

SUBCHAPTER 5 MANAGEMENT OF TUBERCULOSIS

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APPENDIX A.

APPENDIX B.

§ 8:57-5.1 Purpose and scope

(a) The purpose of this subchapter is to control the spread of tuberculosis TB by maximizing the use of currently available and highly effective treatments.

(b) This subchapter applies to persons who have suspected or confirmed TB disease as diagnosed by a health care provider, especially those with suspected or confirmed infectious or potentially infectious TB disease who pose an immediate or imminent risk to the public health.

1. This includes persons identified by public health professionals as contacts to persons with suspected or confirmed infectious or potentially infectious TB disease, and Class B1 or B2 referrals from the Centers for Disease Control and Prevention (CDC) who are residing in New Jersey.

(c) Local health officers, public health nurse case managers, health care providers and administrators of hospitals and correctional facilities are primarily responsible for implementation of this subchapter.

(d) Local health officers in areas where the person with suspected or confirmed, infectious or potentially infectious TB disease resides, frequents or receives care may take any action authorized under this subchapter if he or she determines that it is necessary to protect the health of the person or the public.

(e) The guiding goals underlying this subchapter are:

1. To protect the public from the spread of TB disease and/or latent TB infection; and

2. To diagnose and treat persons with suspected or confirmed TB disease and those with latent TB infection at high risk for progression to TB disease in the least restrictive environment and manner.

HISTORY

HISTORY:

Amended by R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

In (a), substituted "this subchapter" for "these rules" and substituted "TB" for ", particularly new forms of multiple drug resistant TB (MDR-TB),"; rewrote (b); in (c), inserted ", public health nurse case managers, health care providers and administrators and administrators of hospitals and correctional facilities", substituted "this subchapter" for "these rules" and deleted the last sentence; in (d), inserted "with suspected or confirmed, infectious or potentially infectious TB disease resides,", substituted "this subchapter" for "these rules", "he or she" for "the local health officer", "it is" for "they are" and "to protect" for "for" and deleted the last sentence; in the introductory paragraph of (e), substituted "goals" for "principles" and "this subchapter" for "the implementation of these rules"; in (e)1, deleted "active" following "spread of" and inserted "and/or latent TB infection"; and rewrote (e)2.

Chapter Notes

§ 8:57-5.2 Incorporated documents

(a) To further the purposes of this subchapter, the Department incorporates by reference, as amended and supplemented, Morbidity and Mortality Weekly Report (MMWR), Treatment of Tuberculosis, published by the Centers for Disease Control and Prevention on June 20, 2003, volume 52, number RR-11, (hereinafter "MMWR, Treatment of Tuberculosis").

1. The MMWR, Treatment of Tuberculosis is available by written request to the Communicable Disease Service, Public Health Services Branch, New Jersey Department of Health and Senior Services, PO Box 369, Trenton, NJ, 08625-0369, or online at the Centers for Disease Control and Prevention's website at <http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf>.

(b) The Department incorporates by reference the following forms in this subchapter:

1. TB-70: Tuberculosis Case, Suspect and Status Report (Appendix A), which is the form for reporting suspected or confirmed TB disease and updating the status of these patients.

2. TB-41: Record of Contact Interview (Appendix B), which is the form for reporting the identification, results of medical evaluation and final disposition of contacts.

(c) All of the forms in (b) above are available by written request to the Communicable Disease Service, Public Health Services Branch, New Jersey Department of Health and Senior Services, PO Box 369, Trenton, NJ 08625-0369.

1. The TB-41 form is also available online through the Department's "Forms" web page at <http://web.doh.state.nj.us/forms/>.

HISTORY

HISTORY:

New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Former N.J.A.C. 8:57-5.2, Definitions, recodified to N.J.A.C. 8:57-5.3.

Chapter Notes

§ 8:57-5.3 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

“Acid-fast bacilli (AFB)” means organisms that remain stained after being washed in acid solution, may be detected using a microscope, and are then reported as a positive AFB on smear.

1. TB should be considered a possibility when AFB are present on a stained smear, and indicates the likelihood of infectiousness if from a pulmonary source such as, but not limited to, sputum, bronchioalveolar lavage, gastric aspirate, lung tissue, as well as other tissue of the respiratory tract such as the larynx or epiglottis.

“Administrator” means any person having control or supervision over a hospital or correctional facility.

“Class B1 or B2 referrals” means referrals from the CDC’s Division of Global Migration and Quarantine, which informs the Department of persons who are refugees, parolees, asylees, or recent legal immigrants to the United States, and who were screened overseas and classified as either B1 meaning TB, clinically active, not infectious or B2 meaning TB, not clinically active, not infectious.

1. These classifications are made within 12 months of immigration and these referrals require evaluation of their TB status within 30 days of arrival to prevent potential transmission.

“Contact” means a person identified by the public health department who has had exposure to a patient with suspected or confirmed infectious or potentially infectious TB sufficient in both duration and proximity to make him or her at increased risk for recent transmission of latent TB infection.

“Directly observed therapy (DOT)” means the observation, by a person who is trained in the performance of these duties, of the ingestion of anti-TB medication by a patient.

1. DOT is the only method available to reliably determine a patient’s adherence to a prescribed treatment regimen.

“Extensively drug resistant tuberculosis (XDR-TB)” means a form of TB disease that is resistant to at least isoniazid, rifampin, any fluoroquinolone, and either amikacin, kanamycin or capreomycin.

“Field services” means the provision of directly observed therapy (DOT) as ordered by a health care provider.

1. Field services may also include other services the field services provider is trained and equipped to perform (such as, but not limited to, patient interviews, transportation, delinquent investigations).

“Health care provider” means a person who is directly involved in the clinical diagnosis of and the prescribing of medication for individuals with suspected or confirmed TB disease or latent TB infection.

1. Health care providers include physicians, advanced practice nurses, certified nurse midwives, and/or physician assistants.

“Health officer order” means an order issued by a health officer to a patient with suspected or confirmed infectious or potentially infectious TB disease, a contact, or a class B1 or B2 referral at a specified time as described in N.J.A.C. 8:57-5.10, 5.11 or 5.12.

“Hospital” shall have the meaning set forth in the Department’s Hospital Licensing Standards for general hospital and special hospital at N.J.A.C. 8:43G-1.3(b), which treat patients with TB disease.

“Immediate or imminent public health risk” means a patient with suspected or confirmed infectious or potentially infectious TB disease and who does any of the following:

1. Threatens to leave an acute care facility against medical advice;
2. Leaves an acute care facility against medical advice;
3. States he or she will not adhere to infection control measures;
4. Does not adhere to infection control measures;
5. Refuses to take anti-tuberculosis medication as prescribed; or
6. Threatens to travel on a public conveyance.

“Index case” means the patient with suspected or confirmed infectious or potentially infectious TB disease or child less than five years of age whose diagnosis results in a source case investigation.

“Infection control measures” means restrictions imposed by a health care provider, nurse case manager, or health officer to protect the public from transmission of tuberculosis from a patient with suspected or confirmed infectious or potentially infectious TB disease.

1. The measures applicable to each patient will vary based upon the circumstances of the individual.

“Interferon gamma release assay” means QuantiFERON-Gold or T-spot.TB assay.

“Latent TB infection” means the presence of Mycobacterium tuberculosis bacteria in the body as evidenced by a significant reaction to a Mantoux tuberculin skin test or positive interferon gamma release assay.

1. A person with latent TB infection does not have an illness nor is he or she infectious.

“Least restrictive environment or manner” means the intervention that limits the patient’s activities the least while providing protection for the public against the likelihood of TB transmission.

“Multiple drug resistant tuberculosis (MDR-TB)” means a form of TB disease that is resistant to at least isoniazid and rifampin.

“Nucleic acid amplification test” means polymerase chain reaction (PCR) or Mycobacterium tuberculosis direct (MDT) test.

“Public Health Nurse Case Manager” means the nurse providing public health nurse case management services which include, but are not limited to:

1. Patient education regarding the transmission of TB, how to prevent it, and the importance of keeping appointments for clinical assessments and completing treatment;

2. Facilitating the continuity of care for a patient with suspected or confirmed TB until treatment completion by scheduling diagnostic evaluations in a timely manner, monitoring adherence with prescribed therapy, and intervening as appropriate and necessary to address non-adherence;

3. Assessing adherence with community infection control precautions and intervening as appropriate and necessary to address non-adherence;

4. Coordination of TB care with the care of co-existing medical conditions among multiple medical providers;

5. Assessing the quality of care provided by both public and private health care providers with intervention as necessary;

6. Identification of psycho-social barriers to adherence and treatment completion, including, but not limited to: housing, food, transportation, communication, child care, parenting, incarceration, substance abuse and mental illness and intervention as necessary to promote the continuity of treatment;

7. Coordination of contact or source case investigation and care, including, identification, evaluation and appropriate treatment of all identified contacts;

8. Coordination of investigations for all Class B1 and B2 referrals including location, evaluation, and initiation of appropriate treatment;

9. Coordination of all field services, including provision of DOT as prescribed by a health care provider; and

10. Building and maintaining effective working relationships with infection control professionals at hospitals and private health care providers that identify and report tuberculosis in the designated coverage area.

“Public health warning notice” means a notice issued by a public health nurse case manager to a patient with suspected or confirmed infectious or potentially infectious TB disease, a contact, or class B1 or B2 referral as specified in N.J.A.C. 8:57-5.10.

“Risk for flight” means any of the following circumstances pertaining to a patient with suspected or confirmed infectious or potentially infectious TB disease posing an immediate or imminent public health risk:

1. Threatens to leave acute care facility against medical advice;
2. Has left acute care facility against medical advice in the past;
3. Threatens not to appear in court;
4. Has failed to appear in court in the past;
5. Is homeless or residency is unstable;
6. Has been lost to medical supervision in the past; or
7. Threatens to travel on a public conveyance.

“Source case investigation” means the process of identification and evaluation of associates of a patient aged 10 years or less with suspected or confirmed TB disease for the purpose of finding the

source of the child's disease and interrupting additional transmission.

"Suspected or confirmed infectious or potentially infectious TB disease" means one or more of the following:

1. A patient with a smear positive for AFB and/or nucleic acid amplification test positive for M.tb and/or a culture positive for M.tb or M.tb complex;

i. This applies only to specimens from sputum, bronchioalveolar lavage, gastric aspirate, lung tissue or other tissue of the respiratory tract such as the larynx or epiglottis;

2. A patient with a chest radiograph, computed tomography scan, or clinical findings indicative of pulmonary tuberculosis sufficient to prescribe treatment with anti-tuberculosis medications;

3. A patient whose chest radiograph or respiratory symptoms improve while taking anti-tuberculosis medication; or

4. A patient with respiratory symptoms indicative of pulmonary tuberculosis until a diagnostic evaluation is completed to rule out TB as a cause of these symptoms.

"Suspected or confirmed TB disease" means one or more of the following:

1. A patient meeting the definition of suspected or confirmed infectious or potentially infectious TB disease;

2. A patient with a smear positive for AFB and/or nucleic acid amplification test positive for M. tuberculosis and/or a culture positive for M. tuberculosis or M. tuberculosis complex from a location outside the respiratory tract;

3. A patient with extra-pulmonary clinical findings indicative of tuberculosis sufficient to prescribe treatment with anti-tuberculosis medications;

4. A patient whose extra-pulmonary symptoms improve on anti-tuberculosis medications; or

5. A patient with symptoms indicative of extra-pulmonary tuberculosis until a diagnostic evaluation is completed to rule-out TB as the cause of these symptoms.

"Vulnerable population" means persons who are vulnerable to rapid progression to TB disease once infected including, but not limited to, persons with the following conditions or on the following treatments: HIV infection, corticosteroid therapy, tumor necrosis factor (TNF) alpha blocker therapy, cancer chemotherapy, end-stage renal disease, cancer of the head or neck, or children under the age of five years.

HISTORY

HISTORY:

Recodified from N.J.A.C. 8:57-5.2 and amended by R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Rewrote definitions "Acid-fast bacilli (AFB)", "Directly observed therapy (DOT)", "Health care provider", "Health officer order", "Latent TB infection", and "Multiple drug resistant tuberculosis (MDR-TB)"; deleted definitions "Active TB", "Appointment keeping rate", "Clinically suspected active TB", "Close contact", "Commissioner", "Compliance", "Designated commitment facility or unit", "Infectious

tuberculosis”, “Local health officer”, “Loss of contact”, “Manager, TB Program”, “Medical director” “Restraining order”, “Social resources”, “TB control agency”, and “Warning notice”; added definitions “Administrator”, “Class B1 or B2 referrals”, “Contact”, “Hospital”, “Immediate or imminent public health risk”, “Index case”, “Infection control measures”, “Interferon gamma release assay”, “Nucleic acid amplification test”, “Public Health Nurse Case Manager”, “Public health warning notice”, “Risk for flight”, “Source case investigation”, “Suspected or confirmed infectious or potentially infectious TB disease”, “Suspected or confirmed TB disease” and “Vulnerable population”; substituted definition “Least restrictive environment or manner” for definition “Least restrictive alternative”; and rewrote definition “Least restrictive environment or manner”. Former N.J.A.C. 8:57-5.3, Reportable events, repealed.

Chapter Notes

§ 8:57-5.4 Reporting requirements

(a) Health care providers and administrators providing care for any person with a diagnosis of suspected or confirmed TB disease at any site shall report to the Department's TB program or designee the following circumstances utilizing the TB-70 form, available at subchapter Appendix A:

1. A person with suspected or confirmed TB disease within 24 hours of diagnosis.
 - i. A health care provider shall report a patient as a TB suspect within 24 hours of initiation of treatment;
2. Updated monthly information on patients with suspected or confirmed TB disease under their care whenever any of the following occurs: change in clinical status, change in the treatment regimen, treatment ceases for any reason, new laboratory findings, new radiographic findings, change in medical supervision or change in patient locating or contact information.
 - i. The health care provider or administrator shall submit a TB-70 form if any of these events occur, by the 10th day of the following month; and
3. Absent any of the occurrences in (a)2 above, health care providers and administrators shall report updated information on patients with suspected or confirmed TB disease under their care at least every three months after the confirmation of TB disease while treatment is on-going.

(b) The public health nurse case manager shall submit a TB-70 form to the Department's TB Program for patients in accordance with (a) above for patients with suspected or confirmed TB residing in the local health jurisdictions for which he or she has responsibility, when a public health clinic is medically managing these patients.

(c) Health care providers and administrators may report the information required by the TB-70 form to the Department's TB Program Surveillance Unit by telephone (609) 588-7522, or by mail to: New Jersey Department of Health and Senior Services, TB Program, PO Box 369, Trenton, NJ 08625-0369.

1. Health care providers and administrators may also submit the TB-70 form to an appropriate designee of the Department.
 - i. Health care providers and administrators may call the Department's TB Program to determine the appropriate local designee.
 2. Public health nurse case managers shall submit the TB-70 form to the TB Program through the mailing address provided above.

(d) The public health nurse case manager for the jurisdiction in which an index case resides shall report to the Department utilizing the TB-41 form, available at subchapter Appendix B, the identification, evaluation results and final disposition of contacts of the index case with suspected or confirmed TB disease with the following characteristics:

1. Nucleic acid amplification test positive for M.tb from a sputum specimen or sputum culture identified as M.tb or M.tb complex;

2. Cavitory lesions on chest x-ray or computed tomography scan with respiratory symptoms; or
3. Pulmonary or extra-pulmonary TB in children 10 years of age or less.

(e) The public health nurse case manager for an index case shall mail any TB-41 form to the Department's TB Program at New Jersey Department of Health and Senior Services, TB Program, PO Box 369, Trenton, NJ 08625-0369.

(f) Public health nurse case managers in health jurisdictions other than that in which the index case lives shall:

1. Assist the public health nurse case manager of the index case in the identification, evaluation and final disposition of contacts associated with the index case; and
2. Submit the results of these activities to the public health nurse case manager in the index case's jurisdiction of residence for coordination and submission to the Department's TB Program.

(g) If the index case has contacts outside New Jersey, the Department's TB Program shall assist in securing information regarding the identification, evaluation and final disposition of contacts and provide this information to the public health nurse case manager in the index case's health jurisdiction of residence.

(h) Any health care provider that is evaluating and/or treating contacts to a TB index case meeting the criteria set forth in (d) above shall report the evaluation results and final disposition to the public health nurse case manager upon request.

(i) A health care provider who is not working for a public health clinic shall report verbally to the Department's TB Program at (609) 588-7522, whenever any patient with suspected or confirmed infectious or potentially infectious TB disease misses two consecutive appointments for medical assessment.

1. The report shall include the name of the patient, date of birth, residence address, date of last medical assessment, dates of missed appointments and if the provider wishes to retain medical supervision or transfer supervision to the public health clinic.

2. The health care provider may submit the report to an appropriate designee of the Department.

- i. Health care providers may call the Department's TB Program to determine the appropriate local designee.

(j) The administrator of a hospital shall report to the TB Program at (609) 588-7522 within 24 hours any inpatient with suspected or confirmed infectious or potentially infectious TB disease posing an immediate or imminent public health risk as defined in this subchapter.

(k) The administrator of a hospital shall report the proposed discharge date of a patient with suspected or confirmed infectious or potentially infectious TB disease regardless of time on treatment or smear status to the TB Program at (609) 588-7522 on the last business day that is at least 48 hours prior to the planned discharge date.

1. The hospital shall delay discharge if the administrator cannot achieve this timeline.

2. The report shall include the inpatient's name, address, contact phone number and proposed date of discharge.

(l) The administrator of a correctional facility shall report the release of an inmate with suspected or confirmed infectious or potentially infectious TB disease to the TB Program at (609) 588-7522 at least two working days in advance of the release, if anticipated, or within one working day of the date of release, if unanticipated.

1. The report shall include the inmate's name, address, contact phone number and date of release.

(m) An administrator, health care provider or nurse case manager may delegate the reporting requirements in this section to a subordinate, but such delegation does not transfer responsibility for adherence to the reporting requirements.

(n) Failure to comply with the reporting requirements in this section shall subject required reporters to the penalties set forth at N.J.A.C. 8:57-5.18.

(o) No person who reports patient information in order to comply with this section shall be subject to civil, administrative, disciplinary or criminal liability.

HISTORY

HISTORY:

Repeal and New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Case management and outreach services".

Chapter Notes

§ 8:57-5.5 Hospital discharge

(a) A health care provider managing a patient with suspected or confirmed infectious or potentially infectious TB disease in a hospital may discharge the patient upon meeting one of the following criteria:

1. The patient has an established private residence verified as valid and stable by the public health department and this residence is not shared by any individual in a vulnerable population, unless it is known that this individual has latent TB infection;

2. Tuberculosis is ruled out as a cause of disease;

3. The patient is a resident of a congregate living facility, is homeless or reports a private residence that the public health department has not verified as valid and stable, and had sputum smears initially positive for AFB.

i. The patient must have three consecutive sputum smears negative for AFB collected at least eight hours apart;

ii. The patient must have a nucleic acid amplification test negative for *M. tuberculosis*;

iii. The patient must have at least one sputum culture negative for *M. tuberculosis* after initiation of appropriate anti-tuberculosis treatment; or

iv. The Department's TB Program may grant an exception based upon clinical evidence and interview of the patient; or

4. The patient is a resident of a congregate living facility, is homeless or has reported a private residence that the public health department has not verified as valid and stable, and has no sputum smears positive for AFB, and has been on appropriate anti-TB medications for a period of at least two weeks and has no respiratory symptoms.

(b) The Department's Division of Health Facilities Evaluation and Licensing may investigate a hospital's discharge of a patient who does not meet one of the criteria set forth at (a) above.

1. Any hospital that fails to discharge a patient in accordance with (a) above may be subject to penalties for licensure violations as identified by the Department's Division of Health Facilities Evaluation and Licensure.

HISTORY

HISTORY:

Repeal and New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Diagnostic examinations".

[Chapter Notes](#)

§ 8:57-5.6 Health officer responsibilities

(a) Each health officer shall make available a health care provider for medical evaluation and management services for each patient with suspected or confirmed TB disease and latent TB infection in his or her jurisdiction.

1. A health officer may satisfy this requirement through existing staff, contractual arrangement or a Memorandum of Agreement with a public health TB clinic.

(b) Any health care provider providing medical management and treatment to residents of New Jersey with suspected or confirmed TB disease or latent TB infection shall provide these services in accordance with the MMWR Treatment of Tuberculosis as set forth at N.J.A.C. 8:57-5.2(a).

1. A health care provider may also use the Department's Standards of Care for Tuberculosis Disease and Latent TB Infection, (hereinafter "TB Standards of Care") as guidance for the appropriate medical management of patients with suspected or confirmed TB disease or latent TB infection.

i. TB Standards of Care is available by written request to the Communicable Disease Service, Public Health Services Branch, New Jersey Department of Health and Senior Services, PO Box 369, Trenton, NJ 08625-0369 or online at <http://www.state.nj.us/health/cd/tbhome.htm>, then click on "Standards of Care for Tuberculosis Disease and Latent TB Infection."

(c) Each health officer shall make available public health nurse case management services for each patient with suspected or confirmed TB disease, identified contacts, and Class B1 or B2 referrals in his or her jurisdiction.

1. A health officer may satisfy this requirement through existing staff, contractual arrangement or a Memorandum of Agreement with a public health TB clinic.

(d) Each health officer shall make available field services for each patient with suspected or confirmed TB disease, identified contacts, and class B1 or B2 referrals in his or her jurisdiction.

1. A health officer may satisfy this requirement through existing staff, contractual arrangement or a Memorandum of Agreement with a public health TB clinic.

(e) The Department's TB Program shall make verbal translation services accessible to public health clinics, public health nurse case managers and field staff serving patients with TB disease or latent TB infection to overcome communication barriers with the non-English speaking patient population.

HISTORY

HISTORY:

Repeal and New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Management of TB; outpatient basis".

Chapter Notes

§ 8:57-5.7 Notification of precautions to protect the public health

(a) The public health nurse case manager or designee within the health jurisdiction of residence of any patient with a sputum smear positive for AFB or cavitary lesions on chest radiograph or computed tomography scan with respiratory symptoms shall notify the patient verbally and in writing of the infection control measures required to protect the public health within three working days of the receipt of an initial TB-70 form.

(b) If the patient described in (a) above is hospitalized outside the health jurisdiction of his or her residence, the public health nurse case manager or designee in the health jurisdiction where the patient is hospitalized shall deliver the notification as set forth in (a) above within three working days of being informed of the patient's presence in the facility, regardless of patient's health jurisdiction of residence.

(c) The notification described in (a) and (b) above shall list all infection control measures applicable to the patient, and shall request the patient to observe these infection control measures until no longer necessary to protect the public health.

1. Infection control measures shall no longer be required when a person with sputum smear(s) reported positive for AFB initially has:

- i. Three sputum smears reported negative for AFB collected at least eight hours apart;
- ii. A nucleic acid amplification test negative for *M. tuberculosis*;
- iii. At least one sputum culture reported negative for *M. tuberculosis*; or
- iv. TB is ruled out as a cause of disease by a health care provider; or

2. Infection control measures shall no longer be required in the case where no sputum was collected or all sputum smears were reported by a laboratory as negative for AFB, but the patient had cavitary lesions on chest radiograph or computed tomography scan with respiratory symptoms if:

- i. The patient has taken at least two weeks of appropriate treatment and no respiratory symptoms are observed; or
- ii. TB has been ruled out as a cause of disease by a health care provider.

(d) The public health nurse case manager in the patient's health jurisdiction of residence shall inform the patient previously required to comply with infection control measures within one business day of when infection control measures are no longer required.

(e) The health officer or designee in the patient's health jurisdiction of residence shall serve the patient required to comply with infection control measures with either a health officer order for isolation established at N.J.A.C. 8:57-5.11, or health officer order for temporary commitment established at N.J.A.C. 8:57-5.12, whichever is necessary to protect the public health within one business day of any refusal to comply with or violation of infection control measures.

1. The health officer or designee in any health jurisdiction shall serve a health officer order as described in (e) above if the patient required to comply with infection control measures is located in his

or her health jurisdiction.

HISTORY

HISTORY:

New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Former N.J.A.C. 8:57-5.7, Grounds for commitment, recodified to N.J.A.C. 8:57-5.13.

Chapter Notes

§ 8:57-5.8 Diagnostic evaluations

(a) The designated public health nurse case manager for the health jurisdiction of residence shall monitor and facilitate timely diagnostic evaluation of all patients with suspected or confirmed infectious or potentially infectious TB disease, identified contacts to these patients and Class B1 or B2 referrals, regardless of the type of health care provider.

(b) Where a health care provider, based on direct observation or other written clinical and/or laboratory findings, believes that a patient has suspected or confirmed infectious or potentially infectious TB disease, the health care provider shall schedule an appointment for a diagnostic evaluation in his or her office or by referral within five business days of such observation.

(c) The public health nurse case manager shall schedule a diagnostic evaluation in the public health clinic within 10 working days after notification of discharge of a New Jersey resident with suspected or confirmed infectious or potentially infectious TB disease from a hospital or correctional facility inside or outside New Jersey, if the patient will be managed by a public health TB clinic.

(d) The public health nurse case manager shall schedule any contact or Class B1 or B2 referral identified or located during an investigation for a diagnostic evaluation in the public health clinic within 20 working days after identification or notification by the Department's TB Program of his or her residence in the public health nurse case manager's health jurisdiction.

(e) A diagnostic evaluation for a person with suspected or confirmed infectious or potentially infectious TB shall consist of at least a physical examination including visual acuity testing, a chest x-ray, sputum collection or induction and laboratory testing.

1. The health care provider may utilize the Department's TB Standards of Care as a guideline for appropriate practice.

(f) A diagnostic evaluation of a contact or Class B1 or B2 referral shall consist of at least a Mantoux tuberculin skin test or an interferon gamma release assay, and a chest x-ray if the skin test is considered significant or the interferon gamma release assay is positive.

1. If active TB disease is suspected based on the results of the diagnostic evaluation, the health care provider shall complete the requirements at (e) above.

2. The health care provider may utilize the Department's TB Standards of Care as a guideline for appropriate practice.

HISTORY**HISTORY:**

Repeal and New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Hearing process".

Chapter Notes

§ 8:57-5.9 Directly Observed Therapy

(a) Health care providers may prescribe DOT as a method to monitor the adherence of a patient to his or her prescribed treatment for tuberculosis disease.

1. Health care providers may utilize the Department's TB Standards of Care as a guideline for appropriate utilization of DOT.

(b) Only the patient's health care provider shall have the authority to order or discontinue DOT.

1. If a health care provider discontinues an order for DOT:

i. Any health officer requiring DOT shall be immediately rescinded; and

ii. The health officer who petitioned the Superior Court for court ordered DOT, shall request that the court order be rescinded.

(c) The local health officer in the patient's health jurisdiction of residence shall ensure the provision of DOT as ordered by a health care provider by providing field services as established at N.J.A.C. 8:57-5.6.

1. The provision of DOT on a daily, twice weekly or three times weekly basis shall continue until discontinued by the health care provider.

(d) The designated public health nurse case manager or designee for the health jurisdiction of the patient's residence shall negotiate a time and place to provide DOT.

1. The patient may request a reasonable amendment to an established DOT schedule or location from the public health nurse case manager or designee.

2. The public health nurse case manager or designee shall consider the patient's needs and the availability of resources in determining whether to make any accommodation.

(e) The public health nurse case manager shall intervene pursuant to N.J.A.C. 8:57-5.10 if a patient is not at least 80 percent adherent to a prescribed DOT regimen over any one-month period throughout the duration of treatment.

HISTORY**HISTORY:**

New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Former N.J.A.C. 8:57-5.9, Due process, recodified to N.J.A.C. 8:57-5.15.

Chapter Notes

§ 8:57-5.10 Management of non-adherent patients requiring a diagnostic evaluation or DOT

(a) This section is applicable to patients with suspected or confirmed infectious or potentially infectious TB disease, identified contacts and Class B1 or B2 referrals that require a diagnostic evaluation to determine their TB status.

1. A public health nurse case manager, when issuing a public health warning notice to a patient, shall seek a diagnostic evaluation on the patient to assess his or her TB status to adequately protect the public health.

2. A health officer, when issuing a health officer order to a patient, shall require a diagnostic evaluation of the patient to assess his or her TB status to adequately protect the public health.

i. A health officer order for diagnostic evaluation of a contact to a patient with suspected or confirmed infectious or potentially infectious TB disease or Class B1 or B2 referral shall remain in force until a diagnostic evaluation is completed and infectious or potentially infectious TB disease is ruled out by a health care provider.

ii. A health officer order for diagnostic evaluation of a patient with suspected infectious or potentially infectious TB disease shall remain in force until infectious or potentially infectious TB disease is ruled out by a health care provider.

iii. A health officer order for diagnostic evaluation of a patient determined by a health care provider to have infectious or potentially infectious TB disease shall remain in force until treatment is completed as determined by a health care provider.

3. A health officer, when initiating a commitment hearing on a patient, shall require a diagnostic evaluation of the patient to assess his or her TB status to adequately protect the public health.

(b) This section is also applicable to persons with suspected or confirmed infectious or potentially infectious TB disease who are non-adherent with prescribed TB treatment recommendations.

1. A public health nurse case manager, when issuing a public health warning notice to a patient, shall seek DOT to monitor adherence with prescribed treatment to protect the public health.

2. A health officer, when issuing a health officer order to a patient, shall require DOT to monitor adherence with prescribed treatment to protect the public health.

i. A health officer order for DOT of a patient with suspected or confirmed infectious or potentially infectious TB disease shall remain in force until either DOT is discontinued by a health care provider or treatment is completed, as determined by a health care provider.

3. A health officer, when initiating a commitment hearing on a patient, shall require DOT to monitor adherence with prescribed treatment to protect the public health.

(c) If a public health warning notice or health officer order is made pursuant to this section, the health officer or designee shall serve the notice or order by certified mail, return receipt requested or by hand delivery.

1. Successful hand delivery shall include a face-to-face encounter with the patient.

2. Hand delivery by the public health nurse case manager or health officer or designee is preferred, because receipt is witnessed and conditions can be discussed with the patient.

3. The public health nurse case manager, health officer or designee, depending upon who had the face-to-face encounter shall document clearly in the patient's medical record the date and time of the encounter and the patient's response to the conditions of the notice or order.

(d) A health officer order issued pursuant to this section authorizes local law enforcement officers to assist the health officer or designee in hand delivery of the order upon request of the health officer in accordance with N.J.S.A. 26:1A-9.

(e) A public health nurse case manager or designee in the patient's health jurisdiction of residence shall issue a public health warning notice, as set forth in this section, to a person identified in (a) or (b) above within two business days of when the patient:

1. Misses two consecutive scheduled appointments;

2. Falls below a medication adherence rate of 80 percent on a treatment regimen of DOT over a one-month period; or

3. Refuses diagnostic evaluation or DOT.

(f) The public health warning notice shall:

1. State the nature of the non-adherence;

2. Require the patient to contact the health care provider or clinic indicated in the notice within three business days of receipt of the notice to schedule an appointment for diagnostic evaluation or begin or resume a treatment regimen of DOT, whichever is applicable;

3. State the consequences of not satisfying the conditions of the notice; and

4. Be copied and filed in the patient's medical record by the public health nurse case manager or designee.

(g) If the patient described in (e) above fails to meet the conditions of the public health warning notice, the public health nurse case manager shall notify the health officer of the patient's health jurisdiction of residence within two business days of this failure to request a health officer order.

1. If the person is institutionalized or hospitalized, the health officer in the health jurisdiction where the institution or hospital is located shall issue the order.

(h) The health officer shall issue a health officer order within three business days of request by the public health nurse case manager.

(i) The health officer order shall:

1. State the nature of the non-adherence;

2. State the public health consequences of continued non-adherence;

3. Require the patient to contact the health care provider or clinic indicated in the order to schedule

an appointment for diagnostic evaluation or begin or resume a treatment regimen of DOT within three working days of receipt of the order; and

4. State the consequences of not satisfying the conditions of the order.

(j) The public health nurse case manager or designee shall copy and file the health officer order for diagnostic evaluation or DOT in the patient's medical record.

(k) The health officer that issued the order may petition the Superior Court for commitment of the patient violating the order for diagnostic evaluation or DOT pursuant to the hearing process established at N.J.A.C. 8:57-5.14, if the conditions of a health officer order are not met within three business days.

1. The health officer is required to consult with the Department's TB Program or State Epidemiologist or designee before petitioning the Superior Court.

(l) If, at any time during the intervention process described in (e) through (k) above, the patient becomes adherent, the process shall be immediately interrupted.

1. If the patient with suspected or confirmed infectious or potentially infectious TB disease becomes non-adherent again prior to the completion of treatment, the intervention process shall resume at whatever step was next applicable when the patient became adherent.

HISTORY

HISTORY:

Repeal and New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Discharge plan".

Chapter Notes

§ 8:57-5.11 Management of non-adherent patients through a health officer order for isolation

(a) Pursuant to N.J.S.A. 26:4-2, the health officer in the patient's jurisdiction of residence may exclude a patient posing an immediate or imminent risk to the public health from attending his or her place of work or school, or other premises where the health officer determines that such action is necessary to protect the public health.

1. The health officer shall consult with the Department's TB Program or State Epidemiologist or designee before excluding a patient from a workplace, school or other premises through a health officer order.

2. In no case shall a health officer exclude a patient from a workplace, school or other premises for more than 60 days without a court order authorizing such exclusion pursuant to the hearing process established at N.J.A.C. 8:57-5.14.

(b) If a patient excluded from a workplace or school or other premises, pursuant to N.J.S.A. 26:4-2, requests a review of the health officer order, the health officer that issued the order shall make application for a court order authorizing such exclusion within five business days from the date of the request.

1. After any such request, exclusion shall not continue for more than 10 business days without a court order pursuant to the hearing process established at N.J.A.C. 8:57-5.14.

(c) The health officer in the patient's health jurisdiction of residence shall issue a health officer order for isolation within two working days of when the patient meets the definition of immediate or imminent risk to the public health, but is not a risk for flight.

1. If the patient is institutionalized or hospitalized, the health officer in the jurisdiction where the institution or hospital is located shall issue the order.

2. If the patient has suspected or confirmed infectious or potentially infectious TB disease, is suspected or confirmed to have either MDR-TB or XDR-TB, and is non-adherent or threatens non-adherence with infection control measures regardless of his or her risk for flight, the health officer shall serve the patient an order of temporary commitment pursuant to N.J.A.C. 8:57-5.12, rather than an order for isolation due to the severity of the consequences of transmission.

(d) The health officer order shall:

1. State the reason for the order;
2. Reiterate the infection control measures necessary to protect the public health;
3. State the conditions that must be met for the order to be lifted; and
4. State the consequences of violating the order.

(e) The public health nurse case manager or designee shall copy and file the health officer order for isolation in the patient's medical record.

(f) If a health officer order is made pursuant to N.J.A.C. 8:57-5.10, the health officer or designee shall hand deliver the order.

1. Successful hand delivery requires a face-to-face encounter with the patient.

2. The health officer or designee, depending upon who had the face-to-face encounter shall document the date and time of the encounter and the patient's response to the conditions of the order in the medical record.

(g) A health officer may request local law enforcement officers to exercise their authority to assist the health officer or designee in hand delivery of the health officer order in accordance with N.J.S.A. 26:1A-9.

(h) If the patient violates the conditions of the order, the health officer that issued the order may petition the Superior Court for commitment of the patient for the protection of the public health pursuant to the hearing process established at N.J.A.C. 8:57-5.14.

1. The health officer shall consult with the Department's TB Program or the State Epidemiologist or designee before petitioning the Superior Court.

(i) If the health officer seeks court commitment, the Commissioner or State Epidemiologist or designee, in consultation with the health officer and the Department's TB Program, shall designate the least restrictive appropriate placement for the patient during the period of commitment.

1. The placement in (i) above may be an acute care facility or private residence.

2. If the location of commitment is a private residence, law enforcement may use an electronic device to monitor adherence to the commitment order.

(j) The health officer in (c) above may immediately petition the Superior Court for commitment if the patient at any time during the course of treatment again poses an immediate or imminent public health risk and violates the conditions set forth in a health officer order for isolation.

HISTORY

HISTORY:

Repeal and New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Commitment facilities".

Chapter Notes

§ 8:57-5.12 Management of non-adherent patients through health officer order for temporary commitment

(a) If the Commissioner or State Epidemiologist or designee or the health officer in the patient's health jurisdiction of residence determines that the patient is not only an immediate or imminent risk to the public health, but also a risk for flight, the health officer shall immediately order the temporary commitment of the patient to the site designated by the Commissioner or State Epidemiologist or designee, pending an expedited commitment hearing before the Superior Court.

1. The health officer in the jurisdiction where the institution or hospital is located shall issue the order if the person is institutionalized or hospitalized.

2. If the patient has suspected or confirmed infectious or potentially infectious TB disease, is suspected or confirmed to have either MDR-TB or XDR-TB, and is non-adherent or threatens non-adherence with infection control measures, regardless of his or her risk for flight, the health officer shall immediately serve the patient an order of temporary commitment pursuant to this section, rather than an order for isolation due to the severity of the consequences of transmission.

(b) Under no circumstances shall a health officer order for temporary commitment remain in force for more than 30 days without a court order authorizing such commitment pursuant to the hearing process established at N.J.A.C. 8:57-5.14.

(c) The health officer order for temporary commitment shall:

1. State the reason for the order;

2. State the site of commitment;

3. State the conditions of commitment; and

4. State that a Superior Court hearing will occur within the next 30 days or the order will be rescinded.

(d) A health officer order for temporary commitment shall be hand delivered to the effected person by the health officer or designee.

(e) The health officer shall notify the subject of the order for temporary commitment of the date and time of the Superior Court hearing at least two days in advance.

(f) In the circumstance described in (a) above and in accordance with N.J.S.A. 26:1A-9, local law enforcement officers are authorized to take the patient into custody and place him or her at the location designated by the Commissioner or State Epidemiologist or designee and monitor or ensure that the patient remains at that location until the hearing date and that the patient is available for the hearing.

1. If the appropriate placement is determined to be a residence, law enforcement may use an electronic device to enforce temporary commitment.

(g) If the health officer in the patient's health jurisdiction of residence seeks the assistance of local law enforcement officers, the health officer shall provide the following information, as applicable, to

law enforcement:

1. The order under which temporary commitment is authorized;
 2. The site where temporary commitment will be served;
 3. The name, address or last known location, a picture, if available, the skin color, hair color, height, weight, and age of the patient, and any tattoos or scars that could assist in identification; and
 4. The date and time of the expedited commitment hearing.
- (h) The health officer that issued the order for temporary commitment shall seek the assistance of local legal counsel to prepare the petition for commitment by the Superior Court.

HISTORY

HISTORY:

Repeal and New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Procedures for commitment by local health officers".

Chapter Notes

§ 8:57-5.13 Grounds for commitment

(a) In accordance with N.J.S.A. 30:9-57, the Commissioner or local health officer in consultation with the TB Program and/or the State Epidemiologist or designee, may petition the Superior Court for an Order of Commitment whenever a patient violates:

1. A health officer order for diagnostic evaluation or DOT issued pursuant to N.J.A.C. 8:57-5.10;
2. A health officer order for isolation issued pursuant to N.J.A.C. 8:57-5.11; or
3. A health officer order for temporary commitment issued pursuant to N.J.A.C. 8:57-5.12.

(b) The health officer, Commissioner, State Epidemiologist or designee shall petition the Superior Court for an expedited hearing to consider commitment whenever a health officer has issued an order for temporary commitment to a patient pursuant to N.J.A.C. 8:57-5.12.

(c) The health officer, Commissioner, State Epidemiologist or designee shall advise patients for whom he or she is seeking commitment under this section of the reason for the proposed commitment and shall grant an opportunity for a hearing, as set forth at N.J.A.C. 8:57-5.14 and 5.15.

HISTORY

HISTORY:

Recodified from N.J.A.C. 8:57-5.7 and amended by R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Rewrote the section. Former N.J.A.C. 8:57-5.13, Annual report, recodified to N.J.A.C. 8:57-5.16.

Chapter Notes

§ 8:57-5.14 Hearing process

(a) In accordance with N.J.S.A. 30:9-57, the health officer, Commissioner, State Epidemiologist, or designee shall inform the patient to be committed of his or her right to a hearing in the Superior Court.

1. The health officer or designee shall serve the patient considered for commitment a copy of the applicable rules, the reasons for the proposed commitment and notice of the time and place of the hearing at least two days prior to the hearing.

(b) If the Superior Court finds the patient described in (a) above committable, the health officer, Commissioner, State Epidemiologist or designee shall commit the patient to a hospital or private residence designated by the Commissioner, State Epidemiologist or designee.

(c) In no event shall the health officer, Commissioner, State Epidemiologist or designee commit any patient for more than 90 days from the date of the original court order for commitment without seeking further court review.

1. The health officer, Commissioner, State Epidemiologist, or designee shall seek further court review within 90 days of each subsequent court order if the patient continues to pose an immediate or imminent risk to the public health.

(d) If the patient's risk to the public subsides during the 90-day commitment period, the health officer, Commissioner, State Epidemiologist or designee may inform the court and seek an order rescinding the commitment order.

(e) If the location where commitment will be served is a private residence, law enforcement may enforce adherence to the commitment order by electronic device.

(f) The health officer, Commissioner, State Epidemiologist, or designee shall report to the Superior Court any violation of a court order for commitment.

HISTORY

HISTORY:

New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Former N.J.A.C. 8:57-5.14, Confidentiality of records, recodified to N.J.A.C. 8:57-5.17.

Chapter Notes

§ 8:57-5.15 Due process

(a) At any hearing conducted pursuant to this subchapter, a person shall have the following due process rights:

1. Written notice detailing the grounds and underlying facts of the matter;
2. The right to have counsel present at the hearing and, if indigent, the right to appointed counsel; and
3. The right to be present at a court hearing, to cross examine, and to present witnesses, which rights may be exercised through telecommunication technology.

HISTORY

HISTORY:

Recodified from N.J.A.C. 8:57-5.9 by R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Former N.J.A.C. 8:57-5.15, Mandatory exclusion from workplace or school, repealed.

Chapter Notes

§ 8:57-5.16 Annual report

The Manager of the TB Program shall submit to the Commissioner and make available to the public, through the TB Program's website at <http://nj.gov/health/cd/tbhome.htm>, an annual report describing trends in prevalence and incidence of TB in New Jersey.

HISTORY

HISTORY:

Recodified from N.J.A.C. 8:57-5.13 and amended by R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Inserted "and make available to the public, through the TB Program's website at <http://nj.gov/health/cd/tbhome.htm>", deleted "and MDR-TB" preceding "in New Jersey" and deleted the former last two sentences. Former N.J.A.C. 8:57-5.16, Penalties for violation of rules, repealed.

Chapter Notes

§ 8:57-5.17 Confidentiality of information

(a) Patient medical information or information concerning reportable events pursuant to any section of this subchapter shall not be disclosed except under the following circumstances:

1. For research purposes, provided that the study is reviewed and approved by the applicable Institutional Review Board, and is done in a manner that does not identify any person, either by name or other identifying data element;

2. With written consent of the person identified;

3. When the Commissioner, or his or her designee, determines that such disclosure is necessary to enforce public health laws or to protect the life or health of a named party, in accordance with applicable State and Federal laws; or

4. Pursuant to a valid court order.

(b) The reports and forms submitted to the Department pursuant to this subchapter contain demographic and medical information related to the Department's investigations and epidemiological studies of TB and shall not be considered "government records" subject to public access or inspection within the meaning of N.J.S.A. 47:1A-1 et seq. and shall be deemed:

1. "Information relating to medical... history, diagnosis, treatment, or evaluation" within the meaning of Executive Order No. 26, §4(b)1 (McGreevey, August 13, 2002);

2. "Records concerning morbidity, mortality, and reportable diseases of named persons required to be made, maintained or kept by any State or local governmental agency" within the meaning of Executive Order No. 9, §2(c) (Hughes, September 30, 1963); and/or

3. Information "for use in the field of forensic pathology or for use in medical or scientific education or research" pursuant to N.J.S.A. 47:1A-1.1.

HISTORY**HISTORY:**

Recodified from N.J.A.C. 8:57-5.14 and amended by R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

Section was "Confidentiality of records". Rewrote (b).

Chapter Notes

§ 8:57-5.18 Penalties for violation of rules

(a) A health care provider who fails to comply with the requirements of this subchapter shall be subject to a fine as set forth at N.J.S.A. 26:4-129 and 130 or 26:1A-10.

1. The Department may issue a written notification of this failure and a warning to comply prior to initiating any other enforcement action.

2. The Department may also report the health care provider's failure to comply with the provisions of this subchapter to the New Jersey Board of Medical Examiners, which may initiate disciplinary actions as set forth at N.J.A.C. 13:35-6.24.

(b) An administrator of a health care facility who fails to comply with the requirements of this subchapter shall be subject to a fine as set forth at N.J.S.A. 26:4-129 and 130 or 26:1A-10.

1. The Department may issue a written notification of this failure and a warning to comply prior to initiating any other enforcement action.

2. The Department may also report the health care facility's failure to comply with the provisions of this subchapter to the Department's Division of Health Care Quality and Oversight, which may initiate enforcement actions as set forth at N.J.A.C. 8:43E-3.

(c) A health officer who fails to comply with the requirements of this subchapter shall be subject to a fine as set forth at N.J.S.A. 26:4-129 and 130 or 26:1A-10.

1. The Department may issue a written notification of this failure and a warning to comply prior to initiating any other enforcement action.

2. The Department may also report the health officer's failure to comply with the provisions of this subchapter to the Department's Public Health Licensing and Examination Board, which may initiate disciplinary actions as set forth at N.J.A.C. 8:7-1.7 and N.J.S.A. 26:1A-43.

(d) A public health nurse case manager who fails to comply with the requirements of this subchapter shall be subject to a fine as set forth at N.J.S.A. 26:4-129 and 130 or 26:1A-10.

1. The Department may issue a written notification of this failure and a warning to comply prior to initiating any other enforcement action.

2. The Department may also report the public health nurse case manager's failure to comply with the provisions of this subchapter to the Board of Nursing, which may initiate disciplinary actions as set forth at N.J.S.A. 45:1-21.

HISTORY**HISTORY:**

New Rule, R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).