General Assembly **Substitute Bill No. 67**

February Session, 2016 *____SB00067PH___031716___*

AN ACT CONCERNING THE AUTHORITY AND RESPONSIBILITIES OF ADVANCED PRACTICE REGISTERED NURSES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 1-350i of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(b) An agent's authority terminates when:

(1) The principal revokes the authority;

(2) A court terminates the agent's authority pursuant to subsection (b) of section 1-350g;

(3) The agent dies or resigns;

(4) The agent becomes incapacitated. Unless the power of attorney otherwise provides, an agent shall be determined to be incapable of acting as an agent upon a determination in a writing or other record that the agent is incapacitated:

(A) Within the meaning set forth in subparagraph (A) of subdivision (5) of section 1-350a, by:

(i) A judge in a court proceeding;

(ii) Two independent physicians, two independent advanced practice registered nurses or one independent physician and one independent advanced practice registered nurse; or

(iii) A successor agent, designated in accordance with section 1-350j, if a written opinion of a physician or an advanced practice registered nurse cannot be obtained either due to the refusal of an agent to be examined by a physician or an advanced practice registered nurse or due to an agent's failure to execute an authorization to release medical information; or

(B) Within the meaning set forth in subparagraph (B) of subdivision (5) of section 1-350a, by a judge;

(5) An action is filed for the dissolution or annulment of the agent's marriage to the principal or their legal separation, unless the power of attorney otherwise provides; or

(6) The power of attorney terminates.

Sec. 2. Section 3-39j of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in this section and sections 3-39k to 3-39q, inclusive:

(1) "Achieving a better life experience account" or "ABLE account" means an account established and maintained pursuant to sections 3-39k to 3-39q, inclusive, for the purposes of paying the qualified disability expenses related to the blindness or disability of a designated beneficiary.

(2) "Contracting state" means a state without a qualified ABLE program that has entered into a contract with the State Treasurer or other officer of this state to provide residents of the contracting state with access to qualified ABLE programs.

(3) "Deposit" means a deposit, payment, contribution, gift or other transfer of funds.

(4) "Depositor" means any person making a deposit into an ABLE account pursuant to a participation agreement.

(5) "Designated beneficiary" means any individual state resident or resident of a contracting state originally designated in the participation agreement who is an eligible individual and is the owner of an ABLE account.

(6) "Disability certification" means, with respect to an individual, a certification to the satisfaction of the Secretary of the Treasury of the United States by the individual or the parent or guardian of the individual that (A) certifies that (i) the individual has a medically determinable physical or mental impairment, that results in marked and severe functional limitations, and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months, or is blind within the meaning of Section 1614(a)(2) of the Social Security Act, and (ii) such impairment or blindness occurred before the date on which the individual attained the age of twenty-six, and (B) includes a copy of the individual's diagnosis relating to the individual's relevant impairment or blindness that is signed by a physician who is licensed pursuant to chapter 370 or an advanced practice registered nurse who is licensed pursuant to chapter 378.

(7) "Eligible individual" means an individual who is entitled to benefits during a taxable year based on blindness or disability under Title II or XVI of the Social Security Act, and such blindness or disability occurred before the date on which the individual attained the age of twenty-six, provided a disability certification with respect to such individual is filed with the State Treasurer for such taxable year.

(8) "Federal ABLE Act" means the federal ABLE Act of 2014, P.L. 113-295, as amended from time to time.

(9) "Participation agreement" means an agreement between the trust established pursuant to section 3-39k and depositors that provides for participation in an ABLE account for the benefit of a designated beneficiary.

(10) "Qualified disability expenses" means any expenses related to an eligible individual's blindness or disability that are made for the benefit of an eligible individual who is the designated beneficiary, including the following expenses: Education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses that are approved by the Secretary of the Treasury of the United States under regulations adopted by the Secretary pursuant to the federal ABLE Act.

Sec. 3. Subsection (b) of section 3-123aa of the general statutes is repealed and the following are substituted in lieu thereof (*Effective October 1, 2016*):

(b) There is established the Connecticut Homecare Option Program for the Elderly, to allow individuals to plan for the cost of services that will allow them to remain in their homes or in a noninstitutional setting as they age. The Comptroller shall establish the Connecticut Home Care Trust Fund, which shall be comprised of individual savings accounts for those qualified home care expenses not covered by a long-term care insurance policy and for those qualified home care expenses that supplement the coverage provided by a long-term care policy or Medicare. Withdrawals from the fund may be used for qualified home care expenses, upon receipt by the fund of a **[**physician's**]** certification signed by a licensed physician or a licensed advanced practice registered nurse that the designated beneficiary is in need of services for the instrumental activities of daily living. Upon the death of a designated beneficiary, any available funds in such beneficiary's account shall be an asset of the estate of such beneficiary.

Sec. 4. Subsections (c) and (d) of section 5-248a of the 2016 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) Any permanent employee who requests a medical leave of absence due to the employee's serious illness or a family leave of absence due to the serious illness of a child, spouse or parent pursuant to subsection (a) of this section or a military caregiver leave of absence pursuant to subsection (g) of this section shall be required by the employee's appointing authority, prior to the inception of such leave, to provide sufficient written certification from the physician or advanced practice registered nurse of such employee, child, spouse, parent or next of kin of the employee, as appropriate, of the nature of such illness and its probable duration. For the purposes of this section, "serious illness" means an illness, injury, impairment or physical or mental condition that involves (1) inpatient care in a hospital, hospice or residential care facility, or (2) continuing treatment or continuing supervision by a health care provider.

(d) Any permanent employee who requests a medical leave of absence in order to serve as an organ or bone marrow donor pursuant to subsection (a) of this section shall be required by the employee's appointing authority, prior to the inception of such leave, to provide sufficient written certification from the physician or advanced practice registered nurse of such employee of the proposed organ or bone marrow donation and the probable duration of the employee's recovery period from such donation.

Sec. 5. Subdivision (16) of section 10-183b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(16) "Formal application of retirement" means the member's application, birth certificate or notarized statement supported by other evidence satisfactory to the board, in lieu thereof, records of service when required by the board to determine a salary rate or years of

creditable service, statement of payment plan and, in the case of an application for a disability benefit, a physician's or an advanced practice registered nurse's statement of health.

Sec. 6. Subsections (e) and (f) of section 10-212a of the 2016 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) (1) With the written authorization of a student's parent or guardian, and (2) pursuant to a written order of the student's physician licensed under chapter 370 or the student's advanced practice registered nurse licensed under chapter 378, a school nurse or a school principal shall select, and a school nurse shall provide general supervision to, a qualified school employee to administer medication with injectable equipment used to administer glucagon to a student with diabetes that may require prompt treatment in order to protect the student against serious harm or death. Such authorization shall be limited to situations when the school nurse is absent or unavailable. No qualified school employee shall administer medication under this subsection unless (A) such qualified school employee annually completes any training required by the school nurse and school medical advisor, if any, in the administration of medication with injectable equipment used to administer glucagon, (B) the school nurse and school medical advisor, if any, have attested, in writing, that such qualified school employee has completed such training, and (C) such qualified school employee voluntarily agrees to serve as a qualified school employee. For purposes of this subsection, "injectable equipment used to administer glucagon" means an injector or injectable equipment used to deliver glucagon in an appropriate dose for emergency first aid response to diabetes. For purposes of this subsection, "qualified school employee" means a principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by a school district, coach or school paraprofessional.

(f) (1) (A) With the written authorization of a student's parent or guardian, and (B) pursuant to the written order of a physician licensed

under chapter 370 or an advanced practice registered nurse licensed under chapter 378, a school nurse and a school medical advisor, if any, shall select, and a school nurse shall provide general supervision to, a qualified school employee to administer antiepileptic medication, including by rectal syringe, to a specific student with a medically diagnosed epileptic condition that requires prompt treatment in accordance with the student's individual seizure action plan. Such authorization shall be limited to situations when the school nurse is absent or unavailable. No qualified school employee shall administer medication under this subsection unless (i) such qualified school employee annually completes the training program described in subdivision (2) of this subsection, (ii) the school nurse and school medical advisor, if any, have attested, in writing, that such qualified school employee has completed such training, (iii) such qualified school employee receives monthly reviews by the school nurse to confirm such qualified school employee's competency to administer antiepileptic medication under this subsection, and (iv) such qualified school employee voluntarily agrees to serve as a qualified school employee. For purposes of this subsection, "qualified school employee" means a principal, teacher, licensed athletic trainer, licensed physical or occupational therapist employed by a school district, coach or school paraprofessional.

(2) The Department of Education, in consultation with the School Nurse Advisory Council, established pursuant to section 10-212f, and the Association of School Nurses of Connecticut, shall develop an antiepileptic medication administrating training program. Such training program shall include instruction in (A) an overview of childhood epilepsy and types of seizure disorders, (B) interpretation of individual student's emergency seizure action plan and recognition of individual student's seizure activity, (C) emergency management procedures for seizure activity, including administration techniques for emergency seizure medication, (D) when to activate emergency medical services and postseizure procedures and follow-up, (E) reporting procedures after a student has required such delegated

emergency seizure medication, and (F) any other relevant issues or topics related to emergency interventions for students who experience seizures.

Sec. 7. Section 10-220j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) No local or regional board of education may prohibit blood glucose self-testing by children with diabetes who have a written order from a physician or an advanced practice registered nurse stating the need and the capability of such child to conduct self-testing. No local or regional board of education may restrict the time and location of blood glucose self-testing by a child with diabetes on school grounds who has written authorization from a parent or guardian and a written order from a physician or an advanced practice registered nurse stating that such child is capable of conducting self-testing on school grounds.

(b) The Commissioner of Education, in consultation with the Commissioner of Public Health, shall develop guidelines for policies and practices with respect to blood glucose self-testing by children pursuant to subsection (a) of this section. Such guidelines shall not be construed as regulations within the scope of chapter 54.

Sec. 8. Section 10-305 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Each physician, advanced practice registered nurse and optometrist shall report in writing to the Department of Rehabilitation Services within thirty days each blind person coming under his or her private or institutional care within this state. The report of such blind person shall include the name, address, Social Security number, date of birth, date of diagnosis of blindness and degree of vision. Such reports shall not be open to public inspection.

Sec. 9. Subsection (b) of section 14-44 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective October 1, 2016*):

(b) No operator's license bearing a public passenger endorsement shall be issued or renewed in accordance with the provisions of this section or section 14-36a, until the Commissioner of Motor Vehicles, or the commissioner's authorized representative, is satisfied that the applicant is a proper person to receive such an operator's license bearing an endorsement, holds a valid motor vehicle operator's license, or, if necessary for the class of vehicle operated, a commercial driver's license and is at least eighteen years of age. Each applicant for an operator's license bearing a public passenger endorsement or the renewal of such a license shall furnish the Commissioner of Motor Vehicles, or the commissioner's authorized representative, with satisfactory evidence, under oath, to prove that such person has no criminal record and has not been convicted of a violation of subsection (a) of section 14-227a within five years of the date of application and that no reason exists for a refusal to grant or renew such an operator's license bearing a public passenger endorsement. Each applicant for such an operator's license bearing a public passenger endorsement shall submit with the application proof satisfactory to the Commissioner of Motor Vehicles that such applicant has passed a physical examination administered not more than ninety days prior to the date of application, and which is in compliance with safety regulations established from time to time by the United States Department of Transportation. Each applicant for renewal of such license shall present evidence that such applicant is in compliance with the medical qualifications established in 49 CFR 391, as amended, provided an applicant for a Class D operator's license bearing an endorsement described in subsection (c) of section 14-36a, shall be deemed medically qualified if such applicant (1) controls with medication, as certified by a licensed physician <u>or a licensed advanced practice registered nurse</u>, a medical condition that would otherwise deem such applicant not medically qualified, and (2) would qualify for a waiver or exemption under 49 CFR 391, as amended. Each applicant for such an operator's license bearing a public passenger endorsement

shall be fingerprinted before the license bearing a public passenger endorsement is issued.

Sec. 10. Subsection (b) of section 14-73 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(b) Application for an instructor's license shall be in writing and shall contain such information as the commissioner requires. Each applicant for a license shall be fingerprinted and shall furnish evidence satisfactory to the commissioner that such applicant (1) is of good moral character considering such person's state and national criminal history records checks conducted in accordance with section 29-17a, and record, if any, on the state child abuse and neglect registry established pursuant to section 17a-101k. If any applicant for a license or the renewal of a license has a criminal record or is listed on the state child abuse and neglect registry, the commissioner shall make a determination of whether to issue or renew an instructor's license in accordance with the standards and procedures set forth in section 14-44, as amended by this act, and the regulations adopted pursuant to said section; (2) has held a license to drive a motor vehicle for the past four consecutive years and has a driving record satisfactory to the commissioner, including no record of a conviction or administrative license suspension for a drug or alcohol-related offense during such four-year period; (3) has had a recent medical examination by a physician or an advanced practice registered nurse licensed to practice within the state and the physician or advanced practice registered nurse certifies that the applicant is physically fit to operate a motor vehicle and instruct in driving; (4) has received a high school diploma or has an equivalent academic education; and (5) has completed an instructor training course of forty-five clock hours given by a school or agency approved by the commissioner, except that any such course given by an institution under the jurisdiction of the board of trustees of the Connecticut State University System shall be approved by the commissioner and the State Board of Education. During the period of

licensure, an instructor shall notify the commissioner, within forty-eight hours, of an arrest or conviction for a misdemeanor or felony, or an arrest, conviction or administrative license suspension for a drug or alcohol-related offense.

Sec. 11. Subdivision (2) of subsection (c) of section 14-100a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(2) The provisions of subdivision (1) of this subsection shall not apply to (A) any person whose physical disability or impairment would prevent restraint in such safety belt, provided such person obtains a written statement from a licensed physician or a licensed advanced practice registered nurse containing reasons for such person's inability to wear such safety belt and including information concerning the nature and extent of such condition. Such person shall carry the statement on his or her person or in the motor vehicle at all times when it is being operated, or (B) an authorized emergency vehicle, other than fire fighting apparatus, responding to an emergency call or a motor vehicle operated by a rural letter carrier of the United States postal service while performing his or her official duties or by a person engaged in the delivery of newspapers.

Sec. 12. Subsection (c) of section 14-286 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) (1) Notwithstanding the provisions of subsection (b) of this section, the Commissioner of Motor Vehicles may issue to a person who does not hold a valid operator's license a special permit that authorizes such person to ride a motor-driven cycle if (A) such person presents to the commissioner a certificate by a physician licensed to practice medicine in this state or an advanced practice registered nurse licensed pursuant to chapter 378 that such person is physically disabled, as defined in section 1-1f, other than blind, and that, in the physician's or advanced practice registered nurse's opinion, such

person is capable of riding a motor-driven cycle, and (B) such person demonstrates to the Commissioner of Motor Vehicles that he is able to ride a bicycle on level terrain, and a motor-driven cycle. (2) Such permit may contain limitations that the commissioner deems advisable for the safety of such person and for the public safety, including, but not limited to, the maximum speed of the motor such person may use. No person who holds a valid special permit under this subsection shall operate a motor-driven cycle in violation of any limitations imposed in the permit. Any person to whom a special permit is issued shall carry the permit at all times while operating the motor-driven cycle. Each permit issued under this subsection shall expire one year from the date of issuance.

Sec. 13. Section 14-314c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) The Office of the State Traffic Administration, on any state highway, or a local traffic authority, on any highway under its control, shall, upon receipt of an application on behalf of any person under the age of eighteen who is deaf, as certified by a physician or an advanced practice registered nurse, erect one or more signs in the person's neighborhood to warn motor vehicle operators of the presence of the deaf person.

(b) The Office of the State Traffic Administration may adopt regulations in accordance with the provisions of chapter 54 to carry out the purposes of this section.

Sec. 14. Subsection (f) of section 17b-261p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(f) (1) A nursing home, on behalf of an applicant, may request an extension of time to claim undue hardship pursuant to subsections (b) and (e) of this section if (A) the applicant is receiving long-term care services in such nursing home, (B) the applicant has no legal

representative, and (C) the nursing home provides certification from a physician or an advanced practice registered nurse that the applicant is incapable of caring for himself or herself, as defined in section 45a-644, or incapable of managing his or her affairs, as defined in section 45a-644. The commissioner shall grant such request to allow a legal representative to be appointed to act on behalf of the applicant.

(2) The commissioner shall accept any claim filed pursuant to subsection (b) of this section by a nursing home and allow the nursing home to represent the applicant with regard to such claim if the applicant or the legal representative of the applicant gives permission to the nursing home to file a claim pursuant to subsection (b) of this section.

Sec. 15. Section 18-94 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

When the medical officer of, or any physician or advanced practice registered nurse employed in, any correctional or charitable institution reports in writing to the warden, superintendent or other officer in charge of such institution that any inmate thereof committed thereto by any court or supported therein in whole or in part at public expense is afflicted with any venereal disease so that his discharge from such institution would be dangerous to the public health, such inmate shall, with the approval of such warden, superintendent or other officer in charge, be detained in such institution until such medical officer**, [**or**]** physician or advanced practice registered nurse reports in writing to the warden, superintendent or officer in charge of such institution that such inmate may be discharged therefrom without danger to the public health. During detention the person so detained shall be supported in the same manner as before such detention.

Sec. 16. Subsection (h) of section 19a-12e of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(h) As part of an investigation of a petition filed pursuant to this section, the department may order the health care professional to submit to a physical or mental examination to be performed by a physician or an advanced practice registered nurse chosen from a list approved by the department. The department may seek the advice of established medical organizations or licensed health professionals in determining the nature and scope of any diagnostic examinations to be used as part of any such physical or mental examination. The chosen physician or advanced practice registered nurse shall make a written statement of his or her findings.

Sec. 17. Section 19a-262 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Each physician and advanced practice registered nurse shall report in writing the name, age, sex, race, ethnicity, occupation, place where last employed, if known, and address of each person under his or her care known or suspected by such physician or advanced practice registered nurse to have tuberculosis, to the Department of Public Health and the director of health of the town, city or borough in which such person resides, within twenty-four hours after the physician or advanced practice registered nurse knows or suspects the presence of such disease, and the officer in charge of any hospital, dispensary, asylum or other similar institution shall report in like manner concerning each patient having tuberculosis who comes under the care or observation of such officer, within twenty-four hours thereafter. The Commissioner of Public Health and the director of health of each town, city or borough shall keep a record of all such reports received by them, but such records shall not be open to inspection by any person other than the health authorities of the state and of such town, city or borough, and the identity of the person to whom any such report relates shall not be divulged by such health authorities except as may be necessary to carry into effect the provisions of this section, section 19a-263, and section 19a-264. For purposes of this section and said sections a person may be suspected of having tuberculosis if he or

she has (1) an acid fast bacilli identified on a smear of his body fluids or tissue, (2) been prescribed at least two antituberculosis drugs, (3) a preliminary diagnosis which includes ruling out active tuberculosis, or (4) signs or symptoms of active tuberculosis.

Sec. 18. Section 19a-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) For the purposes of this section: (1) "Facility" means an entity certified as a nursing facility under the Medicaid program or an entity certified as a skilled nursing facility under the Medicare program or with respect to facilities that do not participate in the Medicaid or Medicare programs, a chronic and convalescent nursing home or a rest home with nursing supervision as defined in section 19a-521; (2) "continuing care facility which guarantees life care for its residents" has the same meaning as provided in section 17b-354; (3) "transfer" means the movement of a resident from one facility to another facility or institution, including, but not limited to, a hospital emergency department, if the resident is admitted to the facility or institution or is under the care of the facility or institution for more than twenty-four hours; (4) "discharge" means the movement of a resident from a facility to a noninstitutional setting; (5) "self-pay resident" means a resident who is not receiving state or municipal assistance to pay for the cost of care at a facility, but shall not include a resident who has filed an application with the Department of Social Services for Medicaid coverage for facility care but has not received an eligibility determination from the department on such application, provided the resident has timely responded to requests by the department for information that is necessary to make such determination; and (6) "emergency" means a situation in which a failure to effect an immediate transfer or discharge of the resident that would endanger the health, safety or welfare of the resident or other residents.

(b) A facility shall not transfer or discharge a resident from the facility except to meet the welfare of the resident which cannot be met in the facility, or unless the resident no longer needs the services of the

facility due to improved health, the facility is required to transfer the resident pursuant to section 17b-359 or **[**section**]** 17b-360, or the health or safety of individuals in the facility is endangered, or in the case of a self-pay resident, for the resident's nonpayment or arrearage of more than fifteen days of the per diem facility room rate, or the facility ceases to operate. In each case the basis for transfer or discharge shall be documented in the resident's medical record by a physician or an advanced practice registered nurse. In each case where the welfare, health or safety of the resident is concerned the documentation shall be by the resident's physician or the resident's advanced practice registered nurse. A facility **[**which**]** that is part of a continuing care facility which guarantees life care for its residents may transfer or discharge (1) a self-pay resident who is a member of the continuing care community and who has intentionally transferred assets in a sum **[**which**]** that will render the resident unable to pay the costs of facility care in accordance with the contract between the resident and the facility, or (2) a self-pay resident who is not a member of the continuing care community and who has intentionally transferred assets in a sum **[**which**]** that will render the resident unable to pay the costs of a total of forty-two months of facility care from the date of initial admission to the facility.

(c) (1) Before effecting any transfer or discharge of a resident from the facility, the facility shall notify, in writing, the resident and the resident's guardian or conservator, if any, or legally liable relative or other responsible party if known, of the proposed transfer or discharge, the reasons therefor, the effective date of the proposed transfer or discharge, the location to which the resident is to be transferred or discharged, the right to appeal the proposed transfer or discharge and the procedures for initiating such an appeal as determined by the Department of Social Services, the date by which an appeal must be initiated in order to preserve the resident's right to an appeal hearing and the date by which an appeal must be initiated in order to stay the proposed transfer or discharge and the possibility of an exception to the date by which an appeal must be initiated in order

to stay the proposed transfer or discharge for good cause, that the resident may represent himself or herself or be represented by legal counsel, a relative, a friend or other spokesperson, and information as to bed hold and nursing home readmission policy when required in accordance with section 19a-537. The notice shall also include the name, mailing address and telephone number of the State Long-Term Care Ombudsman. If the resident is, or the facility alleges a resident is, mentally ill or developmentally disabled, the notice shall include the name, mailing address and telephone number of the Office of Protection and Advocacy for Persons with Disabilities. The notice shall be given at least thirty days and no more than sixty days prior to the resident's proposed transfer or discharge, except where the health or safety of individuals in the facility are endangered, or where the resident's health improves sufficiently to allow a more immediate transfer or discharge, or where immediate transfer or discharge is necessitated by urgent medical needs or where a resident has not resided in the facility for thirty days, in which cases notice shall be given as many days before the transfer or discharge as practicable.

(2) The resident may initiate an appeal pursuant to this section by submitting a written request to the Commissioner of Social Services not later than sixty calendar days after the facility issues the notice of the proposed transfer or discharge, except as provided in subsection (h) of this section. In order to stay a proposed transfer or discharge, the resident must initiate an appeal not later than twenty days after the date the resident receives the notice of the proposed transfer or discharge from the facility unless the resident demonstrates good cause for failing to initiate such appeal within the twenty-day period.

(d) No resident shall be transferred or discharged from any facility as a result of a change in the resident's status from self-pay or Medicare to Medicaid provided the facility offers services to both categories of residents. Any such resident who wishes to be transferred to another facility **[**which**]** that has agreed to accept the resident may do so upon giving at least fifteen days written notice to the

administrator of the facility from which the resident is to be transferred and a copy thereof to the appropriate advocate of such resident. The resident's advocate may help the resident complete all administrative procedures relating to a transfer.

(e) Except in an emergency or in the case of transfer to a hospital, no resident shall be transferred or discharged from a facility unless a discharge plan has been developed by the personal physician or advanced practice registered nurse of the resident or the medical director in conjunction with the nursing director, social worker or other health care provider. To minimize the disruptive effects of the transfer or discharge on the resident, the person responsible for developing the plan shall consider the feasibility of placement near the resident's relatives, the acceptability of the placement to the resident and the resident's guardian or conservator, if any, or the resident's legally liable relative or other responsible party, if known, and any other relevant factors **[**which**]** that affect the resident's adjustment to the move. The plan shall contain a written evaluation of the effects of the transfer or discharge on the resident and a statement of the action taken to minimize such effects. In addition, the plan shall outline the care and kinds of services **[**which**]** that the resident shall receive upon transfer or discharge. Not less than thirty days prior to an involuntary transfer or discharge, a copy of the discharge plan shall be provided to the resident's personal physician or advanced practice registered nurse if the discharge plan was prepared by the medical director, to the resident and the resident's guardian or conservator, if any, or legally liable relative or other responsible party, if known.

(f) No resident shall be involuntarily transferred or discharged from a facility if such transfer or discharge is medically contraindicated.

(g) The facility shall be responsible for assisting the resident in finding appropriate placement.

(h) (1) Except in the case of an emergency, as provided in subdivision (4) of this subsection, upon receipt of a request for a

hearing to appeal any proposed transfer or discharge, the Commissioner of Social Services or the commissioner's designee shall hold a hearing to determine whether the transfer or discharge is being effected in accordance with this section. A hearing shall be convened not less than ten, but not more than thirty days from the date of receipt of such request and a written decision made by the commissioner or the commissioner's designee not later than thirty days after the date of termination of the hearing or not later than sixty days after the date of the hearing request, whichever occurs sooner. The hearing shall be conducted in accordance with chapter 54. In each case the facility shall prove by a preponderance of the evidence that it has complied with the provisions of this section. Except in the case of an emergency or in circumstances when the resident is not physically present in the facility, whenever the Commissioner of Social Services receives a request for a hearing in response to a notice of proposed transfer or discharge and such notice does not meet the requirements of subsection (c) of this section, the commissioner shall, not later than ten business days after the date of receipt of such notice from the resident or the facility, order the transfer or discharge stayed and return such notice to the facility. Upon receipt of such returned notice, the facility shall issue a revised notice that meets the requirements of subsection (c) of this section.

(2) The resident, the resident's guardian, conservator, legally liable relative or other responsible party shall have an opportunity to examine, during regular business hours at least three business days prior to a hearing conducted pursuant to this section, the contents of the resident's file maintained by the facility and all documents and records to be used by the commissioner or the commissioner's designee or the facility at the hearing. The facility shall have an opportunity to examine during regular business hours at least three business days prior to such a hearing, all documents and records to be used by the resident at the hearing.

(3) If a hearing conducted pursuant to this section involves medical

issues, the commissioner or the commissioner's designee may order an independent medical assessment of the resident at the expense of the Department of Social Services **[**which**]** that shall be made part of the hearing record.

(4) In an emergency the notice required pursuant to subsection (c) of this section shall be provided as soon as practicable. A resident who is transferred or discharged on an emergency basis or a resident who receives notice of such a transfer or discharge may contest the action by requesting a hearing in writing not later than twenty days after the date of receipt of notice or not later than twenty days after the date of transfer or discharge, whichever is later, unless the resident demonstrates good cause for failing to request a hearing within the twenty-day period. A hearing shall be held in accordance with the requirements of this subsection not later than fifteen business days after the date of receipt of the request. The commissioner, or the commissioner's designee, shall issue a decision not later than thirty days after the date on which the hearing record is closed.

(5) Except in the case of a transfer or discharge effected pursuant to subdivision (4) of this subsection, (A) an involuntary transfer or discharge shall be stayed pending a decision by the commissioner or the commissioner's designee, and (B) if the commissioner or the commissioner's designee determines the transfer or discharge is being effected in accordance with this section, the facility may not transfer or discharge the resident prior to fifteen days from the date of receipt of the decision by the resident and the resident's guardian or conservator, if any, or the resident's legally liable relative or other responsible party if known.

(6) If the commissioner, or the commissioner's designee, determines after a hearing held in accordance with this section that the facility has transferred or discharged a resident in violation of this section, the commissioner, or the commissioner's designee, may require the facility to readmit the resident to a bed in a semiprivate room or in a private room, if a private room is medically necessary, regardless of whether

or not the resident has accepted placement in another facility pending the issuance of a hearing decision or is awaiting the availability of a bed in the facility from which the resident was transferred or discharged.

(7) A copy of a decision of the commissioner or the commissioner's designee shall be sent to the facility and to the resident, the resident's guardian, conservator, if any, legally liable relative or other responsible party, if known. The decision shall be deemed to have been received not later than five days after the date it was mailed, unless the facility, the resident or the resident's guardian, conservator, legally liable relative or other responsible party proves otherwise by a preponderance of the evidence. The Superior Court shall consider an appeal from a decision of the Department of Social Services pursuant to this section as a privileged case in order to dispose of the case with the least possible delay.

(i) A resident who receives notice from the Department of Social Services or its agent that the resident is no longer in need of the level of care provided by a facility and that, consequently, the resident's coverage for facility care will end, may request a hearing by the Commissioner of Social Services in accordance with the provisions of section 17b-60. If the resident requests a hearing prior to the date that Medicaid coverage for facility care is to end, Medicaid coverage shall continue pending the outcome of the hearing. If the resident receives a notice of denial of Medicaid coverage from the department or its agent and also receives a notice of discharge from the facility pursuant to subsection (c) of this section and the resident requests a hearing to contest each proposed action, the department may schedule one hearing at which the resident may contest both actions.

Sec. 19. Section 19a-550 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) (1) As used in this section, (A) "nursing home facility" has the

same meaning as provided in section 19a-521, (B) "residential care home" has the same meaning as provided in section 19a-521, and (C) "chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases; and (2) for the purposes of subsections (c) and (d) of this section, and subsection (b) of section 19a-537, "medically contraindicated" means a comprehensive evaluation of the impact of a potential room transfer on the patient's physical, mental and psychosocial well-being, which determines that the transfer would cause new symptoms or exacerbate present symptoms beyond a reasonable adjustment period resulting in a prolonged or significant negative outcome that could not be ameliorated through care plan intervention, as documented by a physician or an advanced practice registered nurse in a patient's medical record.

(b) There is established a patients' bill of rights for any person admitted as a patient to any nursing home facility, residential care home or chronic disease hospital. The patients' bill of rights shall be implemented in accordance with the provisions of Sections 1919(b), 1919(c), 1919(c)(2), 1919(c)(2)(D) and 1919(c)(2)(E) of the Social Security Act. The patients' bill of rights shall provide that each such patient: (1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during the patient's stay, of the rights set forth in this section and of all rules and regulations governing patient conduct and responsibilities; (2) is fully informed, prior to or at the time of admission and during the patient's stay, of services available in such facility or chronic disease hospital, and of related charges including any charges for services not covered under Titles XVIII or XIX of the Social Security Act, or not covered by basic per diem rate; (3) in such facility or hospital is entitled to choose the patient's own physician or advanced practice registered nurse and is fully informed, by a physician or an advanced practice registered nurse, of the patient's medical condition unless medically contraindicated, as documented by the physician or advanced practice registered nurse in the patient's medical record, and is afforded the

opportunity to participate in the planning of the patient's medical treatment and to refuse to participate in experimental research; (4) in a residential care home or a chronic disease hospital is transferred from one room to another within such home or chronic disease hospital only for medical reasons, or for the patient's welfare or that of other patients, as documented in the patient's medical record and such record shall include documentation of action taken to minimize any disruptive effects of such transfer, except a patient who is a Medicaid recipient may be transferred from a private room to a nonprivate room, provided no patient may be involuntarily transferred from one room to another within such home or chronic disease hospital if (A) it is medically established that the move will subject the patient to a reasonable likelihood of serious physical injury or harm, or (B) the patient has a prior established medical history of psychiatric problems and there is psychiatric testimony that as a consequence of the proposed move there will be exacerbation of the psychiatric problem that would last over a significant period of time and require psychiatric intervention; and in the case of an involuntary transfer from one room to another within such home or chronic disease hospital, the patient and, if known, the patient's legally liable relative, guardian or conservator or a person designated by the patient in accordance with section 1-56r, is given not less than thirty days' and not more than sixty days' written notice to ensure orderly transfer from one room to another within such home or chronic disease hospital, except where the health, safety or welfare of other patients is endangered or where immediate transfer from one room to another within such home or chronic disease hospital is necessitated by urgent medical need of the patient or where a patient has resided in such home or chronic disease hospital for less than thirty days, in which case notice shall be given as many days before the transfer as practicable; (5) is encouraged and assisted, throughout the patient's period of stay, to exercise the patient's rights as a patient and as a citizen, and to this end, has the right to be fully informed about patients' rights by state or federally funded patient advocacy programs, and may voice grievances and recommend changes in

policies and services to nursing home facility, residential care home or chronic disease hospital staff or to outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal; (6) shall have prompt efforts made by such nursing home facility, residential care home or chronic disease hospital to resolve grievances the patient may have, including those with respect to the behavior of other patients; (7) may manage the patient's personal financial affairs, and is given a quarterly accounting of financial transactions made on the patient's behalf; (8) is free from mental and physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the patient's medical symptoms. Physical or chemical restraints may be imposed only to ensure the physical safety of the patient or other patients and only upon the written order of a physician or an advanced practice registered nurse that specifies the type of restraint and the duration and circumstances under which the restraints are to be used, except in emergencies until a specific order can be obtained; (9) is assured confidential treatment of the patient's personal and medical records, and may approve or refuse their release to any individual outside the facility, except in case of the patient's transfer to another health care institution or as required by law or third-party payment contract; (10) receives quality care and services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual would be endangered, and is treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and in care for the patient's personal needs; (11) is not required to perform services for the nursing home facility, residential care home or chronic disease hospital that are not included for therapeutic purposes in the patient's plan of care; (12) may associate and communicate privately with persons of the patient's choice, including other patients, send and receive the patient's personal mail unopened and make and receive telephone calls privately, unless medically contraindicated, as documented by the

patient's physician or advanced practice registered nurse in the patient's medical record, and receives adequate notice before the patient's room or roommate in such facility, home or chronic disease hospital is changed; (13) is entitled to organize and participate in patient groups in such facility, home or chronic disease hospital and to participate in social, religious and community activities that do not interfere with the rights of other patients, unless medically contraindicated, as documented by the patient's physician or advanced practice registered nurse in the patient's medical records; (14) may retain and use the patient's personal clothing and possessions unless to do so would infringe upon rights of other patients or unless medically contraindicated, as documented by the patient's physician or advanced practice registered nurse in the patient's medical record; (15) is assured privacy for visits by the patient's spouse or a person designated by the patient in accordance with section 1-56r and, if the patient is married and both the patient and the patient's spouse are inpatients in the facility, they are permitted to share a room, unless medically contraindicated, as documented by the attending physician or advanced practice registered nurse in the medical record; (16) is fully informed of the availability of and may examine all current state, local and federal inspection reports and plans of correction; (17) may organize, maintain and participate in a patient-run resident council, as a means of fostering communication among residents and between residents and staff, encouraging resident independence and addressing the basic rights of nursing home facility, residential care home and chronic disease hospital patients and residents, free from administrative interference or reprisal; (18) is entitled to the opinion of two physicians concerning the need for surgery, except in an emergency situation, prior to such surgery being performed; (19) is entitled to have the patient's family or a person designated by the patient in accordance with section 1-56r meet in such facility, residential care home or chronic disease hospital with the families of other patients in the facility to the extent such facility, residential care home or chronic disease hospital has existing meeting space available that meets applicable building and fire codes; (20) is entitled to file a

complaint with the Department of Social Services and the Department of Public Health regarding patient abuse, neglect or misappropriation of patient property; (21) is entitled to have psychopharmacologic drugs administered only on orders of a physician or an advanced practice registered nurse and only as part of a written plan of care developed in accordance with Section 1919(b)(2) of the Social Security Act and designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent external consultant reviews the appropriateness of the drug plan; (22) is entitled to be transferred or discharged from the facility only pursuant to section 19a-535, as amended by this act, 19a-535a or 19a-535b, as applicable; (23) is entitled to be treated equally with other patients with regard to transfer, discharge and the provision of all services regardless of the source of payment; (24) shall not be required to waive any rights to benefits under Medicare or Medicaid or to give oral or written assurance that the patient is not eligible for, or will not apply for benefits under Medicare or Medicaid; (25) is entitled to be provided information by the nursing home facility or chronic disease hospital as to how to apply for Medicare or Medicaid benefits and how to receive refunds for previous payments covered by such benefits; (26) is entitled to receive a copy of any Medicare or Medicaid application completed by a nursing home facility, residential care home or chronic disease hospital on behalf of the patient or to designate that a family member, or other representative of the patient, receive a copy of any such application; (27) on or after October 1, 1990, shall not be required to give a third-party guarantee of payment to the facility as a condition of admission to, or continued stay in, such facility; (28) is entitled to have such facility not charge, solicit, accept or receive any gift, money, donation, third-party guarantee or other consideration as a precondition of admission or expediting the admission of the individual to such facility or as a requirement for the individual's continued stay in such facility; and (29) shall not be required to deposit the patient's personal funds in such facility, home or chronic disease hospital.

(c) The patients' bill of rights shall provide that a patient in a rest home with nursing supervision or a chronic and convalescent nursing home may be transferred from one room to another within such home only for the purpose of promoting the patient's well-being, except as provided pursuant to subparagraph (C) or (D) of this subsection or subsection (d) of this section. Whenever a patient is to be transferred, such home shall effect the transfer with the least disruption to the patient and shall assess, monitor and adjust care as needed subsequent to the transfer in accordance with subdivision (10) of subsection (b) of this section. When a transfer is initiated by such home and the patient does not consent to the transfer, such home shall establish a consultative process that includes the participation of the attending physician or advanced practice registered nurse, a registered nurse with responsibility for the patient and other appropriate staff in disciplines as determined by the patient's needs, and the participation of the patient, the patient's family, a person designated by the patient in accordance with section 1-56r or other representative. The consultative process shall determine: (1) What caused consideration of the transfer; (2) whether the cause can be removed; and (3) if not, whether such home has attempted alternatives to transfer. The patient shall be informed of the risks and benefits of the transfer and of any alternatives. If subsequent to the completion of the consultative process a patient still does not wish to be transferred, the patient may be transferred without the patient's consent, unless medically contraindicated, only (A) if necessary to accomplish physical plant repairs or renovations that otherwise could not be accomplished; provided, if practicable, the patient, if the patient wishes, shall be returned to the patient's room when the repairs or renovations are completed; (B) due to irreconcilable incompatibility between or among roommates, which is actually or potentially harmful to the well-being of a patient; (C) if such home has two vacancies available for patients of the same sex in different rooms, there is no applicant of that sex pending admission in accordance with the requirements of section 19a-533 and grouping of patients by the same sex in the same room would allow admission of patients of the opposite sex, that otherwise would

not be possible; (D) if necessary to allow access to specialized medical equipment no longer needed by the patient and needed by another patient; or (E) if the patient no longer needs the specialized services or programming that is the focus of the area of such home in which the patient is located. In the case of an involuntary transfer, such home shall, subsequent to completion of the consultative process, provide the patient and the patient's legally liable relative, guardian or conservator if any or other responsible party if known, with at least fifteen days' written notice of the transfer, which shall include the reason for the transfer, the location to which the patient is being transferred, and the name, address and telephone number of the regional long-term care ombudsman, except that in the case of a transfer pursuant to subparagraph (A) of this subsection at least thirty days' notice shall be provided. Notwithstanding the provisions of this subsection, a patient may be involuntarily transferred immediately from one room to another within such home to protect the patient or others from physical harm, to control the spread of an infectious disease, to respond to a physical plant or environmental emergency that threatens the patient's health or safety or to respond to a situation that presents a patient with an immediate danger of death or serious physical harm. In such a case, disruption of patients shall be minimized; the required notice shall be provided not later than twenty-four hours after the transfer; if practicable, the patient, if the patient wishes, shall be returned to the patient's room when the threat to health or safety that prompted the transfer has been eliminated; and, in the case of a transfer effected to protect a patient or others from physical harm, the consultative process shall be established on the next business day.

(d) Notwithstanding the provisions of subsection (c) of this section, unless medically contraindicated, a patient who is a Medicaid recipient may be transferred from a private to a nonprivate room. In the case of such a transfer, the nursing home facility shall (1) give not less than thirty days' written notice to the patient and the patient's legally liable relative, guardian or conservator, if any, a person designated by the

patient in accordance with section 1-56r or other responsible party, if known, which notice shall include the reason for the transfer, the location to which the patient is being transferred and the name, address and telephone number of the regional long-term care ombudsman; and (2) establish a consultative process to effect the transfer with the least disruption to the patient and assess, monitor and adjust care as needed subsequent to the transfer in accordance with subdivision (10) of subsection (b) of this section. The consultative process shall include the participation of the attending physician or advanced practice registered nurse, a registered nurse with responsibility for the patient and other appropriate staff in disciplines as determined by the patient's needs, and the participation of the patient, the patient's family, a person designated by the patient in accordance with section 1-56r or other representative.

(e) Any nursing home facility, residential care home or chronic disease hospital that negligently deprives a patient of any right or benefit created or established for the well-being of the patient by the provisions of this section shall be liable to such patient in a private cause of action for injuries suffered as a result of such deprivation. Upon a finding that a patient has been deprived of such a right or benefit, and that the patient has been injured as a result of such deprivation, damages shall be assessed in the amount sufficient to compensate such patient for such injury. The rights or benefits specified in subsections (b) to (d), inclusive, of this section may not be reduced, rescinded or abrogated by contract. In addition, where the deprivation of any such right or benefit is found to have been wilful or in reckless disregard of the rights of the patient, punitive damages may be assessed. A patient may also maintain an action pursuant to this section for any other type of relief, including injunctive and declaratory relief, permitted by law. Exhaustion of any available administrative remedies shall not be required prior to commencement of suit under this section.

(f) In addition to the rights specified in subsections (b), (c) and (d) of

this section, a patient in a nursing home facility is entitled to have the facility manage the patient's funds as provided in section 19a-551.

Sec. 20. Section 19a-571 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Subject to the provisions of subsection (c) of this section, any physician licensed under chapter 370, any advanced practice registered nurse licensed under chapter 378 or any licensed medical facility who or which withholds, removes or causes the removal of a life support system of an incapacitated patient shall not be liable for damages in any civil action or subject to prosecution in any criminal proceeding for such withholding or removal, provided (1) the decision to withhold or remove such life support system is based on the best medical judgment of the attending physician or advanced practice registered nurse in accordance with the usual and customary standards of medical practice; (2) the attending physician or advanced practice registered nurse deems the patient to be in a terminal condition or, in consultation with a physician qualified to make a neurological diagnosis who has examined the patient, deems the patient to be permanently unconscious; and (3) the attending physician or advanced practice registered nurse has considered the patient's wishes concerning the withholding or withdrawal of life support systems. In the determination of the wishes of the patient, the attending physician or advanced practice registered nurse shall consider the wishes as expressed by a document executed in accordance with sections 19a-575 and 19a-575a, if any such document is presented to, or in the possession of, the attending physician or advanced practice registered nurse at the time the decision to withhold or terminate a life support system is made. If the wishes of the patient have not been expressed in a living will the attending physician or advanced practice registered nurse shall determine the wishes of the patient by consulting any statement made by the patient directly to the attending physician or advanced practice registered nurse and, if available, the patient's health care representative, the patient's next of kin, the patient's legal

guardian or conservator, if any, any person designated by the patient in accordance with section 1-56r and any other person to whom the patient has communicated his or her wishes, if the attending physician or advanced practice registered nurse has knowledge of such person. All persons acting on behalf of the patient shall act in good faith. If the attending physician or advanced practice registered nurse does not deem the incapacitated patient to be in a terminal condition or permanently unconscious, beneficial medical treatment including nutrition and hydration must be provided.

(b) A physician qualified to make a neurological diagnosis who is consulted by the attending physician or advanced practice registered nurse pursuant to subdivision (2) of subsection (a) of this section shall not be liable for damages or subject to criminal prosecution for any determination made in accordance with the usual and customary standards of medical practice.

(c) In the case of an infant, as defined in 45 CFR 1340.15 (b), the physician, advanced practice registered nurse or licensed medical facility shall comply with the provisions of 45 CFR 1340.15 (b)(2) in addition to the provisions of subsection (a) of this section.

Sec. 21. Section 19a-580d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

The Department of Public Health shall adopt regulations, in accordance with chapter 54, to provide for a system governing the recognition and transfer of "do not resuscitate" orders between health care institutions licensed pursuant to chapter 368v and upon intervention by emergency medical services providers certified or licensed pursuant to chapter 368d. The regulations shall include, but not be limited to, procedures concerning the use of "do not resuscitate" bracelets. The regulations shall specify that, upon request of the patient or his or her authorized representative, the physician or advanced practice registered nurse who issued the "do not resuscitate" order shall assist the patient or his or her authorized representative in

utilizing the system. The regulations shall not limit the authority of the Commissioner of Developmental Services under subsection (g) of section 17a-238 concerning orders applied to persons receiving services under the direction of the Commissioner of Developmental Services.

Sec. 22. Subsection (d) of section 19a-582 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(d) The provisions of this section shall not apply to the performance of an HIV-related test:

(1) By licensed medical personnel when the subject is unable to grant or withhold consent and no other person is available who is authorized to consent to health care for the individual and the test results are needed for diagnostic purposes to provide appropriate urgent care, except that in such cases the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided as soon as practical;

(2) By a health care provider or health facility in relation to the procuring, processing, distributing or use of a human body or a human body part, including organs, tissues, eyes, bones, arteries, blood, semen, or other body fluids, for use in medical research or therapy, or for transplantation to individuals, provided if the test results are communicated to the subject, the counseling, referrals and notification of test results described in subsection (c) of this section shall be provided;

(3) For the purpose of research if the testing is performed in a manner by which the identity of the test subject is not known and is unable to be retrieved by the researcher;

(4) On a deceased person when such test is conducted to determine the cause or circumstances of death or for epidemiological purposes;

(5) In cases where a health care provider or other person, including

volunteer emergency medical services, fire and public safety personnel, in the course of his or her occupational duties has had a significant exposure, provided the following criteria are met: (A) The worker is able to document significant exposure during performance of his or her occupation, (B) the worker completes an incident report within forty-eight hours of exposure identifying the parties to the exposure, witnesses, time, place and nature of the event, (C) the worker submits to a baseline HIV test within seventy-two hours of the exposure and is negative on that test, (D) the patient's or person's physician or advanced practice registered nurse or, if the patient or person does not have a personal physician or advanced practice registered nurse or if the patient's or person's physician or advanced practice registered nurse is unavailable, another physician, advanced practice registered nurse or health care provider has approached the patient or person and sought voluntary consent and the patient or person has refused to consent to testing, except in an exposure where the patient or person is deceased, (E) an exposure evaluation group determines that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that the worker has a significant exposure to the blood of a patient or person and the patient or person, or the patient's or person's legal guardian, refuses to grant informed consent for an HIV test. If the patient or person is under the care or custody of the health facility, correctional facility or other institution and a sample of the patient's blood is available, said blood shall be tested. If no sample of blood is available, and the patient is under the care or custody of a health facility, correctional facility or other institution, the patient shall have a blood sample drawn at the health facility, correctional facility or other institution and tested. No member of the exposure evaluation group who determines that a worker has sustained a significant exposure and authorized the HIV testing of a patient or other person, nor the health facility, correctional facility or other institution, nor any person in a health facility or other institution who relies in good faith on the group's determination and performs that test shall have any liability as a result of his or her action carried out pursuant to this section, unless such person acted in bad

faith. If the patient or person is not under the care or custody of a health facility, correctional facility or other institution and a physician or an advanced practice registered nurse not directly involved in the exposure certifies in writing that the criteria specified in subparagraphs (A), (B), (C), (D) and (F) of this subdivision are met and that a significant exposure has occurred, the worker may seek a court order for testing pursuant to subdivision (8) of this subsection, (F) the worker would be able to take meaningful immediate action, if results are known **[**, which**]** that could not otherwise be taken, as defined in regulations adopted pursuant to section 19a-589, (G) the fact that an HIV test was given as a result of an accidental exposure and the results of that test shall not appear in a patient's or person's medical record unless such test result is relevant to the medical care the person is receiving at that time in a health facility or correctional facility or other institution, (H) the counseling described in subsection (c) of this section shall be provided but the patient or person may choose not to be informed about the result of the test, and (I) the cost of the HIV test shall be borne by the employer of the potentially exposed worker;

(6) In facilities operated by the Department of Correction if the facility physician or advanced practice registered nurse determines that testing is needed for diagnostic purposes, to determine the need for treatment or medical care specific to an HIV-related illness, including prophylactic treatment of HIV infection to prevent further progression of disease, provided no reasonable alternative exists that will achieve the same goal;

(7) In facilities operated by the Department of Correction if the facility physician or advanced practice registered nurse and chief administrator of the facility determine that the behavior of the inmate poses a significant risk of transmission to another inmate or has resulted in a significant exposure of another inmate of the facility and no reasonable alternative exists that will achieve the same goal. No involuntary testing shall take place pursuant to subdivisions (6) and (7) of this subsection until reasonable effort has been made to secure

informed consent. When testing without consent takes place pursuant to subdivisions (6) and (7) of this subsection, the counseling referrals and notification of test results described in subsection (c) of this section shall, nonetheless be provided;

(8) Under a court order **[**which**]** that is issued in compliance with the following provisions: (A) No court of this state shall issue such order unless the court finds a clear and imminent danger to the public health or the health of a person and that the person has demonstrated a compelling need for the HIV-related test result **[**which**]** that cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for a test result against the privacy interests of the test subject and the public interest **[**which**]** that may be disserved by involuntary testing, (B) pleadings pertaining to the request for an involuntary test shall substitute a pseudonym for the true name of the subject to be tested. The disclosure to the parties of the subject's true name shall be communicated confidentially, in documents not filed with the court, (C) before granting any such order, the court shall provide the individual on whom a test result is being sought with notice and a reasonable opportunity to participate in the proceeding if he or she is not already a party, (D) court proceedings as to involuntary testing shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice;

(9) When the test is conducted by any life or health insurer or health care center for purposes of assessing a person's fitness for insurance coverage offered by such insurer or health care center; or

(10) When the test is subsequent to a prior confirmed test and the subsequent test is part of a series of repeated testing for the purposes of medical monitoring and treatment, provided (A) the patient has previously given general consent that includes HIV-related tests, (B) the patient, after consultation with the health care provider, has declined reiteration of the general consent, counseling and education

requirements of this section, and (C) a notation to that effect has been entered into the patient's medical record.

Sec. 23. Section 19a-592 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Any licensed physician or advanced practice registered nurse may examine and provide treatment for human immunodeficiency virus infection, or acquired immune deficiency syndrome for a minor, only with the consent of the parents or guardian of the minor unless the physician or advanced practice registered nurse determines that notification of the parents or guardian of the minor will result in treatment being denied or the physician or advanced practice registered nurse determines the minor will not seek, pursue or continue treatment if the parents or guardian are notified and the minor requests that his or her parents or guardian not be notified. The physician or advanced practice registered nurse shall fully document the reasons for the determination to provide treatment without the consent or notification of the parents or guardian of the minor and shall include such documentation, signed by the minor, in the minor's clinical record. The fact of consultation, examination and treatment of a minor under the provisions of this section shall be confidential and shall not be divulged without the minor's consent, including the sending of a bill for the services to any person other than the minor until the physician or advanced practice registered nurse consults with the minor regarding the sending of a bill.

(b) A minor shall be personally liable for all costs and expenses for services afforded **[**him**]** the minor at his or her request under this section.

Sec. 24. Section 20-7h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Any physician licensed under chapter 370, advanced practice registered nurse licensed under chapter 378 and any physical therapist

licensed under chapter 376 shall, during the consultation period with a patient who has suffered a personal injury and prior to any treatment of such patient, disclose to such patient in writing: (1) Whether such physician, advanced practice registered nurse or physical therapist would provide services to such patient on the basis of a letter of protection issued by an attorney representing the patient in a personal injury action, which letter promises that any bill for services rendered by such physician, advanced practice registered nurse or physical therapist to such patient will be paid from the proceeds of any recovery the patient receives from a settlement or judgment in such action or, if there is no recovery or the recovery is insufficient to pay such bill, that such bill will be paid by such patient; and (2) the estimated cost of providing to the patient or an attorney representing the patient in a personal injury action an opinion letter concerning the cause of the personal injury and the diagnosis, treatment and prognosis of the patient, including a disability rating.

Sec. 25. Section 19a-580 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Within a reasonable time prior to withholding or causing the removal of any life support system pursuant to sections 19a-570, 19a-571, as amended by this act, 19a-573 and 19a-575 to 19a-580c, inclusive, the attending physician or advanced practice registered nurse shall make reasonable efforts to notify the individual's health care representative, next-of-kin, legal guardian, conservator or person designated in accordance with section 1-56r, if available.

Sec. 26. Section 20-14m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) As used in this section, (1) "long-term antibiotic therapy" means the administration of oral, intramuscular or intravenous antibiotics, singly or in combination, for periods of time in excess of four weeks; and (2) "Lyme disease" means the clinical diagnosis by a physician, licensed in accordance with chapter 370, or an advanced practice

registered nurse, licensed in accordance with chapter 378, of the presence in a patient of signs or symptoms compatible with acute infection with borrelia burgdorferi; or with late stage or persistent or chronic infection with borrelia burgdorferi, or with complications related to such an infection; or such other strains of borrelia that, on and after July 1, 2009, are recognized by the National Centers for Disease Control and Prevention as a cause of Lyme disease. Lyme disease includes an infection that meets the surveillance criteria set forth by the National Centers for Disease Control and Prevention, and other acute and chronic manifestations of such an infection as determined by a physician, licensed in accordance with the provisions of chapter 370, or an advanced practice registered nurse, licensed in accordance with chapter 378, pursuant to a clinical diagnosis that is based on knowledge obtained through medical history and physical examination alone, or in conjunction with testing that provides supportive data for such clinical diagnosis.

(b) On and after July 1, 2009, a licensed physician or a licensed advanced practice registered nurse may prescribe, administer or dispense long-term antibiotic therapy to a patient for a therapeutic purpose that eliminates such infection or controls a patient's symptoms upon making a clinical diagnosis that such patient has Lyme disease or displays symptoms consistent with a clinical diagnosis of Lyme disease, provided such clinical diagnosis and treatment are documented in the patient's medical record by such licensed physician or licensed advanced practice registered nurse. Notwithstanding the provisions of sections 20-8a and 20-13e, on and after said date, the Department of Public Health shall not initiate a disciplinary action against a licensed physician or a licensed advanced practice registered nurse and such physician or advanced practice registered nurse shall not be subject to disciplinary action by the Connecticut Medical Examining Board or the Connecticut State Board of Examiners for Nursing solely for prescribing, administering or dispensing long-term antibiotic therapy to a patient clinically diagnosed with Lyme disease, provided such clinical diagnosis and treatment has been documented

in the patient's medical record by such licensed physician or licensed advanced practice registered nurse.

(c) Nothing in this section shall prevent the Connecticut Medical Examining Board or the Connecticut State Board of Examiners for Nursing from taking disciplinary action for other reasons against a licensed physician or a licensed advanced practice registered nurse, pursuant to section 19a-17, or from entering into a consent order with such physician or advanced practice registered nurse pursuant to subsection (c) of section 4-177. Subject to the limitation set forth in subsection (b) of this section, for purposes of this section, the Connecticut Medical Examining Board may take disciplinary action against a licensed physician if there is any violation of the provisions of section 20-13c and the Connecticut Board of Examiners for Nursing may take disciplinary action against a licensed advanced practice registered nurse in accordance with the provisions of section 20-99.

Sec. 27. Section 20-162n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in subsection (c) of section 19a-14, this section, and sections **[**20-162n**]** 20-162o to 20-162q, inclusive:

(a) "Commissioner" means the Commissioner of Public Health;

(b) "Respiratory care" means health care under the direction of a physician licensed pursuant to chapter 370 or an advanced practice registered nurse licensed pursuant to chapter 378 and in accordance with written protocols developed by **[**said**]** such physician or advanced practice registered nurse, employed in the therapy, management, rehabilitation, diagnostic evaluation and care of patients with deficiencies and abnormalities that affect the cardiopulmonary system and associated aspects of other system functions and that includes the following: (1) The therapeutic and diagnostic use of medical gases, administering apparatus, humidification and aerosols, administration of drugs and medications to the cardiorespiratory systems, ventilatory

assistance and ventilatory control, postural drainage, chest physiotherapy and breathing exercises, respiratory rehabilitation, cardiopulmonary resuscitation and maintenance of natural airways as well as the insertion and maintenance of artificial airways, (2) the specific testing techniques employed in respiratory therapy to assist in diagnosis, monitoring, treatment and research, including the measurement of ventilatory volumes, pressures and flows, specimen collection of blood and other materials, pulmonary function testing and hemodynamic and other related physiological monitoring of cardiopulmonary systems, (3) performance of a purified protein derivative test to identify exposure to tuberculosis, and (4) patient education in self-care procedures as part of the ongoing program of respiratory care of such patient. The practice of respiratory therapy is not limited to the hospital setting;

(c) "Respiratory care practitioner" means a person who is licensed to practice respiratory care in this state pursuant to section 20-162o and who may transcribe and implement written and verbal orders for respiratory care issued by a physician licensed pursuant to chapter 370, or a physician assistant licensed pursuant to chapter 370 or an advanced practice registered nurse licensed pursuant to chapter 378 who is functioning within the person's respective scope of practice.

Sec. 28. Section 20-206q of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

A certified dietitian-nutritionist may write an order for a patient diet, including, but not limited to, a therapeutic diet for a patient in an institution, as defined in section 19a-490. The certified dietitian-nutritionist shall write such order in the patient's medical record. Any order conveyed under this section shall be acted upon by the institution's nurses and physician assistants with the same authority as if the order were received directly from a physician <u>or an advanced practice registered nurse</u>. Any order conveyed in this manner shall be countersigned by a physician <u>or an advanced practice registered nurse</u>

within seventy-two hours unless otherwise provided by state or federal law or regulations. Nothing in this section shall prohibit a physician or an advanced practice registered nurse from conveying a verbal order for a patient diet to a certified dietitian-nutritionist.

Sec. 29. Section 20-206jj of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in this section and sections **[**20-206jj**]** 20-206kk to 20-206oo, inclusive:

(1) "Advanced emergency medical technician" means an individual who is certified as an advanced emergency medical technician by the Department of Public Health;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "Emergency medical services instructor" means a person who is certified under the provisions of section 20-206*ll* or 20-206mm by the Department of Public Health to teach courses, the completion of which is required in order to become an emergency medical technician;

(4) "Emergency medical responder" means an individual who is certified to practice as an emergency medical responder under the provisions of section 20-206*ll* or 20-206mm;

(5) "Emergency medical services personnel" means an individual certified to practice as an emergency medical responder, emergency medical technician, advanced emergency medical technician, emergency medical services instructor or an individual licensed as a paramedic;

(6) "Emergency medical technician" means a person who is certified to practice as an emergency medical technician under the provisions of section 20-206*ll* or 20-206mm;

(7) "Office of Emergency Medical Services" means the office established within the Department of Public Health pursuant to section 19a-178;

(8) "Paramedicine" means the carrying out of (A) all phases of cardiopulmonary resuscitation and defibrillation, (B) the administration of drugs and intravenous solutions under written or oral authorization from a licensed physician or a licensed advanced practice registered nurse, and (C) the administration of controlled substances, as defined in section 21a-240, in accordance with written protocols or standing orders of a licensed physician or a licensed advanced practice registered nurse; and

(9) "Paramedic" means a person licensed to practice as a paramedic under the provisions of section 20-206*ll*.

Sec. 30. Subsection (e) of section 20-41a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 31. Subsection (c) of section 20-73b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) The continuing education requirements shall be waived for licensees applying for licensure renewal for the first time. The department may, for a licensee who has a medical disability or illness, grant a waiver of the continuing education requirements or may grant the licensee an extension of time in which to fulfill the requirements, provided the licensee submits to the Department of Public Health an application for waiver or extension of time on a form prescribed by said department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by said department. The Department of Public Health may grant a waiver or extension for a period not to exceed one registration period, except that said department may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies to said department for an additional waiver or extension.

Sec. 32. Subsection (f) of section 20-74ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for

a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 33. Subsection (f) of section 20-126c of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 34. Subsection (i) of section 20-126*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(i) In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the requirements of this subsection to any licensee, provided the licensee submits to the Department of Public Health an application for waiver or extension of time on a form prescribed by the commissioner,

along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 35. Subsection (e) of section 20-132a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 36. Subsection (e) of section 20-162r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of

the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 37. Subsection (d) of section 20-191c of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(d) A licensee applying for license renewal for the first time shall be exempt from the continuing education requirements under subsection (a) of this section. In individual cases involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension. The

commissioner may grant a waiver of the continuing education requirements to a licensee who is not engaged in active professional practice, in any form, during a registration period, provided the licensee submits a notarized application on a form prescribed by the commissioner prior to the end of the registration period. A licensee who is granted a waiver under the provisions of this subsection may not engage in professional practice until the licensee has met the continuing education requirements of this section.

Sec. 38. Subsection (f) of section 20-201a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 39. Subdivision (3) of subsection (e) of section 20-206bb of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(3) In individual cases involving medical disability or illness, the commissioner may grant a waiver of the continuing education or certification requirements or an extension of time within which to

fulfill such requirements of this subsection to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the department. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 40. Subsection (f) of section 20-395d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 41. Subdivision (3) of subsection (b) of section 20-402 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(3) In individual cases involving medical disability or illness, the commissioner may grant a waiver of the continuing education requirements or an extension of time within which to fulfill such requirements of this subsection to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the department. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 42. Subsection (f) of section 20-411a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department, prior to the expiration of the registration period, an application for waiver on a form prescribed by the department, along with a certification by a licensed physician or a licensed advanced practice registered nurse of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

Sec. 43. Section 21a-217 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Every contract for health club services shall provide that such contract may be cancelled within three business days after the date of receipt by the buyer of a copy of the contract, by written notice delivered by certified or registered United States mail to the seller or the seller's agent at an address which shall be specified in the contract. After receipt of such cancellation, the health club may request the return of contract forms, membership cards and any and all other documents and evidence of membership previously delivered to the buyer. Cancellation shall be without liability on the part of the buyer, except for the fair market value of services actually received and the buyer shall be entitled to a refund of the entire consideration paid for the contract, if any, less the fair market value of the services or use of facilities already actually received. Such right of cancellation shall not be affected by the terms of the contract and may not be waived or otherwise surrendered. Such contract for health club services shall also contain a clause providing that if the person receiving the benefits of such contract relocates further than twenty-five miles from a health club facility operated by the seller or a substantially similar health club facility which would accept the seller's obligation under the contract, or dies during the membership term following the date of such contract, or if the health club ceases operation at the location where the buyer entered into the contract, the buyer or his estate shall be relieved of any further obligation for payment under the contract not then due and owing. The contract shall also provide that if the buyer becomes disabled during the membership term, the buyer shall have the option of (1) being relieved of liability for payment on that portion of the contract term for which he is disabled, or (2) extending the duration of the original contract at no cost to the buyer for a period equal to the duration of the disability. The health club shall have the right to require and verify reasonable evidence of relocation, disability or death. In the case of disability, the health club may require that a **[**doctor's**]** certificate signed by a licensed physician or a licensed

advanced practice registered nurse be submitted as verification and may also require in such contract that the buyer submit to a physical examination by a **[**doctor**]** licensed physician or a licensed advanced practice registered nurse agreeable to the buyer and the health club, the cost of which examination shall be borne by the health club.

Sec. 44. Subsections (a) to (c), inclusive, of section 21a-218 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) A copy of the health club contract shall be delivered to the buyer at the time the contract is signed. All health club contracts shall be in writing and signed by the buyer, shall designate the date on which the buyer actually signs the contract, shall identify the address of the location at which the buyer entered the contract and shall contain a statement of the buyer's rights which complies with this section. The statement must: (1) Appear in the contract under the conspicuous caption: "BUYER'S RIGHT TO CANCEL", and (2) read as follows:

"If you wish to cancel this contract, you may cancel by mailing a written notice by certified or registered mail to the address specified below. The notice must say that you do not wish to be bound by this contract and must be delivered or mailed before midnight of the third business day after you sign this contract. After you cancel, the health club may request the return of all contracts, membership cards and other documents of evidence of membership. The notice must be delivered or mailed to:

....

....

(Insert name and mailing address for cancellation notice.)

You may also cancel this contract if you relocate your residence further than twenty-five miles from any health club operated by the seller or from any other substantially similar health club which would

accept the obligation of the seller. This contract may also be cancelled if you die, or if the health club ceases operation at the location where you entered into this contract. If you become disabled, you shall have the option of (1) being relieved of liability for payment on that portion of the contract term for which you are disabled, or (2) extending the duration of the original contract at no cost to you for a period equal to the duration of the disability. You must prove such disability by a **[**doctor's**]** certificate signed by a licensed physician or a licensed advanced practice registered nurse, which certificate shall be enclosed with the written notice of disability sent to the health club. The health club may require that you be examined by another physician or advanced practice registered nurse agreeable to you and the health club at its expense. If you cancel, the health club may keep or collect an amount equal to the fair market value of the services or use of facilities you have already received."

The full text of this statement shall be in ten-point bold type.

(b) If a buyer cancels a health club contract pursuant to the three-day cancellation provision or as a result of having moved further than twenty-five miles, or as a result of the health club ceasing operation at the location where the buyer entered into the contract as provided by this chapter, the health club shall send the buyer a written confirmation of cancellation within fifteen days after receipt by the health club of the buyer's cancellation notice. If the health club fails to send such written notice to the buyer within fifteen days, the health club shall be deemed to have accepted the cancellation.

(c) (1) If the buyer notifies the health club that he has become disabled, the health club shall notify the buyer in writing within fifteen days of receipt by the health club of the buyer's notice of disability and any **[**doctor's**]** certificate signed by a licensed physician or a licensed advanced practice registered nurse which may be required under subsection (a) of this section that: (A) The health club will not require the buyer to submit to another physical examination; or (B) the health club requires the buyer to submit to another physical examination and

that the buyer's obligations under the contract are suspended pending determination of disability. If the health club fails to send such written notice to the buyer within fifteen days, the health club shall be deemed to have accepted the disability.

(2) If the health club requires the buyer to submit to another physical examination, all obligations of the buyer for payment under the contract will be suspended as of the date the health club receives notice of disability. The buyer's obligations will not resume until such time as a determination is made, either by consent of the buyer and the health club or through adjudicative proceedings, that disability does not exist.

Sec. 45. Subsection (a) of section 21a-246 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) No person within this state shall manufacture, wholesale, repackage, supply, compound, mix, cultivate or grow, or by other process produce or prepare, controlled substances without first obtaining a license to do so from the Commissioner of Consumer Protection and no person within this state shall operate a laboratory for the purpose of research or analysis using controlled substances without first obtaining a license to do so from the Commissioner of Consumer Protection, except that such activities by pharmacists or pharmacies in the filling and dispensing of prescriptions or activities incident thereto, or the dispensing or administering of controlled substances by dentists, podiatrists, physicians, advanced practice registered nurses or veterinarians, or other persons acting under their supervision, in the treatment of patients shall not be subject to the provisions of this section, and provided laboratories for instruction in dentistry, medicine, nursing, pharmacy, pharmacology and pharmacognosy in institutions duly licensed for such purposes in this state shall not be subject to the provisions of this section except with respect to narcotic drugs and schedule I and II controlled substances. Upon application of any physician licensed pursuant to chapter 370 or

an advanced practice registered nurse licensed pursuant to chapter 378, the Commissioner of Consumer Protection shall without unnecessary delay, (1) license such physician to possess and supply marijuana for the treatment of glaucoma or the side effects of chemotherapy, or (2) license such advanced practice registered nurse to possess and supply marijuana for the treatment of the side effects of chemotherapy. No person outside this state shall sell or supply controlled substances within this state without first obtaining a license to do so from the Commissioner of Consumer Protection, provided no such license shall be required of a manufacturer whose principal place of business is located outside this state and who is registered with the federal Drug Enforcement Administration or other federal agency, and who files a copy of such registration with the appropriate licensing authority under this chapter.

Sec. 46. Section 21a-253 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Any person may possess or have under his control a quantity of marijuana less than or equal to that quantity supplied to him pursuant to a prescription made in accordance with the provisions of section 21a-249 by (1) a physician licensed under the provisions of chapter 370 and further authorized by subsection (a) of section 21a-246, as amended by this act, by the Commissioner of Consumer Protection to possess and supply marijuana for the treatment of glaucoma or the side effects of chemotherapy, or (2) an advanced practice registered nurse licensed under the provisions of chapter 378 and further authorized by subsection (a) of section 21a-246, as amended by this act, by said commissioner to possess and supply marijuana for the treatment of the side effects of chemotherapy.

Sec. 47. Section 21a-408 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

As used in sections 21a-408 to 21a-408o, inclusive, unless the context otherwise requires:

(1) "Advanced practice registered nurse" means an advanced practice registered nurse licensed pursuant to chapter 378;

[(1)**]** (2) "Cultivation" includes planting, propagating, cultivating, growing and harvesting;

[(2)**]** (3) "Debilitating medical condition" means (A) cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or (B) any medical condition, medical treatment or disease approved by the Department of Consumer Protection pursuant to regulations adopted under section 21a-408m, as amended by this act;

[(3)**]** (4) "Licensed dispensary" or "dispensary" means a person licensed as a dispensary pursuant to section 21a-408h;

[(4)**]** (5) "Licensed producer" or "producer" means a person licensed as a producer pursuant to section 21a-408i;

[(5)**]** (6) "Marijuana" means marijuana, as defined in section 21a-240;

[(6)**]** (7) "Palliative use" means the acquisition, distribution, transfer, possession, use or transportation of marijuana or paraphernalia relating to marijuana, including the transfer of marijuana and paraphernalia relating to marijuana from the patient's primary caregiver to the qualifying patient, to alleviate a qualifying patient's symptoms of a debilitating medical condition or the effects of such symptoms, but does not include any such use of marijuana by any person other than the qualifying patient;

[(7)**]** (8) "Paraphernalia" means drug paraphernalia, as defined in section 21a-240;

[(8)**]** (9) "Physician" means a person who is licensed under chapter

370, but does not include a physician assistant, as defined in section 20-12a;

[(9)**]** (10) "Primary caregiver" means a person, other than the qualifying patient and the qualifying patient's physician or advanced practice registered nurse, who is eighteen years of age or older and has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the palliative use of marijuana, provided (A) in the case of a qualifying patient lacking legal capacity, such person shall be a parent, guardian or person having legal custody of such qualifying patient, and (B) the need for such person shall be evaluated by the qualifying patient's physician or advanced practice registered nurse and such need shall be documented in the written certification;

[(10)**]** (11) "Qualifying patient" means a person who is eighteen years of age or older, is a resident of Connecticut and has been diagnosed by a physician or an advanced practice registered nurse as having a debilitating medical condition. "Qualifying patient" does not include an inmate confined in a correctional institution or facility under the supervision of the Department of Correction;

[(11)**]** (12) "Usable marijuana" means the dried leaves and flowers of the marijuana plant, and any mixtures or preparations of such leaves and flowers, that are appropriate for the palliative use of marijuana, but does not include the seeds, stalks and roots of the marijuana plant; and

[(12)**]** (13) "Written certification" means a written certification issued by a physician or an advanced practice registered nurse pursuant to section 21a-408c, as amended by this act.

Sec. 48. Subsection (a) of section 21a-408a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) A qualifying patient shall register with the Department of

Consumer Protection pursuant to section 21a-408d, as amended by this act, prior to engaging in the palliative use of marijuana. A qualifying patient who has a valid registration certificate from the Department of Consumer Protection pursuant to subsection (a) of section 21a-408d, as amended by this act, and complies with the requirements of sections 21a-408 to 21a-408n, inclusive, as amended by this act, shall not be subject to arrest or prosecution, penalized in any manner, including, but not limited to, being subject to any civil penalty, or denied any right or privilege, including, but not limited to, being subject to any disciplinary action by a professional licensing board, for the palliative use of marijuana if:

(1) The qualifying patient's physician or advanced practice registered nurse has issued a written certification to the qualifying patient for the palliative use of marijuana after the physician or advanced practice registered nurse has prescribed, or determined it is not in the best interest of the patient to prescribe, prescription drugs to address the symptoms or effects for which the certification is being issued;

(2) The combined amount of marijuana possessed by the qualifying patient and the primary caregiver for palliative use does not exceed an amount of usable marijuana reasonably necessary to ensure uninterrupted availability for a period of one month, as determined by the Department of Consumer Protection pursuant to regulations adopted under section 21a-408m, as amended by this act; and

(3) The qualifying patient has not more than one primary caregiver at any time.

Sec. 49. Section 21a-408c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) A physician or an advanced practice registered nurse may issue a written certification to a qualifying patient that authorizes the palliative use of marijuana by the qualifying patient. Such written

certification shall be in the form prescribed by the Department of Consumer Protection and shall include a statement signed and dated by the qualifying patient's physician or advanced practice registered nurse stating that, in such physician's or advanced practice registered nurse's professional opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the palliative use of marijuana would likely outweigh the health risks of such use to the qualifying patient.

(b) Any written certification for the palliative use of marijuana issued by a physician or an advanced practice registered nurse under subsection (a) of this section shall be valid for a period not to exceed one year from the date such written certification is signed and dated by the physician or advanced practice registered nurse. Not later than ten calendar days after the expiration of such period, or at any time before the expiration of such period should the qualifying patient no longer wish to possess marijuana for palliative use, the qualifying patient or the primary caregiver shall destroy all usable marijuana possessed by the qualifying patient and the primary caregiver for palliative use.

(c) A physician or an advanced practice registered nurse shall not be subject to arrest or prosecution, penalized in any manner, including, but not limited to, being subject to any civil penalty, or denied any right or privilege, including, but not limited to, being subject to any disciplinary action by the Connecticut Medical Examining Board, the Connecticut State Board of Examiners for Nursing or other professional licensing board, for providing a written certification for the palliative use of marijuana under subdivision (1) of subsection (a) of section 21a-408a, as amended by this act, if:

(1) The physician or advanced practice registered nurse has diagnosed the qualifying patient as having a debilitating medical condition;

(2) The physician or advanced practice registered nurse has

explained the potential risks and benefits of the palliative use of marijuana to the qualifying patient and, if the qualifying patient lacks legal capacity, to a parent, guardian or person having legal custody of the qualifying patient;

(3) The written certification issued by the physician or advanced practice registered nurse is based upon the physician's or advanced practice registered nurse's professional opinion after having completed a medically reasonable assessment of the qualifying patient's medical history and current medical condition made in the course of a bona fide **[**physician-patient**]** health care professional-patient relationship; and

(4) The physician or advanced practice registered nurse has no financial interest in a dispensary licensed under section 21a-408h or a producer licensed under section 21a-408i.

(d) Notwithstanding the provisions of this section, sections 21a-408 to 21a-408b, inclusive, as amended by this act, and sections 21a-408d to 21a-408o, inclusive, as amended by this act, an advanced practice registered nurse shall not issue a written certification to a qualifying patient when the qualifying patient's debilitating medical condition is glaucoma.

Sec. 50. Section 21a-408d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Each qualifying patient who is issued a written certification for the palliative use of marijuana under subdivision (1) of subsection (a) of section 21a-408a, as amended by this act, and the primary caregiver of such qualifying patient, shall register with the Department of Consumer Protection. Such registration shall be effective from the date the Department of Consumer Protection issues a certificate of registration until the expiration of the written certification issued by the physician or advanced practice registered nurse. The qualifying

patient and the primary caregiver shall provide sufficient identifying information, as determined by the department, to establish the personal identity of the qualifying patient and the primary caregiver. The qualifying patient or the primary caregiver shall report any change in such information to the department not later than five business days after such change. The department shall issue a registration certificate to the qualifying patient and to the primary caregiver and may charge a reasonable fee, not to exceed twenty-five dollars, for each registration certificate issued under this subsection. Any registration fees collected by the department under this subsection shall be paid to the State Treasurer and credited to the General Fund.

(b) Information obtained under this section shall be confidential and shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200, except that reasonable access to registry information obtained under this section and temporary registration information obtained under section 21a-408n, as amended by this act, shall be provided to: (1) State agencies, federal agencies and local law enforcement agencies for the purpose of investigating or prosecuting a violation of law; (2) physicians, advanced practice registered nurses and pharmacists for the purpose of providing patient care and drug therapy management and monitoring controlled substances obtained by the qualifying patient; (3) public or private entities for research or educational purposes, provided no individually identifiable health information may be disclosed; (4) a licensed dispensary for the purpose of complying with sections 21a-408 to 21a-408n, inclusive, as amended by this act; (5) a qualifying patient, but only with respect to information related to such qualifying patient or such qualifying patient's primary caregiver; or (6) a primary caregiver, but only with respect to information related to such primary caregiver's qualifying patient.

Sec. 51. Subsection (a) of section 21a-408m of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective October 1, 2016*):

(a) The Commissioner of Consumer Protection may adopt regulations, in accordance with chapter 54, to establish (1) a standard form for written certifications for the palliative use of marijuana issued by physicians and advanced practice registered nurses under subdivision (1) of subsection (a) of section 21a-408a, as amended by this act, and (2) procedures for registrations under section 21a-408d, as amended by this act. Such regulations, if any, shall be adopted after consultation with the Board of Physicians established in section 21a-408*l*.

Sec. 52. Section 21a-408n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) During the period beginning on October 1, 2012, and ending thirty calendar days after the effective date of regulations adopted pursuant to section 21a-408m, as amended by this act, a qualifying patient who would be determined to be eligible for a registration certificate pursuant to subsection (a) of section 21a-408d, as amended by this act, except for the lack of effective regulations concerning licensed dispensaries, licensed producers, distribution systems and amounts of marijuana, may obtain a written certification from a physician or an advanced practice registered nurse and upon presenting the written certification to the Department of Consumer Protection, the department shall issue a temporary registration certificate for the palliative use of marijuana. The department shall indicate on such temporary registration certificate the amount of usable marijuana that constitutes a one month supply which may be possessed pursuant to such temporary registration certificate. The department shall maintain a list of all temporary registration certificates issued pursuant to this section and the information on such list shall be confidential and shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200, except that such information may be disclosed in the manner set forth in subsection (b) of section 21a-408d, as amended by this act.

(b) A qualifying patient possessing a temporary registration certificate and the qualifying patient's primary caregiver shall not be subject to arrest or prosecution, penalized in any manner, including, but not limited to, being subject to any civil penalty, or denied any right or privilege, including, but not limited to, being subject to any disciplinary action by a professional licensing board, for possessing marijuana if the amount of usable marijuana possessed by the qualifying patient and the primary caregiver is not more than the amount specified in the temporary registration certificate.

(c) A physician or an advanced practice registered nurse shall not be subject to arrest or prosecution, penalized in any manner, including, but not limited to, being subject to any civil penalty, or denied any right or privilege, including, but not limited to, being subject to any disciplinary action by the Connecticut Medical Examining Board, the State Board of Examiners for Nursing or other professional licensing board, for providing a written certification for the palliative use of marijuana pursuant to this section.

Sec. 53. Subsection (b) of section 22a-616 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(b) Notwithstanding the provisions of section 22a-617, on and after January 1, 2003, no person shall offer for sale or distribute for promotional purposes mercury fever thermometers except by prescription written by a physician or an advanced practice registered nurse. A manufacturer of mercury fever thermometers shall provide the buyer or the recipient with notice of mercury content, instructions on proper disposal and instructions that clearly describe how to carefully handle the thermometer to avoid breakage and on proper cleanup should a breakage occur.

Sec. 54. Section 26-29a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

No fee shall be charged for any sport fishing license issued under this chapter to any person with intellectual disability, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. Proof of intellectual disability shall consist of a certificate to that effect issued by **[**any person licensed to practice medicine and surgery in this state**]** a licensed physician or a licensed advanced practice registered nurse.

Sec. 55. Section 26-29b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

No fee shall be charged for any hunting, sport fishing or trapping license issued under this chapter to any physically disabled person, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. For the purposes of this section, a "physically disabled person" is any person whose disability consists of the loss of one or more limbs or the permanent loss of the use of one or more limbs. A physically disabled person shall submit to the commissioner a certification, signed by a licensed physician or a licensed advanced practice registered nurse, of such disability. No fee shall be charged for any hunting or sport fishing license issued under this chapter to any physically disabled person who is not a resident of this state if such person is a resident of a state in which a physically disabled person from Connecticut will not be required to pay a fee for a hunting or sport fishing license, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35.

Sec. 56. Section 27-140ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) A physician or an advanced practice registered nurse who has primary responsibility for treating a veteran who believes he may have been exposed to Vietnam herbicides while serving in the armed forces of the United States, shall, at the request of the veteran, submit a report to the Department of Veterans' Affairs. If there is no physician or advanced practice registered nurse having primary responsibility for

treating the veteran, the hospital treating the veteran shall, at the request of the veteran, submit the report to the commission. Any report of a physician, an advanced practice registered nurse or a hospital shall include: (1) Any symptoms of exposure to a Vietnam herbicide; (2) diagnosis of the veteran; and (3) methods of treatment prescribed.

(b) The identity of a veteran about whom a report has been made under this section may not be disclosed unless the veteran consents to the disclosure. Any statistical information collected under this part shall be public information.

(c) Any physician, advanced practice registered nurse or hospital subject to this section who complies with the provisions of this section may not be held civilly or criminally liable for providing the information required by this section.

Sec. 57. Section 29-143t of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) No person shall engage in any boxing match as a boxer or in any mixed martial arts match as a competitor until such person has been examined and found to be physically fit by a competent physician or advanced practice registered nurse approved by the commissioner, licensed to practice under the laws of this state and in practice in this state for at least two years. Such physician or advanced practice registered nurse shall be appointed by the commissioner and shall be in attendance throughout the boxing or mixed martial arts match for which such examination was made. Such physician or advanced practice registered nurse shall certify, in writing, that the boxer or competitor is physically fit to engage in such boxing or mixed martial arts match. Any fee for such physician or advanced practice registered nurse, as determined by the commissioner, shall be paid by the person or club, corporation or association conducting such boxing or mixed martial arts match.

(b) The cost of any physical examination required by this chapter or regulations adopted under this chapter, other than an examination required by subsection (a) of this section, may be assessed by the commissioner on any boxer or competitor examined by a physician or an advanced practice registered nurse appointed by the commissioner or on the person, club, corporation or association conducting the next boxing or mixed martial arts match in which the boxer or competitor is scheduled to compete.

Sec. 58. Section 31-40a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Each physician or advanced practice registered nurse having knowledge of any person whom he or she believes to be suffering from poisoning from lead, phosphorus, arsenic, brass, wood alcohol or mercury or their compounds, or from anthrax or from compressed-air illness or any other disease, contracted as a result of the nature of the employment of such person, shall, within forty-eight hours, mail to the Labor Department, Department of Factory Inspection, as provided in section 31-9, a report stating the name, address and occupation of such patient, the name, address and business of his or her employer, the nature of the disease and such other information as may reasonably be required by said department. The department shall prepare and furnish to the physicians and advanced practice registered nurses of this state suitable blanks for the reports herein required. No report made pursuant to the provisions of this section shall be admissible as evidence of the facts therein stated in any action at law or in any action under the Workers' Compensation Act against any employer of such diseased person. Any physician or advanced practice registered nurse who fails to send any report herein required or who fails to send the same within the time specified herein shall be liable to the state for a penalty of not more than ten dollars, recoverable by civil action in the name of the state by said department. The Labor Department, Department of Factory Inspection, as provided in section 31-9, is authorized to investigate and make recommendations for the

elimination or prevention of occupational diseases reported to it in accordance with the provisions of this section. Said department is also authorized to study and provide advice in regard to conditions suspected of causing occupational diseases, provided information obtained upon investigations made in accordance with the provisions of this section shall not be admissible as evidence in any action at law to recover damages for personal injury or in any action under the Workers' Compensation Act.

Sec. 59. Section 38a-489 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state more than one hundred twenty days after July 1, 1971, that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician <u>or advanced practice registered nurse</u> on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon the policyholder or subscriber for support and maintenance.

(b) Proof of the incapacity and dependency shall be furnished to the insurer, hospital service corporation, medical service corporation or health care center by the policyholder or subscriber within thirty-one days of the child's attainment of the limiting age. The insurer, corporation or health care center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age

the insurer, corporation or health care center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

Sec. 60. Section 38a-492m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2010, that provides coverage for prescription eye drops, shall not deny coverage for a renewal of prescription eye drops when (1) the renewal is requested by the insured less than thirty days from the later of (A) the date the original prescription was distributed to the insured, or (B) the date the last renewal of such prescription was distributed to the insured, and (2) the prescribing physician or advanced practice registered nurse indicates on the original prescription that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed.

Sec. 61. Section 38a-493 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage providing reimbursement for home health care to residents in this state.

(b) For the purposes of this section, "hospital" means an institution **[**which**]** that is primarily engaged in providing, by or under the supervision of physicians, to inpatients (1) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or (2) medical rehabilitation services for the rehabilitation of injured, disabled or sick persons, provided

"hospital" shall not include a residential care home, nursing home, rest home or alcohol or drug treatment facility, as defined in section 19a-490. For the purposes of this section and section 38a-494, "home health care" means the continued care and treatment of a covered person who is under the care of a physician or an advanced practice registered nurse but only if (A) continued hospitalization would otherwise have been required if home health care was not provided, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, and (B) the plan covering the home health care is established and approved in writing by such physician or advanced practice registered nurse within seven days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the covered person was hospitalized, except that in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and (C) such home health care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live.

(c) Home health care shall be provided by a home health agency. The term "home health agency" means an agency or organization **[**which**]** that meets each of the following requirements: (1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services, (2) its policies are established by a professional group associated with such agency or organization, including at least one physician or advanced practice registered nurse and at least one registered nurse, to govern the services provided, (3) it provides for full-time supervision of such services by a physician, an advanced practice registered nurse

or **[**by**]** a registered nurse, (4) it maintains a complete medical record on each patient, and (5) it has an administrator.

(d) Home health care shall consist of, but shall not be limited to, the following: (1) Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; (3) physical, occupational or speech therapy; (4) medical supplies, drugs and medicines prescribed by a physician, advanced practice registered nurse or physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; (5) medical social services, as hereinafter defined, provided to or for the benefit of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live. Medical social services are defined to mean services rendered, under the direction of a physician or an advanced practice registered nurse by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of the overall plan of treatment for such covered person.

(e) The policy may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy or contract, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, the yearly benefit for

medical social services shall not exceed two hundred dollars. Each visit by a representative of a home health agency shall be considered as one home health care visit; four hours of home health aide service shall be considered as one home health care visit.

(f) Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision **[**which**]** that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services. Such policy may also contain reasonable limitations and exclusions applicable to home health care coverage. A "high deductible health plan", as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, used to establish a "medical savings account" or "Archer MSA" pursuant to Section 220 of said Internal Revenue Code or a "health savings account" pursuant to Section 223 of said Internal Revenue Code shall not be subject to the deductible limits set forth in this subsection.

(g) No policy, except any major medical expense policy as described in subsection (j), shall be required to provide home health care coverage to persons eligible for Medicare.

(h) No insurer, hospital service corporation or health care center shall be required to provide benefits beyond the maximum amount limits contained in its policy.

(i) If a person is eligible for home health care coverage under more than one policy, the home health care benefits shall only be provided by that policy **[**which**]** that would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

(j) Each individual major medical expense policy delivered, issued for delivery, renewed, amended or continued in this state shall provide

coverage in accordance with the provisions of this section for home health care to residents in this state whose benefits are no longer provided under Medicare or any applicable individual health insurance policy.

Sec. 62. Section 38a-495 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) As used in this section, "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended (Title I, Part I of P.L. 89-97); "Medicare supplement policy" means any individual health insurance policy delivered or issued for delivery to any resident of the state who is eligible for Medicare, except any long-term care policy as defined in section 38a-501.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any Medicare supplement policy **[**which**]** that has an anticipated loss ratio of less than sixty-five per cent for any individual Medicare supplement policy defined in Section 1882(g) of Title XVIII of the Social Security Act, 42 USC 1395ss(g), as amended. No such company, society or corporation may deliver or issue for delivery any Medicare supplement policy without providing, at the time of solicitation or application for the purchase or sale of such coverage, full and fair disclosure of any coverage supplementing or duplicating Medicare benefits.

(c) Each Medicare supplement policy shall provide coverage for home health aide services for each individual covered under the policy when such services are not paid for by Medicare, provided (1) such services are provided by a certified home health aide employed by a home health care agency licensed pursuant to sections 19a-490 to 19a-503, inclusive, and (2) the individual's physician or advanced practice registered nurse has certified, in writing, that such services are medically necessary. The policy shall not be required to provide

benefits in excess of five hundred dollars per year for such services. No deductible or coinsurance provisions may be applicable to such benefits. If two or more Medicare supplement policies are issued to the same individual by the same insurer, such coverage for home health aide services shall be included in only one such policy. Notwithstanding the provisions of subsection (g) of this section, the provisions of this subsection shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1986.

(d) Whenever a Medicare supplement policy provides coverage for the cost of prescription drugs prescribed after the hospitalization of the insured, outpatient surgical procedures performed on the insured in any licensed hospital shall constitute "hospitalization" for purposes of such prescription drug coverage in such policy.

(e) Notwithstanding the provisions of subsection (g) of this section, each Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1988, shall provide benefits, to any woman covered under the policy, for mammographic examinations every year, or more frequently if recommended by the woman's physician or advanced practice registered nurse, when such examinations are not paid for by Medicare.

(f) The Insurance Commissioner shall adopt such regulations as he deems necessary in accordance with chapter 54 to carry out the purposes of this section.

(g) The provisions of this section shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1987, and prior to the effective date of any regulations adopted pursuant to section 38a-495a.

Sec. 63. Subsection (a) of section 38a-496 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

October 1, 2016):

(a) For the purposes of this section:

(1) "Occupational therapy" means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a physician licensed in accordance with the provisions of chapter 370 or an advanced practice registered nurse licensed in accordance with the provisions of chapter 378, who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility. Such plan shall be reviewed and certified at least every two months by such physician or advanced practice registered nurse.

(2) "Health care facility" means an institution which provides occupational therapy, including, but not limited to, an outpatient clinic, a rehabilitative agency and a skilled or intermediate nursing facility.

(3) "Rehabilitative agency" means an agency which provides an integrated multitreatment program designed to upgrade the function of handicapped disabled individuals by bringing together, as a team, specialized personnel from various allied health fields.

(4) "Partial hospitalization" means a formal program of care provided in a hospital or facility for periods of less than twenty-four hours a day.

Sec. 64. Section 38a-515 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state more than one hundred twenty days after July 1, 1971, that

provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician or advanced practice registered nurse on a form provided by the insurer, hospital service corporation, medical service corporation or health care center, and (2) chiefly dependent upon such employee or member for support and maintenance.

(b) Proof of the incapacity and dependency shall be furnished to the insurer, hospital service corporation, medical service corporation or health care center by the employee or member within thirty-one days of the child's attainment of the limiting age. The insurer, corporation or center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age the insurer, corporation or center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

Sec. 65. Section 38a-518*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2010, that provides coverage for prescription eye drops, shall not deny coverage for a renewal of prescription eye drops when (1) the renewal is requested by the insured less than thirty days from the later of (A) the date the original prescription was distributed to the insured, or (B) the date the last renewal of such prescription was distributed to the insured, and (2) the prescribing physician or advanced practice registered nurse indicates

on the original prescription that additional quantities are needed and the renewal requested by the insured does not exceed the number of additional quantities needed.

Sec. 66. Section 38a-520 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage providing reimbursement for home health care to residents in this state.

(b) For the purposes of this section, "hospital" means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients (1) diagnostic, surgical and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or (2) medical rehabilitation services for the rehabilitation of injured, disabled or sick persons, provided "hospital" shall not include a residential care home, nursing home, rest home or alcohol or drug treatment facility, as defined in section 19a-490. For the purposes of this section and section 38a-494, "home health care" means the continued care and treatment of a covered person who is under the care of a physician or an advanced practice registered nurse but only if (A) continued hospitalization would otherwise have been required if home health care was not provided, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, and (B) the plan covering the home health care is established and approved in writing by such physician or advanced practice registered nurse within seven days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the covered person was hospitalized, except that in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time

irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such seven-day period, and (C) such home health care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live.

(c) Home health care shall be provided by a home health agency. The term "home health agency" means an agency or organization **[**which**]** that meets each of the following requirements: (1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services, (2) its policies are established by a professional group associated with such agency or organization, including at least one physician or advanced practice registered nurse and at least one registered nurse, to govern the services provided, (3) it provides for full-time supervision of such services by a physician, an advanced practice registered nurse or **[**by**]** a registered nurse, (4) it maintains a complete medical record on each patient, and (5) it has an administrator.

(d) Home health care shall consist of, but shall not be limited to, the following: (1) Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; (3) physical, occupational or speech therapy; (4) medical supplies, drugs and medicines prescribed by a physician, an advanced practice registered nurse or a physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; (5) medical social services, as hereinafter defined, provided to or for the benefit of a covered person diagnosed by a physician or an advanced practice

registered nurse as terminally ill with a prognosis of six months or less to live. Medical social services are defined to mean services rendered, under the direction of a physician or an advanced practice registered nurse by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of the overall plan of treatment for such covered person.

(e) The policy may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy, except in the case of a covered person diagnosed by a physician or an advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed two hundred dollars. Each visit by a representative of a home health agency shall be considered as one home health care visit; four hours of home health aide service shall be considered as one home health care visit.

(f) Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision **[**which**]** that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services. Such policy may also contain reasonable limitations and exclusions applicable to home health care coverage. A "high deductible health plan", as defined in Section 220(c)(2) or Section 223(c)(2) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, used to establish a "medical savings account" or "Archer MSA" pursuant to Section 220 of said Internal Revenue Code or a "health savings account" pursuant to Section 223 of said Internal

Revenue Code shall not be subject to the deductible limits set forth in this subsection.

(g) No policy, except any major medical expense policy as described in subsection (j), shall be required to provide home health care coverage to persons eligible for Medicare.

(h) No insurer, hospital service corporation or health care center shall be required to provide benefits beyond the maximum amount limits contained in its policy.

(i) If a person is eligible for home health care coverage under more than one policy, the home health care benefits shall only be provided by that policy **[**which**]** that would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

(j) Each major medical expense policy delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage in accordance with the provisions of this section for home health care to residents in this state whose benefits are no longer provided under Medicare or any applicable individual or group health insurance policy.

Sec. 67. Section 38a-522 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) As used in this section, "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended (Title I, Part I of P.L. 89-97); "Medicare supplement policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of the state who is eligible for Medicare, except any long-term care policy as defined in section 38a-528.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may

deliver or issue for delivery any Medicare supplement policy **[**which**]** that has an anticipated loss ratio of less than seventy per cent for any group Medicare supplement policy except that a minimum anticipated loss ratio of seventy-five per cent shall be required for any group Medicare supplement policy defined in Section 1882(g) of Title XVIII of the Social Security Act, 42 USC 1395ss(g), as amended. No such company, society, corporation or center may deliver or issue for delivery any Medicare supplement policy without providing, at the time of solicitation or application for the purchase or sale of such coverage, full and fair disclosure of any coverage supplementing or duplicating Medicare benefits.

(c) Each Medicare supplement policy shall provide coverage for home health aide services for each individual covered under the policy when such services are not paid for by Medicare, provided (1) such services are provided by a certified home health aide employed by a home health care agency licensed pursuant to sections 19a-490 to 19a-503, inclusive, and (2) the individual's physician or advanced practice registered nurse has certified, in writing, that such services are medically necessary. The policy shall not be required to provide benefits in excess of five hundred dollars per year for such services. No deductible or coinsurance provisions may be applicable to such benefits. If two or more Medicare supplement policies are issued to the same individual by the same insurer, such coverage for home health aide services shall be included in only one such policy. Notwithstanding the provisions of subsection (g) of this section, the provisions of this subsection shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1986.

(d) Whenever a Medicare supplement policy provides coverage for the cost of prescription drugs prescribed after the hospitalization of the insured, outpatient surgical procedures performed on the insured in any licensed hospital shall constitute "hospitalization" for purposes of such prescription drug coverage in such policy.

(e) Notwithstanding the provisions of subsection (g) of this section, each Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1988, shall provide benefits, to any woman covered under the policy, for mammographic examinations every year, or more frequently if recommended by the woman's physician or advanced practice registered nurse, when such examinations are not paid for by Medicare.

(f) The Insurance Commissioner shall adopt such regulations as he deems necessary in accordance with chapter 54 to carry out the purposes of this section.

(g) The provisions of this section shall apply with respect to any Medicare supplement policy delivered, issued for delivery, continued or renewed in this state on or after October 1, 1987, and prior to the effective date of any regulations adopted pursuant to section 38a-495a.

Sec. 68. Subsection (a) of section 38a-523 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) For the purposes of this section:

(1) "Comprehensive rehabilitation services" shall consist of the following when provided in a comprehensive rehabilitation facility pursuant to a plan of care approved in writing by a physician licensed in accordance with the provisions of chapter 370 or an advanced practice registered nurse licensed in accordance with the provisions of chapter 378 and reviewed by such physician or advanced practice registered nurse at least every thirty days to determine that continuation of such services are medically necessary for the rehabilitation of the patient: (A) Physician services, physical and occupational therapy, nursing care, psychological and audiological services and speech therapy provided by health care professionals who are licensed by the appropriate state licensing authority to perform

such services; (B) social services by a social worker holding a master's degree from an accredited school of social work; (C) respiratory therapy by a certified respiratory therapist; (D) prescription drugs and medicines which cannot be self-administered; (E) prosthetic and orthotic devices, including the testing, fitting or instruction in the use of such devices; (F) other supplies or services prescribed by a physician or an advanced practice registered nurse for the rehabilitation of a patient and ordinarily furnished by a comprehensive rehabilitation facility.

(2) "Comprehensive rehabilitation facility" means a facility **[**which**]** that is: (A) Primarily engaged in providing diagnostic, therapeutic and restorative services through such licensed health care professionals to injured, ill or disabled individuals solely on an outpatient basis and (B) accredited for the provision of such services by the Commission on Accreditation for Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

Sec. 69. Subsection (a) of section 38a-524 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) For the purposes of this section:

(1) "Occupational therapy" means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a physician licensed in accordance with the provisions of chapter 370 or an advanced practice registered nurse licensed in accordance with the provisions of chapter 378, who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility. Such plan shall be reviewed and certified at least every two months by such physician or advanced practice registered nurse.

(2) "Health care facility" means an institution which provides

occupational therapy, including, but not limited to, an outpatient clinic, a rehabilitative agency and a skilled or intermediate nursing facility.

(3) "Rehabilitative agency" means an agency which provides an integrated multitreatment program designed to upgrade the function of handicapped disabled individuals by bringing together, as a team, specialized personnel from various allied health fields.

(4) "Partial hospitalization" means a formal program of care provided in a hospital or facility for periods of less than twenty-four hours a day.

Sec. 70. Subsection (b) of section 42-282 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(b) Each diet program contract shall provide the consumer with (1) the right to cancel such contract, without liability, within three business days after the date of receipt by the consumer of a copy of the signed contract; (2) the estimated duration of the diet program necessary to achieve the desired weight loss and all estimated costs of the contract, including, but not limited to, the contract price and the estimated monthly cost of any goods or services required to be purchased under the contract; (3) a list of dietitian-nutritionists, advanced practice registered nurses, registered nurses, physicians or physician assistants employed by or under contract with the diet company who are licensed or certified by the Commissioner of Public Health and who monitor the consumer during the diet program; and (4) the right to cancel the contract if (A) the consumer provides a letter from a <u>licensed</u> physician <u>or a licensed advanced practice registered nurse</u> indicating that continuation of the diet program is adverse to the health of the consumer or (B) the consumer relocates his residence further than twenty-five miles from any facility which the consumer is required to attend under the diet program. If a diet program contract is cancelled by the consumer pursuant to subdivision (4) of this

subsection, the consumer shall be reimbursed on a pro-rata basis for the portion of the contract price paid by the consumer that is attributable to the unused contract period.

Sec. 71. Subsection (i) of section 47-88b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(i) After the conversion of a dwelling unit in a building to condominium ownership, the declarant or unit owner, for the purpose of determining if a lessee's eviction is prohibited under subsection (b) of section 47a-23c, may ask any lessee to provide proof of the age, blindness or physical disability of such lessee or any person residing with him, or of the familial relationship existing between such lessee and any person residing with him. The lessee shall provide such proof, including a statement of a physician or an advanced practice registered nurse in the case of alleged blindness or physical disability, within thirty days.

Sec. 72. Subsection (d) of section 47a-23c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(d) A landlord, to determine whether a tenant is a protected tenant, may request proof of such protected status. On such request, any tenant claiming protection shall provide proof of the protected status within thirty days. The proof shall include a statement of a physician or an advanced practice registered nurse in the case of alleged blindness or other physical disability.

Sec. 73. Subsection (c) of section 51-217 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) The Jury Administrator shall have the authority to establish and maintain a list of persons to be excluded from the summoning process, which shall consist of (1) persons who are disqualified from serving on

jury duty on a permanent basis due to a disability for which a licensed physician or an advanced practice registered nurse has submitted a letter stating the physician's or advanced practice registered nurse's opinion that such disability permanently prevents the person from rendering satisfactory jury service, (2) persons seventy years of age or older who have requested not to be summoned, (3) elected officials enumerated in subdivision (4) of subsection (a) of this section and judges enumerated in subdivision (5) of subsection (a) of this section during their term of office, and (4) persons excused from jury service pursuant to section 51-217a who have not requested to be summoned for jury service pursuant to said section. Persons requesting to be excluded pursuant to subdivisions (1) and (2) of this subsection must provide the Jury Administrator with their names, addresses, dates of birth and federal Social Security numbers for use in matching. The request to be excluded may be rescinded at any time with written notice to the Jury Administrator.

Sec. 74. Section 54-204 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Any person who may be eligible for compensation or restitution services, or both, pursuant to sections 54-201 to 54-233, inclusive, may make application therefor to the Office of Victim Services. If the person entitled to make application is a minor or incompetent person, the application may be made on such person's behalf by a parent, guardian or other legal representative of the minor or incompetent person.

(b) In order to be eligible for compensation or restitution services under sections 54-201 to 54-233, inclusive, the applicant shall prior to a determination on any application made pursuant to sections 54-201 to 54-233, inclusive, submit reports if reasonably available from all physicians or surgeons or advanced practice registered nurses who have treated or examined the victim in relation to the injury for which compensation is claimed at the time of or subsequent to the victim's injury or death. If in the opinion of the Office of Victim Services or, on

review, a victim compensation commissioner, reports on the previous medical history of the victim, examination of the injured victim and a report thereon or a report on the cause of death of the victim by an impartial medical expert would be of material aid to its just determination, said office or commissioner shall order such reports and examinations. Any information received which is confidential in accordance with any provision of the general statutes shall remain confidential while in the custody of the Office of Victim Services or a victim compensation commissioner.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2016*	1-350i(b)
Sec. 2	*October 1, 2016*	3-39j
Sec. 3	*October 1, 2016*	3-123aa(b)
Sec. 4	*October 1, 2016*	5-248a(c) and (d)
Sec. 5	*October 1, 2016*	10-183b(16)
Sec. 6	*October 1, 2016*	10-212a(e) and (f)
Sec. 7	*October 1, 2016*	10-220j
Sec. 8	*October 1, 2016*	10-305
Sec. 9	*October 1, 2016*	14-44(b)
Sec. 10	*October 1, 2016*	14-73(b)
Sec. 11	*October 1, 2016*	14-100a(c)(2)
Sec. 12	*October 1, 2016*	14-286(c)
Sec. 13	*October 1, 2016*	14-314c
Sec. 14	*October 1, 2016*	17b-261p(f)
Sec. 15	*October 1, 2016*	18-94
Sec. 16	*October 1, 2016*	19a-12e(h)
Sec. 17	*October 1, 2016*	19a-262
Sec. 18	*October 1, 2016*	19a-535
Sec. 19	*October 1, 2016*	19a-550
Sec. 20	*October 1, 2016*	19a-571
Sec. 21	*October 1, 2016*	19a-580d
Sec. 22	*October 1, 2016*	19a-582(d)
Sec. 23	*October 1, 2016*	19a-592
Sec. 24	*October 1, 2016*	20-7h
Sec. 25	*October 1, 2016*	19a-580
Sec. 26	*October 1, 2016*	20-14m

Sec. 27	*October 1, 2016*	20-162n
Sec. 28	*October 1, 2016*	20-206q
Sec. 29	*October 1, 2016*	20-206jj
Sec. 30	*October 1, 2016*	20-41a(e)
Sec. 31	*October 1, 2016*	20-73b(c)
Sec. 32	*October 1, 2016*	20-74ff(f)
Sec. 33	*October 1, 2016*	20-126c(f)
Sec. 34	*October 1, 2016*	20-126l(i)
Sec. 35	*October 1, 2016*	20-132a(e)
Sec. 36	*October 1, 2016*	20-162r(e)
Sec. 37	*October 1, 2016*	20-191c(d)
Sec. 38	*October 1, 2016*	20-201a(f)
Sec. 39	*October 1, 2016*	20-206bb(e)(3)
Sec. 40	*October 1, 2016*	20-395d(f)
Sec. 41	*October 1, 2016*	20-402(b)(3)
Sec. 42	*October 1, 2016*	20-411a(f)
Sec. 43	*October 1, 2016*	21a-217
Sec. 44	*October 1, 2016*	21a-218(a) to (c)
Sec. 45	*October 1, 2016*	21a-246(a)
Sec. 46	*October 1, 2016*	21a-253
Sec. 47	*October 1, 2016*	21a-408
Sec. 48	*October 1, 2016*	21a-408a(a)
Sec. 49	*October 1, 2016*	21a-408c
Sec. 50	*October 1, 2016*	21a-408d
Sec. 51	*October 1, 2016*	21a-408m(a)
Sec. 52	*October 1, 2016*	21a-408n
Sec. 53	*October 1, 2016*	22a-616(b)
Sec. 54	*October 1, 2016*	26-29a
Sec. 55	*October 1, 2016*	26-29b
Sec. 56	*October 1, 2016*	27-140ee
Sec. 57	*October 1, 2016*	29-143t
Sec. 58	*October 1, 2016*	31-40a
Sec. 59	*October 1, 2016*	38a-489
Sec. 60	*October 1, 2016*	38a-492m
Sec. 61	*October 1, 2016*	38a-493
Sec. 62	*October 1, 2016*	38a-495
Sec. 63	*October 1, 2016*	38a-496(a)
Sec. 64	*October 1, 2016*	38a-515
Sec. 65	*October 1, 2016*	38a-518*l*
Sec. 66	*October 1, 2016*	38a-520

Sec. 67	*October 1, 2016*	38a-522
Sec. 68	*October 1, 2016*	38a-523(a)
Sec. 69	*October 1, 2016*	38a-524(a)
Sec. 70	*October 1, 2016*	42-282(b)
Sec. 71	*October 1, 2016*	47-88b(i)
Sec. 72	*October 1, 2016*	47a-23c(d)
Sec. 73	*October 1, 2016*	51-217(c)
Sec. 74	*October 1, 2016*	54-204

Statement of Legislative Commissioners:

In Section 11(c)(2)(A), "or an advanced" was changed to "or a licensed advanced" for internal consistency; in three places in Section 22(d)(5), "his" was changed to "his or her" for internal and statutory consistency; in Section 22(d)(8), "he" was changed to "he or she" for internal and statutory consistency; in Section 27(b), "said physician" was changed to "**[**said**]** such physician" for consistency with the drafting conventions of the general statutes; in Section 18(b)(1) and (e), Section 61(c), (f) and (i), Section 62(b), Section 66(c), (f) and (i), and Section 68(a)(2), "which" was changed to "**[**which**]** that" for internal consistency; in Section 26(a)(2), in three places in Section 28, and in Section 57(b), "or advanced practice" was changed to "or an advanced practice" for internal consistency.

PH *Joint Favorable Subst.*