(s), is any part in default? ☐ Yes ☐ No

*New York State Education Law, Section 6501-a

14 Citizenship/Immigration Status:

comply with this Federal law, complete this section of this form and check the appropriate box below which indicates your citizenship/immigration status.

I am: (check one box)

A. A United States citizen or National.
B. An alien lawfully admitted for permanent residence in the United States.
C. An alien granted asylum under Section 208 of the Immigration and Nationality Act.
D. A refugee granted asylum under Section 207 of the Immigration and Nationality Act.
E. An alien paroled into the United States under Section 212 (d)(5) of the Immigration and Nationality Act for a period of at least one year.
F. An alien whose deportation is being withheld under Section 243 (h) of the Immigration and Nationality Act.
G. An alien granted conditional entry pursuant to Section 203 (a)(7) of the Immigration and Nationality Act as in effect prior to April 1980.
H. Non Immigrant (Temporarily in U.S.)

Please list Visa type or immigration status or attach a copy of your passport if you are not required to have a Visa to enter the United States: __________________________________________

If you checked any of the boxes from B-H, enter your alien registration number or control number issued by the United States Citizenship and Immigration Services (USCIS): __________________________

USCIS number

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE U.S. CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) BY CALLING 1-800-375-5283, OR VISIT THEIR WEB SITE AT WWW.USCIS.GOV.

15 Child Support Obligation

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits. The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A. ☐ I am not under an obligation to pay child support

OR

B. ☐ I am under an obligation to pay child support and (please check only one of the following):

☐ I am current and am not four months or more in arrears in the payment of child support; or,
☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
☐ The child support obligation is the subject of a pending court proceeding; or,
☐ I am receiving public assistance or supplemental security income; or,
☐ None of the above four statements apply.

* New York State General Obligations Law, section 3-503.
Photograph Requirement:

DO NOT STAPLE

ATTACH SECURELY IN THIS SPACE A 2" X 2"
PASSPORT STYLE PHOTOGRAPH TAKEN
WITHIN THE PAST YEAR

Date of photo: ______________

Affidavit With Acknowledgment (Notarization required.)

Applicant

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Signature of the applicant: ____________________________________________

Date __________/__________/__________

Month Day Year

Notary

State of ____________________________ County of ____________________________

On the __________________ day of __________________ in the year __________before me, the undersigned, personally appeared ____________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature ____________________________

Notary ID number ____________________________

Expiration date __________/__________/__________

Month Day Year

Notary Stamp

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department

Nurse Practitioner Form 1, Page 4 of 4, Rev. 9/09
Certification of Professional Education

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 11.

2. Send the entire form to the institution(s) you attended. Ask the registrar to complete Section II and forward both pages of the form in an official school envelope directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required by the institution. **This form will not be accepted if submitted by the applicant or any party other than the school official.**

3. You must submit a separate Form 2 for each specialty area in which you are requesting a certificate.

## Section I: Applicant Information

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<td>Social Security Number</td>
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<td>New York State Registered Professional Nurse License Number</td>
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<td>Print Name as It Appears on Your Application for a Certificate (Form 1)</td>
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<td>Mailing Address</td>
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| City |   |   |   |   |
| State | Zip Code |   |   |   |
| Country/ Province |   |   |   |   |

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<td>Print your name as it appears on your degree or diploma.</td>
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<td>School attended:</td>
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| (Name) | (Name) | (Name) | (Name) |
| (city/state or country) | (city/state or country) | (city/state or country) | (city/state or country) |

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<td>Name of degree/diploma:</td>
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<td>Specialty area:</td>
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| date/diploma awarded: |   |   |   |   |

| mo. | day | yr. |   |   |   |

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<td>11</td>
<td>I request and give my permission to the school listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.</td>
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<td>Applicant's Signature</td>
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Applicant's Signature:   /   /   

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<tr>
<th>Section II: Verification of Nurse Practitioner Program</th>
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<tr>
<td><strong>Instructions to Registrar:</strong> Please complete Section II and return both pages of this form <strong>along with an official school transcript</strong>, directly to the <strong>New York State Education Department</strong> at the address at the end of this form. <strong>This form will not be accepted if returned by the applicant or any other party.</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> If the applicant has completed more than one program, a Form 2 must be submitted for each program.</td>
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</table>
| a) It is hereby verified that: __________________________________________________________________________

(Section I, item 6.)

has completed a program qualifying for certified nurse practitioner and the degree/diploma listed below has been awarded. The official program title completed by the applicant is as follows:

Official program title: __________________________________________________________________________
| b) The program contained: __________ hours of classroom instruction and __________ hours of preceptorship with a nurse practitioner or physician. |
| c) Degree/diploma awarded: __________________________________ Date: __________ / __________ / ________

mo. day yr.
| d) The individual named has completed a pharmacotherapeutics component of not less than three semester hours or the equivalent, including instruction in drug management of clients in the nurse practitioner's concentration/specialty area. |

☐ Yes ☐ No
| e) The individual named has completed a pharmacotherapeutics component, including instruction in New York State and Federal laws related to prescriptions and record keeping. |

☐ Yes ☐ No

**Certification**

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the record of the professional education of the individual named on this form.

Signature of Registrar: __________________________________________ Date: __________ / __________ / ________

mo. day yr.

Title or official position: ________________________________

Institution: ____________________________________________

Address: _____________________________________________ (SEAL)

______________________________________________________

Telephone: ______________________ Fax: ______________________

E-mail Address: __________________________________________
### Verification of Instruction in New York State and Federal Laws Related to Prescriptions and Record Keeping

(Use this form ONLY if you have completed a program other than program registered by the New York State Education Department as qualifying for a certificate.)

**Applicant Instructions**

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 8.

2. Send the entire form to the school/institution/professional association where you completed instruction in New York State and federal laws relating to prescriptions and record keeping. Ask them to complete Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required. **This form will not be accepted if submitted by the applicant or any party other than the school official.**

### Section I: Applicant Information

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
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|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

1. **Social Security Number**
   - Leave this blank if you do not have a U.S. Social Security Number

2. **New York State Registered Professional Nurse License Number**

3. **Print Name as It Appears on Your Application for a Certificate (Form 1)**
   - Last
   - First
   - Middle

4. **Mailing Address** (You must notify the Department promptly of any address or name changes.)
   - Line 1
   - Line 2
   - Line 3
   - City
   - State
   - Zip Code
   - Country/Province

5. **Print name under which course was completed (if different from above).**
   - Name:

6. **Name of school/institution/professional association where course was completed:**
   - Address:

7. **I request and give my permission to the school/institution/professional association listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.**
   - Applicant's Signature
   - Date

---

**Nurse Practitioner Form 2B, Page 1 of 2, (Rev. 3/09)**
Section II: Verification of Completion of Prescription Course

Instructions to School/Institution/Professional Association: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. This form will not be accepted if returned by the applicant or any other party.

1. It is hereby verified that: __________________________________________ (Section I, item 6)
   completed instruction in New York State and federal laws related to prescriptions and record keeping.

2. This course was:  ☐ part of nurse practitioner program, or  ☐ supplementary course.

3. Date(s) of the course: _____/_____/______ and _____/_____/______
   mo. day yr.   mo. day yr.

4. The length of the course was: __________________________ or __________________________.
   (semester hours) (clock hours)

Attestation

I hereby attest that to the best of my knowledge and belief the information in Section II is an accurate record of the completion of a course in prescription and record keeping laws of the individual named on this form.

Signature: __________________________________________ Date: _____/_____/______
   mo. day yr.

Print Name: ________________________________

Title or official position: ________________________________

Institution: _______________________________________

Address: __________________________________________ (SEAL)

Telephone: __________________ Fax: __________________

E-mail Address: ________________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Nurse Practitioner Form 2B, Page 2 of 2, (Rev. 3/09)
Verification of Pharmacotherapeutics Course
(Three Semester Hours or the Equivalent)
(Use this form ONLY if you have completed a program other than program registered by the New York State Education Department as qualifying for a certificate.)

Applicant Instructions
1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 8.
2. Send the entire form to the school/institution/professional association where you completed a pharmacotherapeutics course, including instruction in drug management of clients in the nurse practitioner’s specialty area. Ask them to complete Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any This form will not be accepted if submitted by the applicant or any party other than the school official.

Section I: Applicant Information

1 Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

2 Birth Date Month    Day    Year

3 New York State Registered Professional Nurse License Number

4 Print Name as It Appears on Your Application for a Certificate (Form 1)

   Last
   First
   Middle

5 Mailing Address (You must notify the Department promptly of any address or name changes.)

   Line 1
   Line 2
   Line 3
   City
   State
   Zip Code
   Country/Province

6 Print name under which course was completed (if different from above).

   Name: ________________________________

7 Name of school/institution/professional association where course was completed: ________________________________

   Address: ________________________________

8 I request and give my permission to the school/institution/professional association listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.

   Applicant's Signature    mo.  /  day  /  yr.

Section II: Verification of Completion of Pharmacotherapeutics Course

Instructions to School/Institution/Professional Association: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. This form will not be accepted if returned by the applicant or any other party.

1. It is hereby verified that: ________________________________ 

   has completed pharmacotherapeutics instruction in drug management of clients in the nurse practitioner's specialty area of ________________________________.

2. This course was   ☐ part of nurse practitioner program, or
   ☐ supplementary course.

3. The inclusive date(s) of the course were: _____/_____/_____ and _____/_____/_____.

   mo.   day   yr.     mo.   day   yr.

4. The length of the course was: ___________ or ___________.

   (Semester hours)   (Clock hours)

5. In this course, did the individual named receive instruction in New York State and Federal laws relating to prescriptions and record keeping?

   ☐ Yes    ☐ No

Attestation

I hereby attest that to the best of my knowledge and belief the information in Section II is an accurate record of the completion of a course in pharmacotherapeutics by the individual named on this form.

Signature: __________________________________________________________________________ Date: _____/_____/_____

   mo.   day   yr.

Print Name: __________________________________________________________________________

Title or official position: __________________________________________________________________________

Institution: __________________________________________________________________________

Address: __________________________________________________________________________ (SEAL)

____________________________________________________________________________________

Telephone: __________________________ Fax: __________________________

E-mail Address: __________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Nurse Practitioner Form 2C, Page 2 of 2, (Rev. 3/09)
Verification of National Nurse Practitioner Examination
(Use this form ONLY if you are seeking a New York State certificate through a national certifying organization.)

Applicant Instructions
1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 9.
2. Send the entire form to the national certifying organization. Ask them to complete Section II and forward both pages of the form directly to the Office of the Professions at the address at the end of this form. Be sure to include any fee required. This form will not be accepted if submitted by the applicant or any other party.

Section I: Applicant Information
1. Social Security Number
   (Leave this blank if you do not have a U.S. Social Security Number)
2. Birth Date Month Day Year
3. New York State Registered Professional Nurse License Number
4. Print Name as It Appears on Your Application for a Certificate (Form 1)
   Last
   First
   Middle
5. Mailing Address (You must notify the Department promptly of any address or name changes.)
   Line 1
   Line 2
   Line 3
   City
   State
   Zip Code
   Country/Province
6. National certifying organization:
   Certification examination passed: Title: Date: / / mo. day yr.
7. Are you currently certified?  Yes  No
   If yes, certification number: Expiration date: / / mo. day yr.
8. Print name under which certificate was awarded (if different from above).
   Name:
9. I request and give my permission to the national certifying organization listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for a certificate.
   Applicant’s Signature
   / / mo. day yr.
Section II: Verification of National Nurse Practitioner Examination

Instructions to National Certifying Organization: Please complete Section II and return both pages of this form directly to the New York State Education Department at the address at the end of this form. This form will not be accepted if returned by the applicant or any other party.

1. It is hereby verified that: __________________________________________ (Section I, item 8) has passed the nurse practitioner certification examination listed below.

2. Certification examination title: __________________________________________

   Certificate awarded: (Title) __________________________________________

   Certificate number: __________________________________________ Date initial certificate awarded: ______/_______/______

   mo. day yr.

   Is this nurse currently certified? ☐ Yes ☐ No

   Expiration date: ______/_______/______

   mo. day yr.

3. Education program that was basis for admission to the examination:

   Program __________________________________________

   Entrance date ______/_______/______ Completion date ______/_______/______

   mo. day yr. mo. day yr.

   Degree/diploma awarded: __________________________________________ Date: ______/_______/______

   mo. day yr.

   Institution: __________________________________________

   Address: __________________________________________

Certification

I hereby certify that to the best of my knowledge and belief the information in Section II is an accurate record of the examination results of the individual named on this form.

Signature: __________________________________________ Date: ______/_______/______

   mo. day yr.

Print Name: __________________________________________

Title: __________________________________________

Agency: __________________________________________

Address: __________________________________________ (SEAL)

____________________________________________________

Telephone: __________________________ Fax: __________________________

E-mail Address: __________________________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.
Verification of Experience
(Use this form ONLY if you are following pre-1989 alternative requirements for a certificate.)

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1). Be sure to sign and date item 7.

2. Send the entire form to the physician who has been responsible for supervising the work for which you are seeking credit and ask her/him to complete Section II and send both pages of the form directly to the Office of the Professions at the address at the end of this form. This form will not be accepted if submitted by the applicant or any other party.

3. A separate form 4 must be provided by each physician with whom you worked while acquiring the required experience.

Section I: Applicant Information

1 Social Security Number [Blank if you do not have a U.S. Social Security Number]

2 Birth Date Month [Blank] Day [Blank] Year [Blank]

3 New York State Registered Professional Nurse License Number

4 Print Name as It Appears on Your Application for a Certificate (Form 1)

   Last

   First

   Middle

5 Nurse practitioner specialty area for which you are applying:

6 Name of supervising physician:

7 I authorize the physician named above to provide any information requested, including the information requested on this form, to the New York State Education Department.

   Applicant’s Signature  [Blank] / [Blank] / [Blank]  mo. day yr.

Section II: Verification of Experience - To be completed by the Supervising Physician

The individual named above is seeking certification as a nurse practitioner in the specialty area named in (5) above. This application is partially based upon two years of experience prior to April 1, 1989, at least one year of which shall be subsequent to April 1, 1986, in the provision of primary health care services in a health care facility licensed pursuant to Article 28 of the Public Health Law or in a school health demonstration project. The purpose of this objective performance evaluation is to determine the competency of the nurse practitioner to provide primary care in the specified specialty area. It is a summary evaluation based upon your firsthand observation, anecdotal notes, and other documentation of the applicant’s consistent performance.

The rating is either “satisfactory,” “unsatisfactory,” or “not applicable.” A checkmark will indicate the rating. There is space at the end of the form to provide any additional comments you may have regarding the performance of this individual (attach additional sheets, if required).

Please complete Section II, sign and date the certification and return both pages of this form directly to the Office of the Professions at the address at the end of the form.

Name of Institution:

Address:

Article 28 facility? ☐ Yes ☐ No If yes, since: ____________________________ Year

In what capacity was the applicant employed? ____________________________

☐ Full time ☐ Part time Inclusive dates (note interruptions): From _____/_____/_____ to _____/_____/_____  mo. day yr. mo. day yr.

Specialty or clinical area of experience: ____________________________

If available, please attach job description.
### A. Health Assessment

1. Demonstrates skillful interviewing of clients.
2. Elicits an age-appropriate comprehensive health history.
3. Elicits and records information specific to the client’s complaints (e.g., onset, timing, duration, location, associated symptoms, alleviating factors, quantity/intensity, etc.).
4. Performs a complete physical examination.
5. Demonstrates use of appropriate techniques of inspection, palpation, percussion, and auscultation throughout the examination.
6. Prepares client charts for review according to the facilities schedule.
7. Differentiates normal from abnormal findings.
8. Uses appropriate equipment accurately & efficiently when performing a physical examination.
9. Adapts the history and physical to meet the needs of individual clients.
10. Selects appropriate diagnostic tests to gather information necessary to evaluate the health status of a client.
11. Records information in a well-organized, concise manner.
12. Analyzes all data in order to formulate an assessment of the client's status and establish a plan of care.
13. Identifies specific health promotion/maintenance needs of clients and families.
14. Describes etiology, developmental considerations, pathogenesis and clinical manifestations of specific disease processes.
15. Correlates pathophysiology with client’s signs & systems.
16. Correlates pathophysiology with laboratory data.
17. Demonstrates knowledge of pathophysiology of acute and chronic diseases or conditions commonly encountered in the practice setting.

### B. Technical Skills

1. Performs and interprets selected laboratory tests.
2. Performs technical skills specific to practice setting.
3. Performs therapeutic maneuvers skillfully.

### C. Management of Acute and Chronic Illnesses

1. Assesses and manages most common acute illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.
2. Assesses and manages stable chronic illnesses according to areas of preparation, age of client, legal parameters and current standards of practice.
3. Identifies and manages emergency or crisis situations.
4. Collaborates with health team members and makes appropriate referrals.
5. Demonstrates diagnostic reasoning ability in formulating assessments.

**Please attach a comment on the applicant’s overall competence to provide primary care services in the designated specialty area.**

**Certification**

I certify that the information provided in Section II of this form is complete and accurate to the best of my knowledge and that I have personally supervised the person named in this form in the performance of the competencies listed above.

Physician signature: ____________________________ Date: _______ / _______ / _______

Print name: ____________________________________

Title: ________________________________________

New York State medical license number: [ ] [ ] [ ] [ ] [ ]

Telephone: ____________________________ Fax: ____________________________

E-mail: __________________________________

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.
Verification of Collaborative Agreement and Practice Protocol

Applicant Instructions
1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1).
2. You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete Sections II and III and return both pages of the form to the Office of the Professions at the address at the end of the form. Be sure to sign and date item 4 in Section III.

Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required once.

Section I: Applicant Information
1. Social Security Number
2. Birth Date Month Day Year
3. If Already Certified, New York State Nurse Practitioner Certificate Number
4. Print Name as It Appears on Your Application for a Certificate (Form 1)
   Last
   First
   Middle
5. Mailing Address (You must notify the Department promptly of any address or name changes.)
   Line 1
   Line 2
   Line 3
   City
   State
   Country/Province

Section II: Collaborating Physician
1. Name of collaborating physician: Last First Middle
2. Address:
3. Telephone: Fax:
4. E-mail address:
5. New York State medical license number:
6. Area of current practice:
7. Area of specialty practice:
Section III: Practice Protocol

Instructions: You must use an approved practice protocol text that is a standard publication. Please select a protocol text from the approved list (see application instructions, pages 8-9) and submit this form to the Department at the address at the end of the form, no later than 90 days after the commencement of practice.

1. List title, publisher, and date of publication of the approved protocol text.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2. Location and description of practice site(s): (clinic, private office, HMO, etc.)

<table>
<thead>
<tr>
<th>Practice Site</th>
<th>Name</th>
<th>Address</th>
<th>Description</th>
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</tbody>
</table>

3. Description of practice including any mutually agreed upon exceptions:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

4. We hereby verify that we have a written collaborative agreement and have selected a practice protocol(s).

Nurse Practitioner signature: __________________________________________ Date: ______/______/______

Collaborating Physician signature: ______________________________________ Date: ______/______/______

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.
INSTRUCTIONS

Use this form to report a change in your address and/or name. Please read these instructions carefully and be sure you complete the appropriate sections of this form. Please print clearly in ink.

- **For address changes only:** Complete Sections I, II, and IV. For address changes only, you may fax this form to the Records and Archives Unit at 518-486-3617 or provide the required information by E-mail: oparchiv@mail.nysed.gov. Your records will be updated. Currently registered licensed professionals will be sent a new registration certificate.

- **For name changes only:** Complete Sections I, III, IV and V. Name changes require an original notarized signature in your new name and cannot be accepted prior to your official change of name. Sign the Section IV affidavit and have your signature notarized by a notary public. Currently registered licensed professionals will be sent a new registration certificate.

- **For address and name changes:** Complete all sections. Licensed professionals can check the Office of the Professions’ Web site at www.op.nysed.gov to verify your name, city, state, registration expiration date, and license number on record.

**NOTE:** Important information and registration renewals will be sent to the address on file for you. You must notify the Department in writing within 30 days if your address or name changes.

### Section I: Your General Information

1. Name (currently on record): ____________________________

2. Social Security Number: ____________________________
   Birth Date: Month __ Day __ Year
   Telephone: Home: ______-_______-__________ Work: ______-_______-__________
   E-mail: ____________________________ Fax: ______-_______-__________

3. Are you reporting an address and/or name change?  
   - address change  
   - name change  
   - both

4. Effective date of change: ______/______/______(Note: Changes cannot be accepted until after the effective date.)

5. Licensure status in New York State:
   - I am an applicant for licensure in New York State for the licensed profession(s) of: ____________________________
   - I am currently licensed in New York State in the profession(s) of: ____________________________
     (see list of professions on page 2)
     New York State license number: ____________________________
     New York State license number: ____________________________
     New York State license number: ____________________________

### Section II: Address Change (please print)

<table>
<thead>
<tr>
<th>Information Currently On Record</th>
<th>New Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apt./Bldg. ______________________</td>
<td>Apt./Bldg.</td>
</tr>
<tr>
<td>Street __________________________</td>
<td>Street</td>
</tr>
<tr>
<td>City ____________________________</td>
<td>City</td>
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<tr>
<td>State __________________________</td>
<td>State</td>
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<td>Zip Code -</td>
<td>Zip Code</td>
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<tr>
<td>Province or Country (if not U.S.)</td>
<td>Province or Country (if not U.S.)</td>
</tr>
</tbody>
</table>
Collaborative Relationships Attestation Form
To be completed by Certified Nurse Practitioners who have Collaborative Relationships
Pursuant to Education Law §6902(3)(b)

Instructions
This form must be filled out and signed by nurse practitioners (with more than 3,600 hours of qualifying nurse practitioner practice experience) who choose to practice and have collaborative relationships - instead of practicing in accordance with a written practice agreement with a collaborating physician. Once completed, a nurse practitioner must keep this form at the nurse practitioner's practice location and provide it to the New York State Education Department upon request. The nurse practitioner must ensure that information on this form is current, and should complete a new Form NP-CR, as appropriate, to update information. Nurse practitioners who practice in accordance with a written practice agreement with a collaborating physician do not have to fill out a Form NP-CR.

1. Provide your name exactly as it appears on your current New York State Education Department issued nurse practitioner registration certificate(s):
_____________________________________________________________________________________________________________

2. Provide your nurse practitioner registration number(s):
_____________________________________________________________________________________________________________

3. Identify the specialty area(s) of nurse practitioner practice in which you are certified by the New York State Education Department:

☐ Acute Care  ☐ Adult Health  ☐ College Health
☐ Community Health  ☐ Family Health  ☐ Gerontology
☐ Holistic Nursing  ☐ Neonatology  ☐ Obstetrics and Gynecology
☐ Oncology  ☐ Palliative Care  ☐ Pediatrics
☐ Perinatology  ☐ Psychiatry  ☐ School Health
☐ Women's Health

5. By placing your initials below, you attest that you are certified as a Nurse Practitioner in New York State and have more than 3,600 hours of experience practicing as a licensed or certified nurse practitioner pursuant to the laws of New York State or another State or working as a nurse practitioner for the United States veteran's administration, the United States armed forces or the United States public health service.

Place initials here ____________________

6. By placing your initials below, you attest that you have collaborative relationships with one or more New York State licensed physicians qualified to collaborate in the specialty involved or with a New York State Department of Health licensed hospital that provides services through licensed physicians qualified to collaborate in the specialty involved and having privileges at such institution. A collaborative relationship means that you communicate, as required by New York State Education Department regulation, with the qualified physician for the purposes of exchanging information, as needed, in order to provide comprehensive patient care and to make referrals as necessary.

Place initials here ____________________

7. By placing your initials below, you attest that you maintain current and accurate documentation supportive of your collaborative relationships and, upon request by New York State Education Department, you will produce evidence of the collaborative relationships, such as: (a) an agreement or an arrangement with a hospital or a physician practice pursuant to which you may transfer or refer patients for care; (b) written communications or records of consultations and communications for referral; (c) documentation of employment relationships with a physician practice or a hospital, hospice program, licensed home care services agency or licensed mental health care facility with a physician medical director; or (d) documentation of contractual relationship with a physician, physician practice, or a hospital, pursuant to which you provide professional services, or (e) (other please describe):
____________________________________________________________________________________________________________

Place initials here ____________________
8. Identify by name and license number physicians with whom you are currently engaged in collaborative relationships. If you have a collaborative relationship with a New York State Department of Health licensed hospital, include the name and address of the hospital.

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

9. (Optional) You may provide additional information regarding your collaborative relationships here:

____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Attestation

I acknowledge that if reasonable efforts to resolve any dispute that may arise with a collaborating physician, or in the case of collaboration with a hospital, with a physician having professional privileges at such hospital, about a patient's care are not successful, the recommendation of the physician shall prevail.

I attest that, to the best of my knowledge, all information provided by me on this form are true as of the date of my signature below.

_________________________________________ _________________________________
Signature of Nurse Practitioner Date

_________________________________________
Print Name
Appendix G

Instruction for Death Certificate Completion in New York State

Contents
Death Certificate Completion for New York NPs ............................................................. 1
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Death Certificate completion for New York NPs.

Effective January 16, 2012 NPs in New York State are authorized to sign and certify to the facts of death and provide the medical information required by the Certificate of Death. The documents included in this package are instructional and provide the NP with the information necessary to properly complete a Certificate of Death. They are:

- “Instructions for Nurse Practitioners to Complete the New York State Certificate of Death.”
- “CDC Physician Instructions for Completing Cause of Death”.
- “CDC Possible Solutions for Common Death Certification Problems”.
- “CDC Physician handbook on Medical Certification of Death”.
- Link to Centers for Disease Control web page “Writing Cause of Death Statements”.
  http://www.cdc.gov/nchs/nvss/writing_codStatements.htm

It is strongly recommended that NPs read every publication listed above and consult as necessary with the resources available on the linked CDC web page. This will help avoid errors in completion of the Certificate of Death and make things work smoothly for the families of your patients.
Instructions for Nurse Practitioners to complete the New York State Certificate of Death

On January 16, 2012, an amendment to New York State Public Health Law will go into effect which authorizes a New York State Licensed Nurse Practitioner to sign and certify to the facts of death and provide the medical information required by the Certificate of Death. The following are instructions to assist you in completing the certificate.

The New York State Certificate of Death (DOH form 1961) consists of 3 carbon copies and a cover page with instructions for completing select items. The first copy is the state certificate and has "State File Number" printed in the upper right hand corner. Original signatures must be placed on this copy. A certificate without original signatures will not be accepted for filing. The certifier is responsible for completing items 25 through 33. The certifier does NOT complete items 1 through 24. Only a New York State licensed funeral director or coroner/medical examiner may complete these items. You may certify a certificate with these items blank but you must place the decedents name and time and date of death in the space provided in the lower left hand corner (see ex.). The Law requires that the certificate be filed in 72 hours and there may be occasions when a funeral director is not available so please do not delay certifying to the facts of death.

The Certificate of Death will not change to include Nurse Practitioner as a certifier title so it is very important that the Nurse Practitioner place the initials "NP" after the printed name (see ex.). You must write your license number in the space provided and sign and date the certificate. The certificate cannot be filed if these items are blank. The item below your printed name is the certifier title and this will be left blank as there is no certifier title for the Nurse Practitioner. If the certifier in item 25A did not attend the patient then the attending provider will complete item 25C.

Any questions on completing the certificate may be directed to the local registrar of vital statistics or Department of Health, Office of Vital Records. Example:
Instructions for Completing the Cause-of-Death Section of the Death Certificate

Accurate cause-of-death information is important:
- To the public health community in evaluating and improving the health of all citizens, and
- Often to the family, now and in the future, and to the person settling the decedent's estate.

The cause-of-death section consists of two parts. **Part I** is for reporting a chain of events leading directly to death, with the immediate cause of death (the final disease, injury, or complication directly causing death) on Line a and the underlying cause of death (the disease or injury that initiated the chain of morbid events that led directly and inevitably to death) on the lowest used line. **Part II** is for reporting all other significant diseases, conditions, or injuries that contributed to death but which did not result in the underlying cause of death given in **Part I**. The cause-of-death information should be YOUR best medical OPINION. A condition can be listed as “probable” even if it has not been definitively diagnosed.

Examples of properly completed medical certifications

### Part I

**CAUSE OF DEATH (See instructions and examples)**

<table>
<thead>
<tr>
<th>Immediate Cause</th>
<th>Approximate Interval (Onset to Death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rupture of myocardium</td>
<td>Minutes</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>6 days</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
<tr>
<td>Coronary artery thrombosis</td>
<td>5 years</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
<tr>
<td>Atherosclerotic coronary artery disease</td>
<td>7 years</td>
</tr>
</tbody>
</table>

**Diabetes, Chronic obstructive pulmonary disease, smoking**

**32. PART I.** Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

- **IMMEDIATE CAUSE (Final disease or condition resulting in death)**
  - Rupture of myocardium Due to (or as a consequence of):
  - Acute myocardial infarction Due to (or as a consequence of):
  - Coronary artery thrombosis Due to (or as a consequence of):
  - Atherosclerotic coronary artery disease

**33. WAS AN AUTOPSY PERFORMED?**

- Yes
- No

**34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?**

- Yes
- No

### Part II

**Enter other significant conditions contributing to death but not resulting in the underlying cause given in **Part I.**

**35. DID TOBACCO USE CONTRIBUTE TO DEATH?**

- Yes
- No
- Probably
- Unknown

**36. IF FEMALE:**

- Not pregnant within past year
  - Pregnant at time of death
  - Not pregnant, but pregnant within 42 days of death
  - Not pregnant, but pregnant 43 days to 1 year before death
  - Unknown if pregnant within the past year

**37. MANNER OF DEATH**

- Natural
- Accident
- Homicide
- Suicide
- Pending Investigation
- Could not be determined

### Part II

**CAUSE OF DEATH (See instructions and examples)**

<table>
<thead>
<tr>
<th>Immediate Cause</th>
<th>Approximate Interval (Onset to Death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute renal failure</td>
<td>5 days</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
<tr>
<td>Hyperosmolar nonketotic coma</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus, noninsulin dependent</td>
<td>15 years</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
</tbody>
</table>

**33. WAS AN AUTOPSY PERFORMED?**

- Yes
- No

**34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?**

- Yes
- No

### Part I

**32. PART I.** Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

- **IMMEDIATE CAUSE (Final disease or condition resulting in death)**
  - Acute renal failure Due to (or as a consequence of):
  - Hyperosmolar nonketotic coma Due to (or as a consequence of):
  - Diabetes mellitus, noninsulin dependent Due to (or as a consequence of):

**35. DID TOBACCO USE CONTRIBUTE TO DEATH?**

- Yes
- No
- Probably
- Unknown

**36. IF FEMALE:**

- Not pregnant within past year
  - Pregnant at time of death
  - Not pregnant, but pregnant within 42 days of death
  - Not pregnant, but pregnant 43 days to 1 year before death
  - Unknown if pregnant within the past year

**37. MANNER OF DEATH**

- Natural
- Accident
- Homicide
- Suicide
- Pending Investigation
- Could not be determined

### ITEM 32 - CAUSE OF DEATH

Take care to make the entry legible. Use a computer printer with high resolution, typewriter with good black ribbon and clean keys, or print legibly using permanent black ink in completing the cause-of-death section. **Do not abbreviate** conditions entered in section.

**Part I (Chain of events leading directly to death)**

- **Only one** cause should be entered on each line. **Line a** MUST ALWAYS have an entry. **Do NOT** leave blank. Additional lines may be added if necessary.
- If the condition on **Line a** resulted from an underlying condition, put the underlying condition on **Line b**, and so on, until the full sequence is reported. **Always** enter the underlying cause of death on the **lowest used line** in Part I.
- For each cause indicate the best estimate of the interval between the presumed onset and the date of death. The terms “unknown” or “approximately” may be used. General terms, such as minutes, hours, or days, are acceptable, if necessary. **Do NOT** leave blank.
ITEM 37 - MANNER OF DEATH
If the decedent is a female, check the appropriate box. If the female is either too old or too young to be fecund, check the clinical judgment, tobacco use did not contribute to this particular death.

ITEM 35 - DID TOBACCO USE CONTRIBUTE TO DEATH?
Check "Yes" if, in your opinion, the use of tobacco contributed to death. Tobacco use may contribute to deaths due to a wide variety of diseases; for example, tobacco use contributes to many deaths due to emphysema or lung cancer and some heart disease and cancers of the head and neck. Check "No" if, in your clinical judgment, tobacco use did not contribute to this particular death.

ITEM 36 - IF FEMALE, WAS DECEDENT PREGNANT AT TIME OF DEATH OR WITHIN PAST YEAR?
If the decedent is a female, check the appropriate box. If the decedent is either too old or too young to be fecund, check the "Not pregnant within past year" box. If the decedent is a male, leave the item blank. This information is important in determining pregnancy-related mortality.

ITEM 37 - MANNER OF DEATH
- Always check Manner of Death, which is important: 1) in determining accurate causes of death, 2) in processing insurance claims, and 3) in statistical studies of injuries and death.
- Indicate "Could not be determined" ONLY when it is impossible to determine the manner of death.

Common problems in death certification
The elderly decedent should have a clear and distinct etiological sequence for cause of death, if possible. Terms such as senescence, infirmity, old age, and advanced age have little value for public health or medical research. Age is recorded elsewhere on the certificate. When a number of conditions resulted in death, the physician should choose the single sequence that, in his or her opinion, best describes the process leading to death, and place any other pertinent conditions in Part II. If after careful consideration the physician cannot determine a sequence that ends in death, then the medical examiner or coroner should be consulted about conducting an investigation or providing assistance in completing the cause of death.

The infant decedent should have a clear and distinct etiological sequence for cause of death, if possible. "Prematurity" should not be entered without explaining the etiology of prematurity. Maternal conditions may have initiated or affected the sequence that resulted in infant death, and such maternal causes should be reported in addition to the infant causes on the infant's death certificate (e.g., Hyaline membrane disease due to prematurity, 28 weeks due to placental abruption due to blunt trauma to mother's abdomen).

When processes such as the following are reported, additional information about the etiology should be reported:

- Abscess
- Abdominal hemorrhage
- Adhesions
- Adult respiratory distress syndrome
- Acute myocardial infarction
- Altered mental status
- Anemia
- Anoxia
- Anoxic encephalopathy
- Arrhythmia
- Ascieties
- Aspiration
- Atrial fibrillation
- Bacteremia
- Bedridden
- Bilary obstruction
- Bowel obstruction
- Brain injury
- Brain stem herniation
- Carcinogenesis
- Carcinomatosis
- Cardiac arrest
- Cardiac dysrhythmia
- Cardiomyopathy
- Cardiopulmonary arrest
- Cellulitis
- Cerebral edema
- Cerebrovascular accident
- Cerebellar tonsillar herniation
- Chronic bedridden state
- Cirrhosis
- Coagulopathy
- Compression fracture
- Congestive heart failure
- Convulsions
- Decubitus
- Dehydration
- Dementia
- Disseminated intravascular coagulopathy
- Dysrhythmia
- End-stage liver disease
- End-stage renal disease
- Epidural hematoma
- Exsanguination
- Failure to thrive
- Fracture
- Gangrene
- Gastrointestinal hemorrhage
- Heart failure
- Hemolysis
- Hepatic failure
- Hepatitis
- Hepatorenal syndrome
- Hypercalcemia
- Hypervolemic shock
- Hyponatremia
- Hypotension
- Immunosuppression
- Increased intracranial pressure
- Intracranial hemorrhage
- Malnutrition
- Metallic encephalopathy
- Multi-organ failure
- Multi-system organ failure
- Myocardial infarction
- Necrotizing soft-tissue infection
- Old age
- Open (or closed) head injury
- Pancytopenia
- Paralysis
- Perforated gallbladder
- Peritonitis
- Pleural effusions
- Pneumonia
- Pulmonary arrest
- Pulmonary edema
- Pulmonary embolism
- Pulmonary insufficiency
- Renal failure
- Respiratory arrest
- Seizures
- Sepsis
- Septic shock
- Shock
- Starvation
- Subarachnoid hemorrhage
- Subdural hematoma
- Sudden death
- Thrombocytopenia
- Urinary tract infection
- Ventricular fibrillation
- Ventricular tachycardia
- Volume depletion

If the certifier is unable to determine the etiology of a process as those shown above, the process must be qualified as being of an unknown, undetermined, probable, presumed, or unspecified etiology so it is clear that a distinct etiology was not inadvertently or carelessly omitted.

The following conditions and types of death might seem to be specific or natural but when the medical history is examined further may be found to be complications of an injury or poisoning (possibly occurring long ago). Such cases should be reported to the medical examiner/coroner.
Introduction
A death certificate is a permanent record of an individual’s death. One purpose of the death certificate is to obtain a simple description of the sequence or process leading to death rather than a record describing all medical conditions present at death.

Causes of death on the death certificate represent a medical opinion that might vary among individual physicians. In signing the death certificate, the physician, medical examiner, or coroner certifies that, in his/her medical opinion, the individual died from the reported causes of death. The certifier’s opinion and confidence in that opinion are based upon his/her training, knowledge of medicine, available medical history, symptoms, diagnostic tests, and available autopsy results for the decedent. Even if extensive information is available to the certifier, causes of death may be difficult to determine, so the certifier may indicate uncertainty by qualifying the causes on the death certificate.

Cause-of-death data is important for surveillance, research, design of public health and medical interventions, and funding decisions for research and development. While the death certificate is a legal document used for legal, family, and insurance purposes, it may not be the only record used, because, in some cases, the death certificate may only be admissible as proof of death. The following provides suggestions, largely from Hanzlick (1994), for handling situations where cause of death is difficult to certify.

Uncertainty
Often several acceptable ways of writing a cause-of-death statement exist. Optimally, a certifier will be able to provide a simple description of the process leading to death that is etiologically clear and to be confident that this is the correct sequence of causes. However, realistically, description of the process is sometimes difficult because the certifier is not certain.
In this case, the certifier should think through the causes about which he/she is confident and what possible etiologies could have resulted in these conditions. The certifier should select the causes that are suspected to have been involved and use words such as "probable" or "presumed" to indicate that the description provided is not completely certain. If the initiating condition reported on the death certificate could have arisen from a pre-existing condition but the certifier cannot determine the etiology, he/she should state that the etiology is unknown, undetermined, or unspecified, so it is clear that the certifier did not have enough information to provide even a qualified etiology.

The Elderly

When preparing a cause-of-death statement for an elderly decedent, the causes should present a clear and distinct etiological sequence, if possible. Causes of death on the death certificate should not include terms such as senescence, old age, infirmity, and advanced age because they have little value for public health or medical research. Age is recorded elsewhere on the death certificate. When malnutrition is involved, the certifier should consider if other medical conditions could have led to malnutrition.

When a number of conditions or multiple organ/system failure resulted in death, the physician, medical examiner, or coroner should choose a single sequence to describe the process leading to death and list the other conditions in Part II of the certification section. "Multiple system failure" could be included as an "other significant condition" but also specify the systems involved. In other instances, conditions listed in Part II of the death certificate may include causes that resulted from the underlying cause but did not fit into the sequence resulting in death.

If the certifier cannot determine a descriptive sequence of causes of death despite carefully considering all information available and circumstances of death did not warrant investigation by the medical examiner or coroner, death may be reported as "unspecified natural causes." If any potentially lethal medical conditions are known but cannot be cited as part of the sequence leading to death, they should be listed as other significant conditions.

Infant Deaths

Maternal conditions may have initiated or affected the sequence that resulted in an infant death. These maternal conditions should be reported in the cause-of-death statement in addition to the infant causes.

When Sudden infant death syndrome (SIDS) is suspected, a complete investigation should be conducted, typically by a medical examiner. If the infant is under 1 year of age, no cause of death is determined after scene investigation, clinical history is reviewed, and a complete autopsy is performed, then the death can be reported as (SIDS). If the investigation is not complete, the death may be reported as presumed to be (SIDS).

Avoid Ambiguity
Most certifiers will find themselves, at some point, in the circumstance in which they are unable to provide a simple description of the process of death. In this situation, the certifier should try to provide a clear sequence, qualify the causes about which he/she is uncertain, and be able to explain the certification chosen.

When processes such as the following are reported, additional information about the etiology should be reported if possible:

<table>
<thead>
<tr>
<th>Cardiovascular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute myocardial infarction</td>
</tr>
<tr>
<td>Arrhythmia</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>Cardiac dysrhythmia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Central Nervous System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered mental status</td>
</tr>
<tr>
<td>Anoxic encephalopathy</td>
</tr>
<tr>
<td>Brain injury</td>
</tr>
<tr>
<td>Brain stem herniation</td>
</tr>
<tr>
<td>Cerebrovascular accident</td>
</tr>
<tr>
<td>Cerebellar tonsillar herniation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration</td>
</tr>
<tr>
<td>Pleural effusions</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
<tr>
<td>Biliary obstruction</td>
</tr>
<tr>
<td>Bowel obstruction</td>
</tr>
<tr>
<td>Cirrhosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Blood, Renal, Immune</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coagulopathy</td>
<td>Hepatorenal syndrome</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Disseminated intravascular</td>
<td>Immunosuppression</td>
<td>Thrombocytopenia</td>
</tr>
<tr>
<td>coagulopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End-stage renal disease</td>
<td>Pancytopenia</td>
<td>Urinary tract infection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Not System-Oriented</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal hemorrhage</td>
<td>Decubiti</td>
<td>Hyponatremia</td>
</tr>
<tr>
<td>Ascites</td>
<td>Dehydration</td>
<td>Multi-organ failure</td>
</tr>
<tr>
<td>Anoxia</td>
<td>Exsanguination</td>
<td>Necrotizing soft-tissue infection</td>
</tr>
<tr>
<td>Bacteremia</td>
<td>Failure to thrive</td>
<td>Peritonitis</td>
</tr>
<tr>
<td>Bedridden</td>
<td>Gangrene</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Carcinogenesis</td>
<td>Hemothorax</td>
<td>Septic shock</td>
</tr>
<tr>
<td>Carcinomatosis</td>
<td>Hyperglycemia</td>
<td>Shock</td>
</tr>
<tr>
<td>Chronic bedridden state</td>
<td>Hyperkalemia</td>
<td>Volume depletion</td>
</tr>
</tbody>
</table>

(Hanzlick pp. 106-7)

If the certifier is unable to determine the etiology of a process such as those shown above, the process must be qualified as being of an unknown, undetermined, probable, presumed, or unspecified etiology so it is clear that a distinct etiology was not inadvertently or carelessly omitted.
The following conditions and types of death might seem to be specific but when the medical history is examined further may be found to be complications of an injury or poisoning (possibly occurring long ago):

- Subdural hematoma
- Epidural hematoma
- Subarachnoid hemorrhage
- Fracture
- Pulmonary emboli
- Thermal burns/chemical burns
- Sepsis
- Hyperthermia
- Hypothermia
- Hip fracture
- Seizure disorder
- Drug or alcohol overdose/drug or alcohol abuse

(Hanzlick p. 68)

Is it possible that the underlying cause of death was the result of an injury or poisoning? If it might be, check with the medical examiner/coroner to find out if the death should be reported to him/her.

When indicating neoplasms as a cause of death indicate the following:

1. primary site or that the primary site is unknown,
2. benign or malignant,
3. cell type or that the cell type is unknown,
4. grade of a neoplasm, and
5. part or lobe of an organ affected. For example, a well-differentiated squamous cell carcinoma, lung, left upper lobe (Hanzlick p. 58).

Medical Examiner or Coroner

The medical examiner/coroner investigates deaths that are unexpected, unexplained, or if an injury or poisoning was involved. State laws often provide guidelines for when a medical examiner/coroner must be notified. In the case of deaths known or suspected to have resulted from injury or poisoning, report the death to the medical examiner/coroner as required by State law. The medical examiner/coroner will either complete the cause-of-death section of the death certificate or waive that responsibility. If the medical examiner/coroner does not accept the case, then the certifier will need to complete the cause-of-death section.

References and Sources


Additional Information Can Also be Found at: National Association of Medical Examiners (N.A.M.E.)

Contact Us:

- Division of Vital Statistics
  National Center for Health Statistics
  3311 Toledo Rd
  Hyattsville, MD 20782
- 1 (800) 232-4636
- cdcinfo@cdc.gov
Physicians' Handbook on Medical Certification of Death

2003 Revision

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

Hyattsville, Maryland
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National Center for Health Statistics

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Preface

This handbook contains instructions for physicians on cause-of-death certification. It was prepared by the Department of Health and Human Services’ Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS). These instructions pertain to the 2003 revision of the U.S. Standard Certificate of Death and the 1992 revision of the Model State Vital Statistics Act and Regulations. This handbook serves as a model that can be adapted by any vital statistics registration area.

Other handbooks and references on preparing and registering vital records are mentioned at the end of the section on Medical Certification of Death and are listed in the references. For most of these resources, the State vital statistics office or NCHS can provide as many copies as desired.

For detailed information on completing other items on the death certificate, refer to the Medical Examiners’ and Coroners’ Handbook on Death Registration and Fetal Death Reporting or the Funeral Directors’ Handbook on Death Registration and Fetal Death Reporting.

Keywords: medical certification • death certificate • guidelines • handbook
Acknowledgments

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This handbook was edited by Demarius V. Miller, typeset by Jacqueline M. Davis, and the graphics produced by Jarmila G. Ogburn of the Publications Branch, Division of Data Services.
<table>
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<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
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<td>39</td>
</tr>
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</tr>
<tr>
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</tr>
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<td>43</td>
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</tbody>
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Introduction

Purpose
This handbook is designed to acquaint physicians, medical students, and others with the vital registration system in the United States and to provide instructions for completing and filing death certificates. Emphasis is directed toward the certification of medical information, the primary responsibility of the physician, and a critical piece of information on the death certificate.

Importance of death registration
The death certificate is a permanent record of the fact of death, and depending on the State of death, may be needed to get a burial permit. State law specifies the required time for completing and filing the death certificate.

The death certificate provides important personal information about the decedent and about the circumstances and cause of death. This information has many uses related to the settlement of the estate and provides family members closure, peace of mind, and documentation of the cause of death.

The death certificate is the source for State and national mortality statistics (figures 1-3) and is used to determine which medical conditions receive research and development funding, to set public health goals, and to measure health status at local, State, national, and international levels. The Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) publishes summary mortality data in the National Vital Statistics Report publication “Deaths: Final data” and on the Internet at http://www.cdc.gov/nchs (under vital statistics, mortality).

These mortality data are valuable to physicians indirectly by influencing funding that supports medical and health research that may alter clinical practice and directly as a research tool. Research topics include identifying disease etiology, evaluating diagnostic and therapeutic techniques,
Figure 1. Deaths by age

Figure 2. Deaths by cause
examine medical or mental health problems that may be found among specific groups of people (1), and indicating areas in which medical research can have the greatest impact on reducing mortality.

Analyses typically focus on a single condition reported on the death certificate, but some analyses do consider all conditions mentioned. Such analyses are important in studying certain diseases and conditions and in investigating relationships between conditions reported on the same death certificate (for example, types of fatal injuries and automobile crashes or types of infections and HIV).

Because statistical data derived from death certificates can be no more accurate than the information on the certificate, it is very important that all persons concerned with the registration of deaths strive not only for complete registration, but also for accuracy and promptness in reporting these events. Furthermore, the potential usefulness of detailed specific information is greater than more general information.

**U.S. Standard Certificate of Death**

The registration of deaths is a State function supported by individual State laws and regulations. The original death certificates are filed in the States
and stored in accordance with State practice. Each State has a contract with NCHS that allows the Federal Government to use information from the State records to produce national vital statistics. The national data program is called the National Vital Statistics System (NVSS) (2,3).

To ensure consistency in the NVSS, NCHS provides leadership and coordination in the development of a standard certificate of death for the States to use as a model. The standard certificate is revised periodically to ensure that the data collected relate to current and anticipated needs. In the revision process, stakeholders review and evaluate each item on the standard certificate for its registration, legal, genealogical, statistical, medical, and research value. The associations on the stakeholder panel that recommended the current U.S. Standard Certificate of Death included the American Medical Association, the National Association of Medical Examiners, the College of American Pathologists, and the American Hospital Association (2).

Most State certificates conform closely in content and arrangement to the standard. Minor modifications are sometimes necessary to comply with State laws or regulations or to meet specific information needs. Having similar forms promotes uniformity of data and comparable national statistics. They also allow the comparison of individual State data with national data and of individual State data with national data and data from other States. Uniformity of death certificates among the States also increases their acceptability as legal records.

Confidentiality of vital records

To encourage appropriate access to vital records, NCHS promotes the development of model vital statistics laws concerning confidentiality (4). State laws and supporting regulations define which persons have authorized access to vital records. Some States have few restrictions on access to death certificates. However, there are restrictions on access to death certificates in the majority of States. Legal safeguards to the confidentiality of vital records have been strengthened over time in some States.

Physician’s responsibility

The physician’s principal responsibility in death registration is to complete the medical part of the death certificate. In fulfilling the role of the certifier (i.e., person completing the medical part of the death certificate), the physician performs the final act of care to a patient by providing closure with a well-thought-out and complete death certificate that will allow the
family to close the person’s affairs. At the same time, the physician performs a service for the larger community.

The physician is to:

- Be familiar with State and local regulations on medical certifications for deaths without medical attendance or involving external causes that may require the physician to report the case to a medical examiner or coroner.
- Complete relevant portions of the death certificate.
- Deliver the signed or electronically authenticated death certificate to the funeral director promptly so that the funeral director can file it with the State or local registrar within the State’s prescribed time period.
- Assist the State or local registrar by answering inquiries promptly.
- Deliver a supplemental report of cause of death to the State vital statistics office when autopsy findings or further investigation reveals the cause of death to be different from what was originally reported.

In some States, hospitals and other institutions are authorized to initiate the preparation of the death certificate when the death occurred in that hospital or institution. In such cases, the attending physician will usually complete the cause-of-death section and sign the certificate at the hospital or other institution. Jurisdictions with electronic registration systems may have other ways to authenticate the certification than by using a signature on paper. In a few States, when the attending physician (physician in charge of the patient’s care for the condition that resulted in death) is not available at the time of death to certify the cause of death, another physician on duty at the hospital or other institution may pronounce the decedent legally dead; and, with the permission of the attending physician, the “pronouncing physician” may authorize release of the body to the funeral director. In such cases, the attending physician will certify the cause of death at a later time.

In all cases, the attending physician is responsible for certifying the cause of death. In most cases, he or she will both pronounce death and certify the cause of death. Only in the instances when the attending physician is unavailable to certify the cause of death at the time of death, and State law provides for a pronouncing physician, will a different physician pronounce death.

If completed properly, the cause of death will communicate the same essential information (11) that a case history would. For example, the following cause-of-death statement is complete:
I  a) Septic shock
   b) Infected decubitus ulcers
   c) Complications of cerebral infarction
   d) Cerebral artery atherosclerosis
II  Insulin-dependent diabetes mellitus

If not completed properly, information may be missing from the cause-of-death section, so someone reading the cause of death would not know why the condition on the lowest used line developed. For example:

I  a) Pneumonia
   b) Malnutrition
   c)
II

This example does not explain what caused malnutrition. A variety of different circumstances could cause malnutrition, so the statement is incomplete and ambiguous.

In some cases, the physician will be contacted to verify information reported on a death certificate or to provide additional information to clarify what was meant. The original cause-of-death statement may not be wrong from a clinical standpoint, but may not include sufficient information for assigning codes for statistical purposes. Following guidelines in this handbook should minimize the frequency with which a physician will need to spend additional time answering follow-up questions about a patient’s cause of death.
General Instructions for Completing Death Certificates

Death certificates are permanent legal records from which official copies are made. It is essential that the certificate be prepared accurately. Funeral directors are responsible for completing most of the information on the death certificate with the assistance of an informant who is usually a family member.

Completing a death certificate involves the following guidelines:

- Use the current form designated by the State.
- Complete each item, following the specific instructions for that item.
- Make the entry legible. Use a computer printer with high resolution, typewriter with good black ribbon and clean keys, or print legibly using permanent black ink.
- Do not use abbreviations except those recommended in the specific item instructions.
- Verify with the informant the spelling of names, especially those that have different spellings for the same sound (Smith or Smyth, Gail or Gayle, Wolf or Wolfe, and so forth).
- Refer problems not covered in these instructions to the State office of vital statistics or to the local registrar.
- Obtain all signatures; rubber stamps or other facsimile signatures are not acceptable. If jurisdiction provides, authenticate electronically.
- Do not make alterations or erasures.
- File the original certificate or report with the registrar. Reproductions or duplicates are not acceptable.

Most States require that the death certificate be completed and filed within a specified time period. Physicians are expected to use medical training, knowledge of medicine, available medical history, symptoms, diagnostic tests, and autopsy results, if available, to determine the cause of death. Generally, it is possible to file a certificate with the cause of death listed as pending or pending further study. This is especially useful when additional
investigation such as autopsy results are expected, but it obligates the attending physician to update the original information after the additional information becomes available.
Medical Certification of Death

The physician’s primary responsibility in death registration is pronouncing the death and, when he or she is the attending physician, reporting cause of death. The medical part of the certificate includes:

- Date and time pronounced dead
- Date and time of death
- Question on whether the case was referred to the medical examiner or coroner
- Cause-of-death section including cause of death, manner of death, tobacco use, and females’ pregnancy status items
- Injury items for cases involving injuries
- Certifier section with signatures

In most cases, a physician will both pronounce death and certify or report the cause of death. A different physician will pronounce death only when the attending physician is unavailable to certify the cause of death at the time of death and if State law provides for this option. If an inquiry is required by a State Post-Mortem Examinations Act, a medical examiner or coroner is responsible for determining cause of death (4).

Pronouncing date and time of death

Items 24 and 25 must be completed by the person who pronounces death. This may be the pronouncing physician, pronouncing/certifying physician, or the medical examiner or coroner. For cases involving a pronouncing physician different from the certifying physician, the pronouncing physician must also complete items 26–28.

Cause of death

This section must be completed by either the attending physician, the medical examiner, or the coroner. The cause-of-death section, a facsimile of which is shown below, follows guidelines recommended by the World Health Organization. An important feature is the reported underlying cause
of death determined by the certifying physician and defined as (a) the disease or injury that initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence that produced the fatal injury. In addition to the underlying cause of death, this section provides for reporting the entire sequence of events leading to death as well as other conditions significantly contributing to death (5).

The cause-of-death section is designed to elicit the opinion of the medical certifier. Causes of death on the death certificate represent a medical opinion that might vary among individual physicians. A properly completed cause-of-death section provides an etiologic explanation of the order, type, and association of events resulting in death. The initial condition that starts the etiologic sequence is specific if it does not leave any doubt as to why it developed. For example, sepsis is not specific because a number of different conditions may have resulted in sepsis, whereas human immunodeficiency virus syndrome is specific.

<table>
<thead>
<tr>
<th>CAUSE OF DEATH (See instructions and examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. PART A. Enter the disease, abnormality, or poisoning that initiated the train of morbid events leading directly to death. DO NOT enter terminal events such as cancer or AIDS. Enter one cause on a line. Add additional line if necessary.</td>
</tr>
<tr>
<td>33. PART B. Enter other conditions contributing to death but not listed in the preceding cause given in PART A.</td>
</tr>
<tr>
<td>34. PART C. Enter postmortem conditions contributing to death.</td>
</tr>
<tr>
<td>35. PART D. Enter the circumstances of the accident or violence that produced the fatal injury.</td>
</tr>
<tr>
<td>36. PART E. Enter other conditions significantly contributing to death.</td>
</tr>
</tbody>
</table>

In certifying the cause of death, any disease, abnormality, injury, or poisoning, if believed to have adversely affected the decedent, should be reported. If the use of alcohol and/or other substance, a smoking history, a recent pregnancy, injury, or surgery was believed to have contributed to death, then this condition should be reported. The conditions present at the time of death may be completely unrelated, arising independently of each other; they may be causally related to each other, that is, one condition may lead to another which in turn leads to a third condition; and so forth. Death may also result from the combined effect of two or more conditions.
As can be seen, the cause-of-death section consists of two parts. The first part is for reporting the sequence of events leading to death, proceeding backwards from the final disease or condition resulting in death. So each condition in Part I should cause the condition above it. A specific cause of death should be reported in the last entry in Part I so there is no ambiguity about the etiology of this cause. Other significant conditions that contributed to the death, but did not lead to the underlying cause, are reported in Part II.

In addition, there are questions relating to autopsy, manner of death (for example, accident), and injury. The cause of death should include information provided by the pathologist if an autopsy or other type of postmortem examination is done. For deaths that have microscopic examinations pending at the time the certificate is filed, the additional information should be reported as soon as it is available. If the physician has any questions about the procedure for doing this, he or she should contact his or her State registrar.

For statistical and research purposes, it is important that the causes of death and, in particular, the underlying cause of death be reported as specifically and as precisely as possible. Careful reporting results in statistics for both underlying and multiple causes of death (i.e., all conditions mentioned on a death certificate) reflecting the best medical opinion.

Every cause-of-death statement is coded and tabulated in the statistical offices according to the latest revision of the International Classification of Diseases (5). When there is a problem with the reported cause of death (e.g., when a causal sequence is reported in reverse order), the rules provide a consistent way to select the most likely underlying cause. However, it is better when rules designed to compensate for poor reporting are not invoked so that the rules are confirming the physician’s statement rather than imposing assumptions about what the physician meant.

Statistically, mortality research focuses on the underlying cause of death because public health interventions seek to break the sequence of causally related medical conditions as early as possible. However, all cause information reported on death certificates is important and is analyzed.

In the sections that follow, detailed instructions on how to complete Parts I and II are given. A number of examples of properly completed certificates with case histories are provided in this section to illustrate how the cause of death should be reported. Some common problems are also discussed later in this section.
Changes to cause of death

Should additional medical information or autopsy findings become available that would change the cause or causes of death originally reported, the certifying physician should amend the original death certificate by immediately reporting the revised cause of death to the State vital records office or local registrar.

Instructions

The cause-of-death section consists of two parts. Part I is for reporting a chain of events leading directly to death, with the immediate cause of death (the final disease, injury, or complication directly causing death) on line (a) and the underlying cause of death (the disease or injury that initiated the chain of events that led directly and inevitably to death) on the lowest used line. Part II is for reporting all other significant diseases, conditions, or injuries that contributed to death but which did not result in the underlying cause of death given in Part I.

The cause-of-death information should be the physician's best medical opinion. Report each disease, abnormality, injury, or poisoning that the physician believes adversely affected the decedent. A condition can be listed as “probable” if it has not been definitively diagnosed.

If an organ system failure such as congestive heart failure, hepatic failure, renal failure, or respiratory failure is listed as a cause of death, always report its etiology on the line(s) beneath it (for example, renal failure due to Type I diabetes mellitus).

When indicating neoplasms as a cause of death, include the following: 1) primary site or that the primary site is unknown, 2) benign or malignant, 3) cell type or that the cell type is unknown, 4) grade of neoplasm, and 5) part or lobe of organ affected. (For example, a primary well-differentiated squamous cell carcinoma, lung, left upper lobe.)

For each fatal injury (for example, stab wound of chest), always report the trauma (for example, transection of subclavian vein), and impairment of function (for example, air embolism) that contributed to death.

Part I of the cause-of-death section

Only one cause is to be entered on each line of Part I. Additional lines should be added between the printed lines when necessary. For each cause, indicate in the space provided the approximate interval between the date of onset (not necessarily the date of diagnosis) and the date of death.
For clarity, do not use parenthetical statements and abbreviations when reporting the cause of death. The underlying cause of death should be entered on the LOWEST LINE USED IN PART I. The underlying cause of death is the disease or injury that started the sequence of events leading directly to death or the circumstances of the accident or violence that produced the fatal injury. In the case of a violent death, the form of external violence or accident is antecedent to an injury entered, although the two events may be almost simultaneous.

**Line (a) immediate cause**

In Part I, the immediate cause of death is reported on line (a). This is the final disease, injury, or complication directly causing the death. An immediate cause of death must always be reported on line (a). It can be the sole entry in the cause-of-death section if that condition is the only condition causing the death.

The immediate cause does not mean the mechanism of death or terminal event (for example, cardiac arrest or respiratory arrest). The mechanism of death (for example, cardiac or respiratory arrest) should not be reported as the immediate cause of death as it is a statement not specifically related to the disease process, and it merely attests to the fact of death. Therefore, the mechanism of death provides no additional information on the cause of death.

**Lines (b), (c), and (d) due to (or as a consequence of)**

On line (b) report the disease, injury, or complication, if any, that gave rise to the immediate cause of death reported on line (a). If this in turn resulted from a further condition, record that condition on line (c). If this in turn resulted from a further condition, record that condition on line (d). For as many conditions as are involved, write the full sequence, one condition per line, with the most recent condition at the top, and the underlying cause of death reported on the lowest line used in Part I. If more than four lines are needed, add additional lines (writing “due to” between conditions on the same line is the same as drawing an additional line) rather than using space in Part II to continue the sequence. The following certification is an example in which an additional line was necessary.
The words "due to (or as a consequence of),” which are printed between the lines of Part I, apply not only in sequences with an etiological or pathological basis and usually a chronological time ordering, but also to sequences in which an antecedent condition is believed to have prepared the way for a subsequent cause by damage to tissues or impairment of function.

If the immediate cause of death arose as a complication of or from an error or accident in surgery or other medical procedure or treatment, it is important to report what condition was being treated, what medical procedure was performed, what the complication or error was, and what the result of the complication or error was.

Approximate interval between onset and death

Space is provided to the right of lines (a), (b), (c), and (d) for recording the interval between the presumed onset of the condition (not the diagnosis of the condition) and the date of death. This should be entered for all conditions in Part I. These intervals usually are established by the physician on the basis of available information. In some cases the interval will have to be estimated. The terms “unknown” or “approximately” may be used. General terms, such as minutes, hours, or days, are acceptable, if necessary. If the time of onset is entirely unknown, state that the interval is “Unknown.” Do not leave these items blank.

This information is useful in coding certain diseases and also provides a useful check on the accuracy of the reported sequence of conditions.

Part II of the cause-of-death section (other significant conditions)

All other important diseases or conditions that were present at the time of death and that may have contributed to the death, but did not lead to the
underlying cause of death listed in Part I or were not reported in the chain of events in Part I, should be recorded on these lines. (More than one condition can be reported per line in Part II.)

Multiple conditions and sequences of conditions resulting in death are common, particularly among the elderly. When there are two or more possible sequences resulting in death, or if two conditions seem to have added together, choose and report in Part I the sequence though to have had the greatest impact. Other conditions or conditions from the other sequence(s) should be reported in Part II. For example, in the case of a diabetic male with chronic ischemic heart disease who dies from pneumonia, his certifying physician must choose the sequence of conditions that had the greatest impact and report this sequence in Part I. One possible sequence that the certifier might report would be pneumonia due to diabetes mellitus in Part I with chronic ischemic heart disease reported in Part II. Another possibility would be pneumonia due to the chronic ischemic heart disease entered in Part I with diabetes mellitus reported in Part II. Or the certifier might consider the pneumonia to be due to the ischemic heart disease that was due to the diabetes mellitus and report this entire sequence in Part I. Because these three different possibilities would be coded very differently, it is important for the certifying physician to decide which sequence most accurately describes the conditions causing death.

Doubt and cause of death

In cases of doubt, it may be necessary to use qualifying phrases in either Part I or Part II to reflect uncertainty as to which conditions led to death. In cases where the certifier is unable to establish a cause of death based upon reasonable medical certainty, he or she should enter “Unknown” in the cause-of-death section. However, this should be shown only after all efforts have been made to determine the cause of death. An autopsy should be performed, if possible.

Other items for medical certification

The remaining items that require the physician’s certification relate to autopsy, manner of death, injury, female decedent’s pregnancy status, if tobacco use contributed to death, and whether the case was referred to the medical examiner or coroner.

The physician should indicate whether an autopsy was performed and whether the findings were available to complete the cause of death. If additional medical information or autopsy findings are received after the
physician has certified the cause of death and he or she determines the cause to be different from what was originally entered on the death certificate, the original certificate should be amended by filing a supplemental report of cause of death with the State registrar. Information on the proper form to use and procedure to follow can be obtained from the State registrar.

In most cases the manner of death will be checked “Natural.” In those cases when an accident, suicide, or homicide has occurred, the medical examiner or coroner must be notified. If the medical examiner or coroner does not assume jurisdiction, the physician should check the appropriate manner of death and describe the injury and accident.

**Completing the certifier section**

Physicians can play different roles in medical certification. A *pronouncing physician* is a physician who determines that the decedent is legally dead, but was not in charge of the patient’s care for the illness or condition that resulted in death. The attending physician is responsible for completing the cause-of-death section (item 32). If a pronouncing physician is involved, the attending physician plays the role of a *certifying physician*. If no pronouncing physician is involved, the attending physician plays the role of both the *pronouncing* and *certifying* physician. The *medical examiner or coroner* investigates certain types of deaths according to State law and complete the cause of death for these cases.

The following chart specifies the items to be completed by each type of medical certifier.

<table>
<thead>
<tr>
<th>Medical certifier</th>
<th>Complete items</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Pronouncing physician</em></td>
<td>24–31</td>
</tr>
<tr>
<td><em>Certifying physician</em></td>
<td>32–37, 45–49 (sometimes 38–44)</td>
</tr>
<tr>
<td><em>Pronouncing and certifying physician</em></td>
<td>24, 25, 29–37, and 45–49 (sometimes 38–44)</td>
</tr>
<tr>
<td><em>Medical examiner or coroner</em></td>
<td>24, 25, 29, 30, and 32–49</td>
</tr>
</tbody>
</table>

The attending physician is usually in a better position than any other individual to make a judgment as to which of the conditions led directly to death and to state the antecedent conditions, if any, that gave rise to this cause.
Because the items completed by the pronouncing or pronouncing and certifying physician, and medical examiner or coroner differ, separate statements are provided that specify to what information each physician is attesting. This agreement is denoted when each physician signs the completed statement, adding his or her degree or title and license number. Certain jurisdictions may provide for electronic authentication instead of a signature on the paper document. The date of certification and mailing address of the physician should also be provided.

**Examples of cause-of-death certification**

**Case history no. 1**

Shortly after dinner on the day prior to admission to the hospital, this 48-year-old male developed a cramping, epigastric pain, which radiated to his back, followed by nausea and vomiting. The pain was not relieved by positional changes or antacids. The pain persisted, and 24 hours after its onset, the patient sought medical attention. He had a 10-year history of excessive alcohol consumption and a 2-year history of frequent episodes of similar epigastric pain. The patient denied diarrhea, constipation, hematemesis, or melena. The patient was admitted to the hospital with a diagnosis of an acute exacerbation of chronic pancreatitis. Radiological findings included a duodenal ileus and pancreatic calcification. Serum amylase was 4,032 units per liter. The day after admission, the patient seemed to improve. However, that evening he became disoriented, restless, and hypotensive. Despite intravenous fluids and vasopressors, the patient remained hypotensive and died. Autopsy findings revealed many areas of fibrosis in the pancreas with the remaining areas showing multiple foci of acute inflammation and necrosis.
Notes on death certification:

Duodenal ileus and pancreatic calcification are nonspecific processes and neither could be listed as an underlying cause of death.

Case history no. 2

A 68-year-old male was admitted to the hospital with progressive right lower quadrant pain of several weeks’ duration. The patient had lost approximately 40 pounds, with progressive weakness and malaise. On physical examination, the patient had an enlarged liver span that was four finger breadths below the right costal margin. Rectal examination was normal and stool was negative for occult blood. Routine laboratory studies were within normal limits. A chest x ray and barium enema were negative. His EKG showed a right bundle branch block. CT scan showed numerous masses within both lobes of the liver. A needle biopsy of the liver was diagnostic of moderately differentiated hepatocellular carcinoma, and the patient was started on chemotherapy. Three months after the diagnosis, the patient developed sharp diminution of liver function as well as a deep venous thrombosis of his left thigh, and he was admitted to the hospital. On his third day, the patient developed a pulmonary embolism and died 30 minutes later.
This 75-year-old male was admitted to the hospital complaining of severe chest pain. He had a 10-year history of arteriosclerotic heart disease with EKG findings of myocardial ischemia and several episodes of congestive heart failure controlled by digitalis preparations and diuretics. Five months before this admission, the patient was found to be anemic, with a hematocrit of 17, and to have occult blood in the stool. A barium enema revealed a large polypoid mass in the cecum diagnosed as carcinoma by biopsy.

Because of the patient’s cardiac status, he was not considered to be a surgical candidate. Instead, he was treated with a 5-week course of radiation therapy and periodic packed red cell transfusions. He completed this course 3 months before this hospital admission. On this admission the EKG was diagnostic of an acute anterior wall myocardial infarction. He expired 2 days later.
Notes on death certification:

Acute myocardial infarction, listed in Part I line (a) as the immediate cause of death, is a direct consequence of arteriosclerotic heart disease, the underlying cause listed in Part I line (b).

Carcinoma of cecum is listed in Part II because it caused anemia and weakened the patient, but it did not cause arteriosclerotic heart disease.

Congestive heart failure is listed in Part II because it also weakened the patient. Although it was caused by the arteriosclerotic heart disease, it was not part of the causal sequence leading to the acute myocardial infarction.

Case history no. 4

A 68-year-old female was admitted to the ICU with dyspnea and moderate retrosternal pain of 5-hours duration, which did not respond to nitroglycerin. There was a past history of obesity, noninsulin-dependent diabetes mellitus, hypertension, and episodes of nonexertional chest pain, diagnosed as angina pectoris, for 8 years. Over the first 72 hours, she developed a significant elevation of the MB isoenzyme of creatine phosphokinase, confirming an acute myocardial infarction. A Type II second-degree AV block developed, and a temporary pacemaker was put in place. She subsequently developed dyspnea with fluid retention and cardiomegaly on chest radiograph. She improved with diuretics. On the seventh hospital day, during ambulation, she suddenly developed chest pain and increased dyspnea. An acute pulmonary embolism was suspected and intravenous heparin was started. The diagnosis of pulmonary embolism was confirmed by a ventilation/perfusion scan as well as arterial blood gas measurements. One hour later, she became unresponsive and resuscitation efforts were unsuccessful.
Notes on death certification:

In this case, noninsulin-dependent diabetes mellitus, obesity, hypertension, and congestive heart failure would all be considered factors that contributed to the death. However, they would not be in the direct causal sequence of Part I, so they would be placed in Part II.

Case history no. 5

A 78-year-old female with a temperature of 102.6° F was admitted to the hospital from a nursing home. She first became a resident of the nursing home 2 years earlier following a cerebrovascular accident, which left her with a residual left hemiparesis. Over the next year, she became increasingly dependent on others to help with her activities of daily living, eventually requiring an in-dwelling bladder catheter 6 months before the current admission. For the 3 days prior to admission, she was noted to have lost her appetite and to have become increasingly withdrawn.

On admission to the hospital her leukocyte count was 19,700, she had pyuria, and gram-negative rods were seen on a gram stain of urine. Ampicillin and gentamicin were administered intravenously. On the third hospital day, admission blood cultures turned positive for *Pseudomonas aeruginosa*, which was resistant to ampicillin and gentamicin. Antibiotic therapy was changed to ticarcillin clavulanate, to which the organism was sensitive. Despite the antibiotics and intravenous fluid support, the patient’s fever persisted. On the fourth hospital day, she became hypotensive and died.

This case illustrates that additional lines may be added to Part I.
Case history no. 6

A 34-year-old male was admitted to the hospital with severe shortness of breath. He had a 9-month history of unintentional weight loss, night sweats, and diarrhea. The patient had no history of any medical condition that would cause immunodeficiency. An Elisa test and confirmatory Western Blot test for human immunodeficiency virus (HIV) were positive. T-lymphocyte tests indicated a low T helper-suppressor ratio. A lung biopsy was positive for pneumocystis carinii pneumonia (PCP), indicating a diagnosis of acquired immunodeficiency syndrome (AIDS).

The patient’s pneumonia responded to pentamidine therapy, and the patient was discharged. The patient had two additional admissions for PCP. Seventeen months after the patient was first discovered to be HIV positive, he again developed PCP but did not respond to therapy. He died 2 weeks later.
Notes on death certification:

By definition, AIDS is due to HIV infection; even though it may seem redundant to specify HIV infection in the causal sequence death, it is desirable to do so. HIV infection and AIDS are not synonymous, and there is a variable clinical course between the time of HIV infection and onset of AIDS.

Case history no. 7

A 75-year-old male had a 10-year history of chronic bronchitis associated with smoking two packs of cigarettes a day for more than 40 years. When seen by his physician approximately 2 years prior to his terminal episode, he had moderately reduced FEV₁ and FVC with no response to bronchodilators. During his last year, he required corticosteroids to prevent wheezing and coughing at night; however, he was unable to reduce his smoking to less than one pack of cigarettes per day. When seen 3 months prior to his terminal episode, he had significantly reduced FEV₁ and FVC with no response to bronchodilators. He awoke one evening complaining to his wife about coughing and worsening shortness of breath. He was taken to the emergency room where he was found to have an acute exacerbation of obstructive airway disease. He was admitted to the hospital. At the patient’s request, no mechanical ventilation was employed, and he died 12 hours later in respiratory arrest.
Notes on death certification:

In this case, respiratory arrest is considered a mechanism of death, and it would not be listed as the Immediate Cause of Death.

Case history no. 8

A 75-year-old female had a 15-year history of noninsulin-dependent diabetes mellitus, a 13-year history of mild hypertension treated with thiazide diuretics, and an uncomplicated myocardial infarction 6 years prior to the present illness. She was found disoriented in her apartment and brought to the hospital. On admission she was noted to be unresponsive, without focal neurologic signs, and severely dehydrated with a blood pressure of 90/60. Initial laboratory tests disclosed severe hyperglycemia, hyperosmolarity, azotemia, and mild ketosis without acidosis. A diagnosis of hyperosmolar nonketotic coma was made.

The patient was vigorously treated with fluids, electrolytes, insulin, and broad-spectrum antibiotics, although no source for infection was documented. Within 72 hours, the patient's hyperosmolar, hyperglycemic state was resolved. However, she remained anuric with progressive azotemia. Attempts at renal dialysis were unsuccessful, and the patient died on the 8th hospital day in severe renal failure.
Notes on death certification:

In this case, hypertension and a previous myocardial infarction would both be considered factors that contributed to the death. However, they would not be in the direct causal sequence of Part I, so they would be placed in Part II.

Case history no. 9

This 53-year-old male was admitted to the hospital following 2 days of intermittent midepigastric and left-sided chest pain. The pain radiated to his left arm and was accompanied by nausea and vomiting. He gave a history that included 2 years of occasional chest discomfort, a near syncope episode 6 months prior, hypertension, a 30-year history of one-pack-per-day cigarette smoking, congenital blindness, and insulin-dependent diabetes mellitus. He was noted to be markedly obese and to have severe hypercholesterolemia.

At the time of admission, his enzyme studies were normal, but the EKG suggested myocardial ischemia. Two days later, he experienced an episode of severe chest pain that did not respond to nitroglycerin and was accompanied by ST-segment elevation. A cardiac catheterization demonstrated severe multivessel coronary artery stenosis. He underwent quadruple coronary artery bypass surgery. Shortly, after being taken off the cardiopulmonary bypass machine, he went into cardiac arrest. As resuscitation was being attempted by open cardiac massage, a rupture developed in his left ventricular wall that resulted in rapid exsanguination and death.
Notes on death certification:

In this case, insulin-dependent diabetes mellitus, cigarette smoking, hypertension, and hypercholesterolemia would all be considered factors that contributed to the death. However, they would not be in the direct causal sequence of Part I, so they would be placed in Part II. The surgery probably played a role in death but did not cause the coronary artery disease, so it is also listed in Part II.

Case history no. 10

A 1,480-gram male infant was born at 32-weeks gestation to a 20-year-old primiparous woman. Newborn screening found elevated levels of immunoreactive trypsinogen in the blood. The infant developed respiratory distress syndrome and required mechanical ventilation for 7 days. Despite receiving adequate calories for growth, the infant gained weight poorly and had persistent diarrhea. Steatorrhea was confirmed upon microscopic examination. Results from a sweat chloride test given on the 21st day after birth were negative, but the patient had an elevated sweat chloride concentration of 85 millimoles per liter when the test was repeated at 35 days of age. On the 37th day after birth, the infant became lethargic and was noted to be edematous. Escherichia coli was cultured from the infant’s cerebral spinal fluid, total serum proteins were reported to be low, and clotting studies were prolonged. The infant died at 45 days of age despite appropriate life-saving efforts. Gross autopsy confirmed the clinical impression of cystic fibrosis.
Notes on death certification:

In this case, prematurity, malabsorption, respiratory distress syndrome, and failure to thrive would all be considered factors that contributed to the death. However, they would not be in the direct causal sequence of Part I, so they would be placed in Part II.

Case history no. 11

A 30-year-old, gravida-six, para-five, with a history of gestational hypertension, reported to the emergency room at 36 weeks gestation with complaints of abdominal cramping and light vaginal bleeding during the past 12 hours. At time of first assessment, fetal heart tones were detected. The uterus was tense, irritable, and tender. The mother was hypotensive with tachycardia. A presumptive diagnosis of abruptio placenta was made, and an emergency cesarean section was performed under general anesthesia. The baby was stillborn. The mother continued to bleed from her uterus and phlebotomy sites and went into profound shock secondary to disseminated intravascular coagulation. Despite administration of blood and clotting factors, intravascular pressure could not be maintained, and the mother died on the operating table. Maternal autopsy confirmed the clinical diagnosis.

A death certificate would be completed for the mother and a fetal death report for the fetus. The cause of fetal death is reported using a different format. Please refer to the *Medical Examiners’ and Coroners’ Handbook on Death Registration and Fetal Death Reporting* for further information.
Maternal death certificate:

<table>
<thead>
<tr>
<th>Immediate Cause (Final Disease or Condition)</th>
<th>Minutes</th>
<th>Gregational Hypertension, 36 weeks into pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Hemorrhagic shock</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Disseminated intravascular coagulopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Abruptio placenta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Other causes of death</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes on death certification:

In this case, gestational hypertension would be considered a factor that contributed to the death. However, it would not be in the direct causal sequence of Part I, so it would be placed in Part II.
Fetal death report:

**Case history no. 12**

A 92-year-old male was found dead in bed. He had no significant medical history. Autopsy disclosed minimal coronary disease and generalized atrophic changes commonly associated with aging. No specific cause of death was identified. Toxicology was negative.
Note: In some cases, no overwhelming cause presents itself. It is acceptable to indicate that a thorough investigation was performed; however, no cause could be determined.

Case history no. 13

A 102-year-old female was brought to the hospital because her word combinations were not comprehensible. However, at admission, her sentences were lucid. She was placed on blood anticoagulants. She had a history of arthritis, hypertension, blocked arteries, coronary thrombosis (25 years before), stroke (10 years before), periodic TIAs (8-year period), and congestive heart failure (hospitalized 6 years before). On the fourth day in the hospital, a colonoscopy indicated internal bleeding, so the anticoagulant was discontinued. She was released from the hospital after 7 days. After discharge, language and motor skills were impaired although functioning was better earlier in the day; moreover, her leg coloration started changing. After a week at home, the woman was re-admitted to the hospital following a spell of vomiting. Vascular imaging indicated that circulation was blocked at the groin, there was no improvement in language, ability to eat and keep food down deteriorated, and heart rate periodically was arrhythmic with periods of third-degree heart block. After a week of hospitalization, she was sent home under hospice care and died 2 days later. Her attending physician completed the death certificate.
Often several acceptable ways of writing a cause-of-death statement exist. Optimally, a certifier will be able to provide a simple description of the process leading to death that is etiologically clear and be confident that this is the correct sequence of causes. However, realistically, description of the process is sometimes difficult because the certifier is not certain.

In this case, the certifier should think through the causes about which he/she is confident and what possible etiologies could have resulted in these conditions. The certifier should select the causes that are suspected to have been involved and use words such as "probable" or "presumed" to indicate that the description provided is not completely certain. If the initiating condition reported on the death certificate could have arisen from a pre-existing condition, but the certifier cannot determine the etiology, he/she should state that the etiology is unknown, undetermined, or unspecified, so it is clear that the certifier did not have enough information to provide even a qualified etiology. Reporting a cause of death as unknown should be a last resort.

The elderly decedent should have a clear and distinct etiological sequence for cause of death, if possible. Terms such as senescence, infirmity, old age, and advanced age have little value for public health or medical research. Age is recorded elsewhere on the certificate. When a number of conditions resulted in death, the physician should choose the single sequence that, in his or her opinion, best describes the process leading to death, and place any other pertinent conditions in Part II. "Multiple system failure" could be included in Part II, but the systems need to be specified to ensure that the information is captured. If after careful
consideration, the physician cannot determine a sequence that ends in death, then the medical examiner or coroner should be consulted about conducting an investigation or providing assistance in completing the cause of death.

The **infant decedent** should have a clear and distinct etiological sequence for cause of death, if possible. “Prematurity” should not be entered without explaining the etiology of prematurity. Maternal conditions may have initiated or affected the sequence that resulted in infant death, and such maternal causes should be reported in addition to the infant causes on the infant's death certificate (e.g., hyaline membrane disease due to prematurity, 28 weeks due to placental abruption due to blunt trauma to mother’s abdomen).

When **Sudden Infant Death Syndrome** (SIDS) is suspected, a complete investigation should be conducted, typically by a medical examiner or coroner. If the infant is under 1 year of age, no cause of death is determined after scene investigation, review of clinical history, and a complete autopsy. The death then can be reported as SIDS. Refer to the *Medical Examiners’ and Coroners’ Handbook on Death Registration and Fetal Death Reporting* for more information.

Most certifiers will find themselves, at some point, in the circumstance in which they are unable to provide a simple description of the process of death. In this situation, the certifier should try to provide a clear sequence, qualify the causes about which he/she is uncertain, and be able to explain the certification chosen.

When processes such as the following are reported, additional information about the etiology should be reported:

<table>
<thead>
<tr>
<th>Abscess</th>
<th>Cerebrovascular accident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal hemorrhage</td>
<td>Cerebellar tonsillar herniation</td>
</tr>
<tr>
<td>Adhesions</td>
<td>Chronic bedridden state</td>
</tr>
<tr>
<td>Adult respiratory distress</td>
<td>Cirrhosis</td>
</tr>
<tr>
<td>syndrome</td>
<td>Coagulopathy</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>Compression fracture</td>
</tr>
<tr>
<td>Altered mental status</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Anemia</td>
<td>Convulsions</td>
</tr>
<tr>
<td>Anoxia</td>
<td>Decubitus</td>
</tr>
<tr>
<td>Anoxic encephalopathy</td>
<td>Dehydration</td>
</tr>
<tr>
<td>Ascites</td>
<td>Dementia (when not other­wise specified)</td>
</tr>
<tr>
<td>Aspiration</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>Disseminated intra vascular coagulopathy</td>
</tr>
<tr>
<td>Bactremia</td>
<td>Dysrhythmia</td>
</tr>
<tr>
<td>Bedridden</td>
<td>End-stage liver disease</td>
</tr>
<tr>
<td>Biliary obstruction</td>
<td>End-stage renal disease</td>
</tr>
<tr>
<td>Bowel obstruction</td>
<td>Epidural hematoma</td>
</tr>
<tr>
<td>Brain injury</td>
<td>Exanguination</td>
</tr>
<tr>
<td>Brain stem herniation</td>
<td>Failure to thrive</td>
</tr>
<tr>
<td>Carcinogenesis</td>
<td>Fracture</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>Gangrene</td>
</tr>
<tr>
<td>Cardiac dysrhythmia</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Cardiopulmonary arrest</td>
<td>hemorrhage</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Heart failure</td>
</tr>
<tr>
<td>Cerebral edema</td>
<td>Hemothorax</td>
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<tr>
<td></td>
<td>Hepatic failure</td>
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<tr>
<td></td>
<td>Hepatitis</td>
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<tr>
<td></td>
<td>Hepatorenal syndrome</td>
</tr>
<tr>
<td></td>
<td>Hyperpyrexia</td>
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<tr>
<td></td>
<td>Hyperkalemia</td>
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<tr>
<td></td>
<td>Hypovolemic shock</td>
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<tr>
<td></td>
<td>Hypotension</td>
</tr>
<tr>
<td></td>
<td>Immunosuppression</td>
</tr>
<tr>
<td></td>
<td>Increased intra cranial pressure</td>
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<tr>
<td></td>
<td>Intra cranial hemorrhage</td>
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<tr>
<td></td>
<td>Malnutrition</td>
</tr>
<tr>
<td></td>
<td>Metabolic encephalopathy</td>
</tr>
<tr>
<td></td>
<td>Multimorgan failure</td>
</tr>
<tr>
<td></td>
<td>Multisystem organ failure</td>
</tr>
<tr>
<td></td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td></td>
<td>Necrotizing soft-tissue infection</td>
</tr>
<tr>
<td></td>
<td>Old age</td>
</tr>
<tr>
<td></td>
<td>Open (or closed) head</td>
</tr>
<tr>
<td></td>
<td>Paralytic</td>
</tr>
<tr>
<td></td>
<td>Pancreatitis</td>
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<tr>
<td></td>
<td>Perforated gallbladder</td>
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<tr>
<td></td>
<td>Peritonitis</td>
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<tr>
<td></td>
<td>Pleural effusions</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td>Pulmonary arrest</td>
</tr>
<tr>
<td></td>
<td>Pulmonary edema</td>
</tr>
<tr>
<td></td>
<td>Pulmonary embolism</td>
</tr>
<tr>
<td></td>
<td>Pulmonary insufficiency</td>
</tr>
<tr>
<td></td>
<td>Renal failure</td>
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<tr>
<td></td>
<td>Respiratory arrest</td>
</tr>
<tr>
<td></td>
<td>Seizures</td>
</tr>
<tr>
<td></td>
<td>Septic shock</td>
</tr>
<tr>
<td></td>
<td>Shock</td>
</tr>
<tr>
<td></td>
<td>Starvation</td>
</tr>
<tr>
<td></td>
<td>Subdural hematoma</td>
</tr>
<tr>
<td></td>
<td>Subarachnoid</td>
</tr>
<tr>
<td></td>
<td>Sudden death</td>
</tr>
<tr>
<td></td>
<td>Thrombocytopenia</td>
</tr>
<tr>
<td></td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td></td>
<td>Ventricular fibrillation</td>
</tr>
<tr>
<td></td>
<td>Volume depletion</td>
</tr>
</tbody>
</table>
If the certifier is unable to determine the etiology of a process such as those shown above, the process must be qualified as being of an unknown, undetermined, probable, presumed, or unspecified etiology so it is clear that a distinct etiology was not inadvertently or carelessly omitted.

The following conditions and types of death might seem to be specific or natural. However, when the medical history is examined further it may be found to be complications of an injury or poisoning (possibly occurring long ago). Such cases should be reported to the medical examiner or coroner.

- Asphyxia
- Bolus
- Choking
- Drug or alcohol overdose/drug or alcohol abuse
- Epidural hematoma
- Exsanguination
- Fall
- Fracture
- Hip fracture
- Hyperthermia
- Hypothermia
- Open reduction of fracture
- Pulmonary emboli
- Seizure disorder
- Sepsis
- Subarachnoid hemorrhage
- Subdural hematoma
- Surgery
- Thermal burns/chemical burns

**Additional resources**

In addition to the series of handbooks, additional resources include manuals, guidelines, and Web sites (7–15). Resources on completing death certificates should be kept with or near blank death certificates for easy reference. Additional copies of government-produced resources are available from the State vital statistics offices, the National Center for Health Statistics, and the Internet at [http://www.cdc.gov/nchs](http://www.cdc.gov/nchs) (under vital statistics, mortality, writing cause-of-death statements).
Completing Other Items on the Death Certificate

These instructions pertain to the 2003 revision of the U.S. Standard Certificate of Death.

NAME OF DECEDEENT: For use by physician or institution

The left-hand margin of the certificate contains a line where the physician or hospital can write in the name of the decedent. This allows the hospital to assist in completing the death certificate before the body is removed by the funeral director. However, because the funeral director is responsible for completion of the personal information about the decedent and because the hospital frequently does not have the complete legal name of the decedent, the hospital or physician should enter the name they have for the decedent in this item. The funeral director will then enter the full legal name in item 1.

14. PLACE OF DEATH (Check only one; see instructions)

Check the type of place where the decedent was pronounced dead.

Hospital deaths

If the decedent was pronounced dead in a hospital, check the box indicating the decedent’s status at the hospital: Inpatient, Emergency Room/Outpatient (ER) or Dead on Arrival (DOA). Hospitals are licensed institutions providing patients diagnostic and therapeutic services by a medical staff.

Nonhospital deaths

If the decedent was pronounced dead somewhere else, check the box indicating whether pronouncement occurred at a Hospice facility, Nursing home/Long-term care facility, Decedent's home, or other location.

Hospice facility refers to a licensed institution providing hospice care (e.g., palliative and supportive care for the dying), not to hospice care that might be provided in a number of different settings, including a patient’s home.
If death was pronounced at a licensed long-term care facility, check the box that indicates Nursing home/Long term care facility. A long-term care facility is not a hospital, but provides patient care beyond custodial care (e.g., nursing home, skilled nursing facility, long-term care facilities, convalescent care facility, extended care facility, intermediate care facility, residential care facility, congregate care facility).

If death was pronounced in the decedent's home, check the box that indicates decedent's home. A decedent's home includes independent living units including private homes, apartments, bungalows, and cottages.

If death was pronounced at a licensed ambulatory/surgical center, orphanage, prison ward, public building, birthing center, facilities offering housing and custodial care, but not patient care (e.g., board and care home, group home, custodial care facility, foster home), check “Other (Specify).” If “Other (Specify)” is checked, specify where death was legally pronounced, such as a prison ward, physician’s office, the highway where a traffic accident occurred, a vessel, orphanage, group home, or at work.

If the place of death is unknown, but the body is found in a State, enter the place where the body is found as the place of death.

15. FACILITY NAME (If not an institution, give street and number)

Institution deaths

If the death occurred in a hospital, enter the full name of the hospital.

If death occurred en route to or on arrival at a hospital, enter the full name of the hospital. Deaths that occur in an ambulance or emergency squad vehicle en route to a hospital fall in this category.

If the death occurred in another type of institution such as a nursing home, enter the name of the institution where the decedent died.

Noninstitution deaths

If the death occurred at home, enter the house number and street name.

If the death occurred at some place other than those described above, enter the number and street name of the place or building (if at a building) where the decedent died.

If the death occurred on a moving conveyance, enter the name of the vessel, for example, S.S. Olive Seas (at sea) or “Eastern Airlines Flight 296 (in flight).”
16. CITY OR TOWN, STATE, AND ZIP CODE

Enter the name of the city, town, village, or location, State, and zip code where death occurred.

17. COUNTY OF DEATH

Enter the name of the county of the institution or address given in item 15 where death occurred. If the death occurred on a moving conveyance in the United States and the body is first removed from the conveyance in this State, complete a death certificate and enter as the place of death the address where the body was first removed from the conveyance.

If the death occurred on a moving conveyance in international waters, international airspace, or in a foreign country or its airspace, and the body is first removed from the conveyance in this State, register the death in this State, but enter the actual place of death insofar as can be determined.

*These items are used to identify the place of death to determine who has jurisdiction for deaths that legally require investigation by a medical examiner or coroner. These items are also used for research and statistics comparing hospital and nonhospital deaths. Valuable information is also provided for health planning and the utilization of health facilities.*

**Items on when death occurred**

Items 24 and 25 and 29–31 should always be completed. If the facility uses a separate pronouncer or other person to indicate that death has taken place with another person more familiar with the case completing the remainder of the medical portion of the death certificate, the pronouncer completes Items 24–28. In all other cases, the certifier completes Items 24, 25, 29–37, and 45–49, and Items 26–28 are left blank.

24. DATE PRONOUNCED DEAD (Month, Day, and Year)

Enter the exact month, day, and four-digit year that the decedent was pronounced dead. Complete this item even when it is the same as Item 29, the actual or presumed date.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

*This is used to identify the date the decedent was legally pronounced dead. This information is very helpful in those cases where a body of a person who has been dead for some time is found and the death is pronounced by a medical examiner or coroner.*
25. TIME PRONOUNCED DEAD

Enter the exact time (hour and minute using a 24-hour clock) the decedent was pronounced dead according to local time. If daylight saving time is the official prevailing time where death occurs, it should be used to record the time of death. Be sure to indicate the time using a 24-hour clock.

<table>
<thead>
<tr>
<th>24-hour clock</th>
<th>12-hour clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000</td>
<td>12 midnight</td>
</tr>
<tr>
<td>0100</td>
<td>1:00 a.m.</td>
</tr>
<tr>
<td>0200</td>
<td>2:00 a.m.</td>
</tr>
<tr>
<td>0300</td>
<td>3:00 a.m.</td>
</tr>
<tr>
<td>0400</td>
<td>4:00 a.m.</td>
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<tr>
<td>0500</td>
<td>5:00 a.m.</td>
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<tr>
<td>0600</td>
<td>6:00 a.m.</td>
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<tr>
<td>0700</td>
<td>7:00 a.m.</td>
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<tr>
<td>0800</td>
<td>8:00 a.m.</td>
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<tr>
<td>0900</td>
<td>9:00 a.m.</td>
</tr>
<tr>
<td>1000</td>
<td>10:00 a.m.</td>
</tr>
<tr>
<td>1100</td>
<td>11:00 a.m.</td>
</tr>
<tr>
<td>1200</td>
<td>12 noon</td>
</tr>
<tr>
<td>1300</td>
<td>1:00 p.m.</td>
</tr>
<tr>
<td>1400</td>
<td>2:00 p.m.</td>
</tr>
<tr>
<td>1500</td>
<td>3:00 p.m.</td>
</tr>
<tr>
<td>1600</td>
<td>4:00 p.m.</td>
</tr>
<tr>
<td>1700</td>
<td>5:00 p.m.</td>
</tr>
<tr>
<td>1800</td>
<td>6:00 p.m.</td>
</tr>
<tr>
<td>1900</td>
<td>7:00 p.m.</td>
</tr>
<tr>
<td>2000</td>
<td>8:00 p.m.</td>
</tr>
<tr>
<td>2100</td>
<td>9:00 p.m.</td>
</tr>
<tr>
<td>2200</td>
<td>10:00 p.m.</td>
</tr>
<tr>
<td>2300</td>
<td>11:00 p.m.</td>
</tr>
</tbody>
</table>

A death that occurs at 2400 or 0000 midnight belongs to the start of the new day. One minute after 12 midnight is entered as 0001 of the new day.

If the exact time of death is unknown, the time should be approximated by the person who pronounces the body dead. “Approx” should be placed before the time.

26–28 PRONOUNCING PHYSICIAN ONLY

Items 26–28 are to be completed only when the physician responsible for completing the medical certification of cause of death is not available at the time of death to certify the cause of death and when State law provides for a pronouncing physician. In this situation, a pronouncing physician is the person who determines that the decedent is legally dead, but who was not in charge of the patient’s care for the illness or condition that resulted
in death. This hospital physician certifies to the fact and time of death (Items 24 and 25) and signs and dates the death certificate (Items 26–28) so the body can be released to the funeral director when the attending physician is not available. The attending physician is still responsible for completing the cause-of-death section (Item 32). See Part II of this handbook for a more detailed discussion of the completion of Item 32.

COMPLETE ITEMS 26–28 ONLY WHEN CERTIFYING PHYSICIAN IS NOT AVAILABLE AT TIME OF DEATH CERTIFY CAUSE OF DEATH

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)

Obtain the signature and the degree or title of the physician who pronounces death in ink. This physician certifies to the time, date, and place of death only. Rubber stamps or facsimile signatures are not permitted on paper certificates. Jurisdictions with electronic death certificates may have other ways to authenticate the certification than by using a signature.

27. LICENSE NUMBER (Only when applicable)

Enter the State license number of the physician who pronounces death.

28. DATE SIGNED (Month, Day, and Year) (Only when applicable)

Enter the exact month, day, and year that the pronouncing physician signs the certificate. Do not use a number to designate the month.


This information is useful for the quality control program indicating that the medical certification was provided by the attending physician.

Items 24 and 25 must be completed by the person who pronounces death—the pronouncing physician, pronouncing/certifying physician, or medical examiner or coroner.

29. ACTUAL OR PRESUMED DATE OF DEATH (Month, Day, and Year)

Enter the exact month, day, and year that death occurred.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.
Pay particular attention to the entry of month, day, and year when the death occurs around midnight or December 31. Consider a death at midnight to have occurred at the beginning of the next day rather than the end of the previous day. For example, the date for a death that occurs at 11:59 p.m. or 2359 on December 31 should be recorded as December 31 while those occurring the next minute 0000 should be recorded as January 1.

If the exact date of death is unknown, it should be approximated by the person completing the medical certification. “Approx” should be placed before the date. If date cannot be determined by approximating, the date found should be entered and identified as such.

*This item is used in conjunction with the hour of death to establish the exact time of death of the decedent. Epidemiologists also use date of death in conjunction with the cause-of-death section for research on intervals between injuries, onset of conditions, and death.*

**30. ACTUAL OR PRESUMED TIME OF DEATH**

Enter the exact time (hour and minute using a 24-hour clock) of death according to local time. If daylight saving time is the official prevailing time where death occurs, it should be used to record the time of death. Be sure to indicate the time using a 24-hour clock.

<table>
<thead>
<tr>
<th>24-hour clock</th>
<th>12-hour clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000 (medical facilities); 2400 (military facilities)</td>
<td>12 midnight</td>
</tr>
<tr>
<td>0100</td>
<td>1:00 a.m.</td>
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<tr>
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<td>10:00 p.m.</td>
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<tr>
<td>2300</td>
<td>11:00 p.m.</td>
</tr>
</tbody>
</table>
A death that occurs at 2400 or 0000 midnight belongs to the start of the new day. One minute after 12 midnight is entered as 0001 of the new day.

If the exact time of death is unknown, the time should be approximated by the person who certifies the death. “Approx” should be placed before the time.

This item establishes the exact time of death, which is important in inheritance cases when there is a question of who died first. This is often important in the case of multiple deaths in the same family.

31. WAS MEDICAL EXAMINER OR CORONER CONTACTED?

<table>
<thead>
<tr>
<th>31. WAS MEDICAL EXAMINER OR CORONER CONTACTED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Enter “Yes” if the medical examiner or coroner was contacted in reference to this case. Otherwise enter “No.” Do not leave this item blank.

In cases of accident, suicide, or homicide, the medical examiner or coroner must be notified.

This item records whether the medical examiner or coroner was informed when the circumstances require such action. In such cases, the physician must ensure that this is done.

32. CAUSE OF DEATH

Detailed instructions for this item, together with case records, are contained in the section on Medical Certification of Death in this handbook.

These items are to be completed by the attending physician or medical examiner or coroner certifying or reporting his or her opinion on the cause of death.

Part I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

The cause of death means the disease, abnormality, injury, or poisoning that caused the death, not the mechanism of death, such as cardiac or respiratory arrest, shock, or heart failure.
In Part I, the immediate cause of death (final disease or condition resulting in death) is reported on line (a). Antecedent conditions, if any, that gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause (disease or injury that initiated events resulting in death) should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the sequence of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE.

Provide the best estimate of the interval between the onset of each condition and death. Do not leave the space for the interval blank; if unknown, so specify.

Part II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

In Part II, enter other important diseases or conditions that contributed to death but did not result in the underlying cause of death given in Part I.

Cause of death is the most important statistical research item on the death certificate. It provides medical information that serves as a basis for describing trends in human health and mortality and for analyzing the conditions leading to death. Mortality statistics provide a basis for epidemiological studies that focus on leading causes of death by age, race, or sex (for example, HIV, heart disease, and cancer). They also provide a basis for research in disease etiology and evaluation of diagnostic techniques, which in turn lead to improvements in patient care.

All conditions reported are important and are analyzed. For example, analyses may examine associations between conditions reported on the same death certificates such as types of conditions reported in combination with hepatitis.

33. WAS AN AUTOPSY PERFORMED?

Enter “Yes” if a partial or complete autopsy was performed. Otherwise enter “No.”

An autopsy is important in giving additional insight into the conditions that lead to death. This additional information is particularly important in arriving at the immediate and underlying causes when the cause is not immediately clear.
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?

Enter “Yes” if the autopsy findings were available at the time that cause of death was determined. Otherwise enter “No.” Leave this item blank if no autopsy was performed.

This information assists in determining whether, for the 9 percent of cases for which an autopsy is done, the information was available to assist in determining the cause of death. Knowing whether the autopsy results were available for determining the cause of death gives insight into the quality of the cause-of-death data.

35. DID TOBACCO USE CONTRIBUTE TO DEATH?

Check “Yes” if, in the physician’s opinion, any use of tobacco or tobacco exposure contributed to death. For example, tobacco use may contribute to deaths due to emphysema or lung cancer. Tobacco use also may contribute to some heart disease and cancers of the head and neck. Tobacco use should also be reported in deaths due to fires started by smoking. Check “Yes,” if, in the physician’s clinical judgment, tobacco use contributed to this particular death. Check “No,” if, in the physician’s opinion, the use of tobacco did not contribute to death.

36. IF FEMALE, WAS DECEDEANT PREGNANT AT TIME OF DEATH OR WITHIN PAST YEAR?

If the decedent is a female, check the appropriate box in Item 36. If the decedent is a male, leave the item blank. If the female is either too old or too young to be fecund, check the “Not pregnant within the past year” box.

This information is important in determining the scale of mortality amongst this population and will be of assistance with maternal mortality review programs.

37. MANNER OF DEATH

- Natural
- Homicide
- Accident
- Pending Investigation
- Suicide
- Could not be determined
Complete this item for all deaths. Check the box corresponding to the manner of death. Deaths not due to external causes should be identified as “Natural.” Usually, these are the only types of deaths a physician will certify.

Indicate “Pending investigation” if the manner of death cannot be determined to be accident, homicide, or suicide within the statutory time limit for filing the death certificate. This should be changed later to one of the other terms.

Indicate “Could not be determined” ONLY when it is impossible to determine the manner of death.

_in cases of accidental death, this information is used to justify the payment of double indemnity on life insurance policies. It is also used to obtain a more accurate determination of cause of death._

All deaths due to external causes must be referred to the medical examiner or coroner. If the manner of death checked in Item 37 was anything other than natural, Items 38–44 must be completed. If a situation ever arises where the physician must complete the cause, manner, and circumstances (Items 32, 37, and 38–44) of death in an accidental case, please refer to the Medical Examiners’ and Coroners’ Handbook on Death Registration and Fetal Death Reporting. Case histories with properly completed death certificates are also included in that handbook.

The National Association of Medical Examiners have put together a guide on how manner of death may be determined (6). In certain cases, there is a conflict between the manner of death preferred by the medical examiner community and the disease classification. As a result, it is important to specify the circumstances involved so that both communities are able to make use of the information.

38–44 ACCIDENT OR INJURY—To be filled out in all cases of deaths due to injury or poisoning

Complete these items in cases where injury caused or contributed to the death. All deaths resulting from injury must be reported to a medical examiner or coroner, who will usually certify to the cause of death. However, there may be instances in which a medical examiner or coroner will not assume jurisdiction and the attending physician will certify to an accidental death. In these cases when the manner of death is anything other than natural, the attending physician is to complete Items 38–44.
38. DATE OF INJURY (Month, Day, and Year)
Enter the exact month, day, and year that the injury occurred. Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

The date of injury may not necessarily be the same as the date of death.

Estimates may be provided with “Approx” placed before the date.

39. TIME OF INJURY
Enter the exact time (hour and minute using a 24-hour clock) when the injury occurred, according to local time. If daylight saving time is the official prevailing time where death occurs, it should be used to record the time of death. Be sure to indicate the time using a 24-hour clock.

<table>
<thead>
<tr>
<th>24-hour clock</th>
<th>12-hour clock</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000 (medical facilities); 2400 (military facilities)</td>
<td>12 midnight</td>
</tr>
<tr>
<td>0100</td>
<td>1:00 a.m.</td>
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<tr>
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<tr>
<td>2300</td>
<td>11:00 p.m</td>
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</tbody>
</table>

If the exact time of death is unknown, the time should be approximated by the person who certifies the death. “Approx” should be placed before the time.

The date of injury may differ from the date of death.
40. PLACE OF INJURY (e.g., Decedent’s home, construction site, restaurant, wooded area)

Enter the general type of place (such as restaurant, vacant lot, baseball field, construction site, office building, or decedent’s home) where the injury occurred. DO NOT enter firm or organization names. (For example, enter “factory,” not “Standard Manufacturing, Inc.”)

41. INJURY AT WORK?

Complete if anything other than natural disease is mentioned in Part I or Part II of the medical certification (Item 32), including homicides, suicides, and accidents or if anything other than “Natural” is checked for manner of death (Item 37). This includes all motor vehicle deaths. The item must be completed for decedents ages 14 years or over and may be completed for those less than 14 years of age, if warranted.

Enter “Yes” if the injury occurred at work. Otherwise enter “No.” An injury may occur at work regardless of whether the injury occurred in the course of the decedent’s “usual” occupation.

Examples of injury at work and injury not at work follow:

<table>
<thead>
<tr>
<th>Injury at work</th>
<th>Injury not at work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury while working or in vocational training on job premises</td>
<td>Injury while engaged in personal recreational activity on job premises</td>
</tr>
<tr>
<td>Injury while working on break or at lunch or in parking lot on job premises</td>
<td>Injury while a visitor (not on official work business) to job premises</td>
</tr>
<tr>
<td>Injury while working for pay or compensation, including at home</td>
<td>Homemaker working at homemaking activities</td>
</tr>
<tr>
<td>Injury while working as a volunteer law enforcement official etc.</td>
<td>Student in school</td>
</tr>
<tr>
<td>Injury while traveling on business, including to or from business contacts</td>
<td>Working for self for non profit (mowing yard, repairing own roof, hobby)</td>
</tr>
<tr>
<td></td>
<td>Commuting to or from work</td>
</tr>
</tbody>
</table>

These guidelines were developed jointly by: The National Association for Public Health Statistics and Information Systems (NAPHSIS), the National Institute of Occupational Safety and Health (NIOSH), the National Center for Health Statistics (NCHS), and the National Center for Environmental Health and Injury Control (NCEHIC). For questions contact the State vital statistics office.

42. LOCATION OF INJURY (Street and Number, City or Town, State, Apartment No., ZIP Code)

Enter the complete address where the injury took place, including ZIP code. Fill in as many of the items as is known.

43. DESCRIBE HOW INJURY OCCURRED

Enter, in narrative form, a brief but specific and clear description of how the injury occurred. Explain the circumstances or cause of the injury,
such as “fell off ladder while painting house,” “driver of car ran off roadway,” or “passenger in car in car-truck collision.” Specify **type of gun** (e.g., handgun, hunting rifle) or **type of vehicle** (e.g., car, bulldozer, train, etc.) when relevant to circumstances. Indicate if more than one vehicle was involved; specify type of vehicle decedent was in. For motor vehicle accidents, indicate whether the decedent was a driver, passenger, or pedestrian.

If known, indicate what activity the decedent was engaged in when the injury occurred (e.g., playing a sport, working for income, hanging out at a bar).

*In cases of accidental death, Items 38–43 are used in justifying the payment of double indemnity on life insurance policies. They are also needed for a more accurate determination of causes of death. Information from these items forms the basis of statistical studies of occupational injuries.*

**44. IF TRANSPORTATION INJURY, SPECIFY:**

Specify role of decedent (e.g., driver, passenger) in the transportation accident. “Driver/Operator” and “Passenger” should be designated for modes other than motor vehicles such as bicycles. “Other” applies to watercraft, aircraft, animal, or people attached to outside of vehicles (e.g., “surfers”) but are not bonafide passengers or drivers.

*Details will help assign deaths to categories that may be used to assess trends and effectiveness of safety programs.*

**45–49 CERTIFIER**

**45. CERTIFIER (Check only one)**

<table>
<thead>
<tr>
<th>45. CERTIFIER (Check only one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Certifying physician—To the best of my knowledge, death occurred due to the cause(s) and manner stated.</td>
</tr>
<tr>
<td>☐ Pronouncing &amp; Certifying physician—To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.</td>
</tr>
<tr>
<td>☐ Medical Examiner/Coroner—On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.</td>
</tr>
</tbody>
</table>

Signature of certifier

The Certifying physician is the person who determines the cause of death (Item 32). This box should be checked only in those cases when the person
who is completing the medical certification of cause of death is not the person who pronounced death (Items 24 and 25). The certifying physician is responsible for completing Items 32–49.

The Pronouncing & Certifying physician box should be checked when the same person is responsible for completing Items 24 through 49, that is, when the same physician has both pronounced death and certified to the cause of death. If this box is checked, Items 26–28 should be left blank.

The Medical Examiner/Coroner box should be checked when investigation is required by the Post Mortem Examination Act and the cause of death is completed by a medical examiner or coroner. The medical examiner or coroner is then responsible for completing Items 24–46.

If the attending physician is available to certify the fact of death, Items 26–28 should not be completed; the attending physician should then complete Items 24, 25, 29–37, and 45–49 as both pronouncing and certifying physician.

The two-physician certifier concept allows a hospital physician to certify to only the fact and time of death so the body can be released to the funeral director. The attending physician should complete the cause-of-death section. This certification method should result in improved data on cause of death because the physician having the most knowledge about the case completes the cause-of-death section.

Signature of certifier

The physician who certifies to the cause of death in Item 32 signs the certificate in permanent black ink. Jurisdictions with an electronic death certificate may allow electronic authentication. The degree or title of the physician should also be indicated. Rubber stamps or facsimile signatures are not permitted.

46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (ITEM 32)

Type or print the full name and address of the person whose signature or authentication appears in Item 45.

This information is used by the State office of vital statistics for querying the certifier when a question about cause of death arises.

48. LICENSE NUMBER

Enter the State license number of the physician who signs or authenticates the certificate in Item 45.
This number assists in State quality control programs when it is necessary to contact the certifier for additional information concerning the death.

49. DATE CERTIFIED (Month, Day, and Year)

Enter the exact month, day, and year that the certifier signed the certificate.

Enter the full name of the month—January, February, March, etc. Do not use a number or an abbreviation to designate the month.

These items are of legal value in attesting that the medical certification was completed and signed within the time limit required by statute.
References

Appendixes

A. The U.S. Standard Certificate of Death ....................... 52
B. The Vital Statistics Registration System in the United States ... 54
# Appendix A

## U.S. Standard Certificate of Death

### LOCAL FILE NO.  STATE FILE NO.

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>DATE OF DEATH</strong></td>
<td>June 22, 2005</td>
</tr>
<tr>
<td>2. <strong>DATE OF BIRTH</strong></td>
<td>7/23/1911</td>
</tr>
<tr>
<td>3. <strong>SEX</strong></td>
<td>Male</td>
</tr>
<tr>
<td>4. <strong>RACE</strong></td>
<td>White</td>
</tr>
<tr>
<td>5. <strong>DATE OF ISSUE</strong></td>
<td>June 22, 2005</td>
</tr>
<tr>
<td>6. <strong>CERTIFICATOR</strong></td>
<td>Robert J. Boone</td>
</tr>
<tr>
<td>7. <strong>SPONSOR</strong></td>
<td>Edward Matthew Stone, M.D.</td>
</tr>
</tbody>
</table>

### U.S. STANDARD CERTIFICATE OF DEATH

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>DATE OF DEATH</strong></td>
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</tr>
<tr>
<td>2. <strong>DATE OF BIRTH</strong></td>
<td>7/23/1911</td>
</tr>
<tr>
<td>3. <strong>SEX</strong></td>
<td>Male</td>
</tr>
<tr>
<td>4. <strong>RACE</strong></td>
<td>White</td>
</tr>
<tr>
<td>5. <strong>DATE OF ISSUE</strong></td>
<td>June 22, 2005</td>
</tr>
<tr>
<td>6. <strong>CERTIFICATOR</strong></td>
<td>Robert J. Boone</td>
</tr>
<tr>
<td>7. <strong>SPONSOR</strong></td>
<td>Edward Matthew Stone, M.D.</td>
</tr>
</tbody>
</table>

### CAUSE OF DEATH

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death. Write each as a separate cause, including the time, duration, and relationship to the death. **PART II.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death. **PART III.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### DIAGNOSIS OF DEATH

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL EXAMINATION

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL CONCLUSIONS

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL OPINION

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL CERTIFICATION

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL SIGNATURE

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL DATE

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL ADDRESS

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.

### MEDICAL PHONE NUMBER

**PART I.** Enter all conditions existing during the last illness and death which contributed to the death, but are not included in the above. Write each as a separate cause, including the time, duration, and relationship to the death.
<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. TITLE OF CERTIFIER</td>
<td>M.D.</td>
</tr>
<tr>
<td>42. LICENSE NUMBER</td>
<td>12399054</td>
</tr>
<tr>
<td>43. DATE CERTIFIED (Month/Day/Year)</td>
<td>June 22, 2003</td>
</tr>
<tr>
<td>44. FOR REGISTRANT ONLY - DATE FILLED (Month/Day/Year)</td>
<td>June 23, 2003</td>
</tr>
<tr>
<td>47. EDUCATION:</td>
<td>Check the box that best describes the highest grade or level of school completed.</td>
</tr>
<tr>
<td>48. Decedent's Highest Degree</td>
<td></td>
</tr>
<tr>
<td>47a. 9th grade or less</td>
<td></td>
</tr>
<tr>
<td>47b. 10th grade, no diploma</td>
<td></td>
</tr>
<tr>
<td>47c. High school graduate or GED completed</td>
<td></td>
</tr>
<tr>
<td>47d. Some college credit, but no degree</td>
<td></td>
</tr>
<tr>
<td>47e. Associates degree (e.g., AA, AD, AS)</td>
<td></td>
</tr>
<tr>
<td>47f. Bachelor's degree (e.g., BA, AB, BS)</td>
<td></td>
</tr>
<tr>
<td>47g. Master's degree (e.g., MA, MS, ME, MEd, MEd)</td>
<td></td>
</tr>
<tr>
<td>47h. Doctorate or other professional degree (e.g., Ph.D., 0.D., D.D.S., M.D.)</td>
<td></td>
</tr>
<tr>
<td>49. DECEASED'S OCCUPATION</td>
<td></td>
</tr>
<tr>
<td>50. Kind of Business/Industry</td>
<td>Self-employed</td>
</tr>
<tr>
<td>51. DECEASED'S ETHNIC ORIGIN</td>
<td></td>
</tr>
<tr>
<td>52. DECEASED'S RACE</td>
<td>Check one or more boxes to indicate what the decedent considered himself/herself to be.</td>
</tr>
<tr>
<td>52a. White</td>
<td></td>
</tr>
<tr>
<td>52b. Black or African American</td>
<td></td>
</tr>
<tr>
<td>52c. American Indian or Alaska Native (Specify)</td>
<td>Cherokee</td>
</tr>
<tr>
<td>52d. Asian (Specify)</td>
<td>Korean</td>
</tr>
<tr>
<td>52e. Pacific Islander (Specify)</td>
<td>Korean</td>
</tr>
<tr>
<td>52f. Other Asian (Specify)</td>
<td>Korean</td>
</tr>
<tr>
<td>52g. Native Hawaiian</td>
<td>Other Pacific Islander (Specify)</td>
</tr>
<tr>
<td>52h. Other Native American (Specify)</td>
<td>Other Pacific Islander (Specify)</td>
</tr>
<tr>
<td>53. DECEASED'S LANGUAGE (Indicate type of work done during most of working life; DO NOT USE RETIRED)</td>
<td></td>
</tr>
<tr>
<td>54. Public accountant</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

The Vital Statistics Registration System in the United States

The registration of births, deaths, fetal deaths, and other vital events in the United States is a State and local function. The civil laws of every State provide for a continuous, permanent, and compulsory vital registration system. Each system depends to a very great extent upon the conscientious efforts of the physicians, hospital personnel, funeral directors, coroners, and medical examiners in preparing or certifying information needed to complete the original records. For a graphic presentation of the registration system, see the accompanying chart, “The Vital Statistics Registration System in the United States.”

Most States are divided geographically into local registration districts or units to facilitate the collection of vital records. A district may be a township, village, town, city, county, or other geographic area or a combination of two or more of these areas. In some States, however, the law provides that records of birth, death, and/or fetal death be sent directly from the reporting source (hospital, physician, or funeral director) to the State vital statistics office. In this system, functions normally performed by a local registration official are assumed by the staff of the State office.

In States with a local registrar system, the local registrar collects the records of events occurring in his or her area and transmits them to the State vital statistics office. The local registrar is required to see that a complete certificate is filed for each event occurring in that district. In many States, this official also has the duty of issuing burial-transit permits to authorize the disposition of dead human bodies. In many States, this official is also required to keep a file of all events occurring within his or her district and, if authorized by State law and subject to the restrictions on issuance of copies as specified by the law, may be permitted to issue copies of these records.

1Vital events are defined as live births, deaths, fetal deaths, marriages, divorces, and induced terminations of pregnancy, together with any change in civil status that may occur during an individual’s lifetime.
The State vital statistics office inspects each record for promptness of filing, completeness, and accuracy of information; queries for missing or inconsistent information; numbers the records; prepares indexes; processes the records; and stores the documents for permanent reference and safekeeping. Statistical information from the records is tabulated for use by State and local health departments, other governmental agencies, and various private and voluntary organizations. The data are used to evaluate health problems and to plan programs and services for the public. An important function of the State office is to issue certified copies of the certificates to individuals in need of such records and to verify the facts of birth and death for agencies requiring legal evidence of such facts.

The Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS) is vested with the authority for administering the vital statistics functions at the national level (3). Electronic data files derived from individual records registered in the State offices or, in a few cases, copies of the individual records themselves, are transmitted to NCHS. From these data, monthly, annual, and special statistical reports are prepared for the United States as a whole and for the component parts—cities, counties, States, and regions—by various characteristics such as sex, race, and cause of death. These statistics are essential in the fields of social welfare, public health, and demography. They are also used for various administrative purposes, in both business and government. NCHS serves as a focal point, exercising leadership in establishing uniform practices through model laws, standard certificate forms, handbooks, and other instructional materials for the continued improvement of the vital statistics system in the United States.
The Vital Statistics Registration System in the United States

<table>
<thead>
<tr>
<th>Responsible Person or Agency</th>
<th>Birth Certificate</th>
<th>Death Certificate</th>
<th>Fetal Death Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital authority</td>
<td>1. Completes entire certificate using mother and facility worksheets. 2. Files certificate with local office or State office per State law.</td>
<td>When death occurs in hospital, may initiate preparation of certificate: Completes information on name, date, and place of death; obtains certification of cause of death from physician; and gives certificate to funeral director. NOTE: If the attending physician is unavailable to certify to the cause of death, some States allow a hospital physician to certify to only the fact and time of death. With legal pronouncement of the death and permission of the attending physician, the body can then be released to the funeral director. The attending physician still must complete the cause-of-death section prior to final disposition of the body.</td>
<td>1. Completes entire report using patient and facility worksheets. 2. Obtains cause of fetal death from physician. 3. Obtains authorization for final disposition of fetus. 4. Files report with local office or State office per State law.</td>
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<tr>
<td>Funeral director</td>
<td></td>
<td></td>
<td>If fetus is to be buried, the funeral director is responsible for obtaining authorization for final disposition. NOTE: In some States, the funeral director, or person acting as such, is responsible for all duties shown above under hospital authority.</td>
</tr>
<tr>
<td>Physician or other professional attendant</td>
<td>For in-hospital birth, verifies accuracy of medical information and signs certificate. For out-of-hospital birth, duties are same as those for hospital authority, shown above.</td>
<td>Completes certification of cause of death and signs certificate.</td>
<td>Provides cause of fetal death and information not available from the medical records.</td>
</tr>
<tr>
<td>Local office** (may be local registrar or city or county health department)</td>
<td>City and county health departments</td>
<td>State registrar, office of vital statistics</td>
<td>Centers for Disease Control and Prevention, National Center for Health Statistics</td>
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<tr>
<td>1. Verifies completeness and accuracy of certificate and queries incomplete or inconsistent certificates. 2. If authorized by State law, makes copy or index for local use. 3. Sends certificates to State registrar.</td>
<td>1. Use data derived from these records in allocating medical and nursing services. 2. Follow up on infectious diseases. 3. Plan programs. 4. Measure effectiveness of services. 5. Conduct research studies.</td>
<td>1. Queries incomplete or inconsistent information. 2. Maintains files for permanent reference and is the source of certified copies. 3. Develops vital statistics for use in planning, evaluating, and administering State and local health activities and for research studies. 4. Compiles health-related statistics for State and civil divisions of State for use of the health department and other agencies and groups interested in the fields of medical science, public health, demography, and social welfare. 5. Sends data for all events filed to the National Center for Health Statistics.</td>
<td>1. Evaluates quality of State vital statistics data and works with States to assure quality. 2. Compiles national statistical data file and runs edits to fully process data. 3. Prepares and publishes national statistics of births, deaths, and fetal deaths; constructs the official U.S. life tables and related actuarial tables. 4. Conducts health and social research studies based on vital records and on sampling surveys linked to records. 5. Conducts research and methodological studies in vital statistics methods, including the technical, administrative, and legal aspects of vital records registration and administration. 6. Maintains a continuing technical assistance program to improve the quality and usefulness of vital statistics. 7. Provides leadership and coordination in the development of standard certificates and report and model laws.</td>
</tr>
</tbody>
</table>
| If State law requires routing of fetal death reports through local office, the local office performs the same functions as shown for the birth and death certificate. | | | **Some States do not have local vital registration offices. In these States, the certificates or reports are transmitted directly to the State office of vital statistics.**