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LEGISLATIVE ACTION

| Senate | . | House |
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| Floor: WD | . | |
| 04/28/2025 06:01 PM | . | |
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Senator Collins moved the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause and insert:

Section 1. Effective upon becoming a law, or, if this act fails to become a law until after June 1, 2025, operating retroactively to June 1, 2025, section 9 of chapter 2023-43, Laws of Florida, is amended to read:

Section 9. Sections 381.00316(2)(g) and 381.00319(1)(e), Florida Statutes, as created by this act, are repealed June 1, 2027 ~~2025~~.

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Section 2. Effective upon becoming a law, or, if this act fails to become a law until after June 1, 2025, operating retroactively to June 1, 2025, paragraph (g) of subsection (2) of section 381.00316, Florida Statutes, is reenacted to read:

381.00316 Discrimination by governmental and business entities based on health care choices; prohibition.—

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

(g) "Messenger ribonucleic acid vaccine" means any vaccine that uses laboratory-produced messenger ribonucleic acid to trigger the human body's immune system to generate an immune response.

Section 3. Effective upon becoming a law, or, if this act fails to become a law until after June 1, 2025, operating retroactively to June 1, 2025, paragraph (e) of subsection (1) of section 381.00319, Florida Statutes, is reenacted to read:

381.00319 Prohibition on mask mandates and vaccination and testing mandates for educational institutions.—

(1) For purposes of this section, the term:

(e) "Messenger ribonucleic acid vaccine" has the same meaning as in s. 381.00316.

Section 4. Paragraphs (b) and (d) of subsection (4) and subsection (6) of section 381.026, Florida Statutes, are amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(4) RIGHTS OF PATIENTS.—Each health care facility or provider shall observe the following standards:

(b) *Information.*—

1. A patient has the right to know the name, function, and

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qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak

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English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

8. A health care provider or health care facility shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care provider or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or safety of others, may make such a verbal or written inquiry.

9. A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

10. A health care provider or health care facility may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

11. A health care provider or health care facility shall respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about

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firearm ownership during an examination.

12. A health care provider or health care facility may not discriminate against a patient based solely upon the patient's vaccination status.

(d) *Access to health care.*—

1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, vaccination status, or source of payment.

2. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.

3. A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with the provisions of s. 456.41.

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.—Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL
OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care

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provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot


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be reasonably accommodated by the facility or provider.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, <u>vaccination status,</u> or source of payment.

A patient has the right to treatment for any

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emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments

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and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Section 5. Paragraphs (b), (e), and (f) of subsection (8) of section 381.986, Florida Statutes, are amended to read:

381.986 Medical use of marijuana.—

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(b) An applicant for licensure as a medical marijuana treatment center must ~~shall~~ apply to the department on a form prescribed by the department and adopted in rule. The department shall adopt rules pursuant to ss. 120.536(1) and 120.54 establishing a procedure for the issuance and biennial renewal of licenses, including initial application and biennial renewal fees sufficient to cover the costs of implementing and administering this section, and establishing supplemental licensure fees for payment beginning May 1, 2018, sufficient to cover the costs of administering ss. 381.989 and 1004.4351. The department shall identify applicants with strong diversity plans reflecting this state's commitment to diversity and implement

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training programs and other educational programs to enable minority persons and minority business enterprises, as defined in s. 288.703, and veteran business enterprises, as defined in s. 295.187, to compete for medical marijuana treatment center licensure and contracts. Subject to the requirements in subparagraphs (a)2.-4., the department shall issue a license to an applicant if the applicant meets the requirements of this section and pays the initial application fee. The department shall renew the licensure of a medical marijuana treatment center biennially if the licensee meets the requirements of this section and pays the biennial renewal fee. However, the department may not renew the license of a medical marijuana treatment center that has not begun to cultivate, process, and dispense marijuana by the date that the medical marijuana treatment center is required to renew its license. An individual may not be an applicant, owner, officer, board member, or manager on more than one application for licensure as a medical marijuana treatment center. An individual or entity may not be awarded more than one license as a medical marijuana treatment center. An applicant for licensure as a medical marijuana treatment center must demonstrate:

1. That, for the 5 consecutive years before submitting the application, the applicant has been registered to do business in this ~~the~~ state.

2. Possession of a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131.

3. The technical and technological ability to cultivate and produce marijuana, including, but not limited to, low-THC

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cannabis.

4. The ability to secure the premises, resources, and personnel necessary to operate as a medical marijuana treatment center.

5. The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

6. An infrastructure reasonably located to dispense marijuana to registered qualified patients statewide or regionally as determined by the department.

7. The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financial statements to the department.

a. Upon approval, the applicant must post a $5 million performance bond issued by an authorized surety insurance company rated in one of the three highest rating categories by a nationally recognized rating service. However, a medical marijuana treatment center serving at least 1,000 qualified patients is only required to maintain a $2 million performance bond.

b. In lieu of the performance bond required under sub-subparagraph a., the applicant may provide an irrevocable letter of credit payable to the department or provide cash to the department. If provided with cash under this sub-subparagraph, the department must ~~shall~~ deposit the cash in the Grants and Donations Trust Fund within the Department of Health, subject to the same conditions as the bond regarding requirements for the applicant to forfeit ownership of the funds. If the funds

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deposited under this sub-subparagraph generate interest, the amount of that interest must ~~shall~~ be used by the department for the administration of this section.

8. That all owners~~, officers, board members,~~ and managers have passed a background screening pursuant to subsection (9). As used in this subparagraph, the term:

a. "Manager" means any person with the authority to exercise or contribute to the operational control, direction, or management of an applicant or a medical marijuana treatment center or who has authority to supervise any employee of an applicant or a medical marijuana treatment center. The term includes an individual with the power or authority to direct or influence the direction or operation of an applicant or a medical marijuana treatment center through board membership, an agreement, or a contract.

b. "Owner" means any person who owns or controls a 5 percent or greater share of interests of the applicant or a medical marijuana treatment center which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the voting rights with respect to such interests, then in such case, both are considered the owner of such interests.

9. The employment of a medical director to supervise the activities of the medical marijuana treatment center.

10. A diversity plan that promotes and ensures the involvement of minority persons and minority business enterprises, as defined in s. 288.703, or veteran business enterprises, as defined in s. 295.187, in ownership, management, and employment. An applicant for licensure renewal must show the

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effectiveness of the diversity plan by including the following with his or her application for renewal:

a. Representation of minority persons and veterans in the medical marijuana treatment center's workforce;

b. Efforts to recruit minority persons and veterans for employment; and

c. A record of contracts for services with minority business enterprises and veteran business enterprises.

(e) A licensed medical marijuana treatment center shall cultivate, process, transport, and dispense marijuana for medical use. A licensed medical marijuana treatment center may not contract for services directly related to the cultivation, processing, and dispensing of marijuana or marijuana delivery devices, except that a medical marijuana treatment center licensed pursuant to subparagraph (a)1. may contract with a single entity for the cultivation, processing, transporting, and dispensing of marijuana and marijuana delivery devices. A licensed medical marijuana treatment center shall ~~must~~, at all times, maintain compliance with the criteria demonstrated and representations made in the initial application and the criteria established in this subsection. Upon request, the department may grant a medical marijuana treatment center a variance from the representations made in the initial application. Consideration of such a request must ~~shall~~ be based upon the individual facts and circumstances surrounding the request. A variance may not be granted unless the requesting medical marijuana treatment center can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the

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specific representation in a way that the department can reasonably determine will not be a lower standard than the specific representation in the application. A variance may not be granted from the requirements in subparagraph 2. and subparagraphs (b)1. and 2.

1. A licensed medical marijuana treatment center may transfer ownership to an individual or entity who meets the requirements of this section. A publicly traded corporation or publicly traded company that meets the requirements of this section is not precluded from ownership of a medical marijuana treatment center. To accommodate a change in ownership:

a. The licensed medical marijuana treatment center shall notify the department in writing at least 60 days before the anticipated date of the change of ownership.

b. The individual or entity applying for initial licensure due to a change of ownership must submit an application that must be received by the department at least 60 days before the date of change of ownership.

c. Upon receipt of an application for a license, the department shall examine the application and, within 30 days after receipt, notify the applicant in writing of any apparent errors or omissions and request any additional information required.

d. Requested information omitted from an application for licensure must be filed with the department within 21 days after the department’s request for omitted information or the application will ~~shall~~ be deemed incomplete and ~~shall be~~ withdrawn from further consideration and the fees ~~shall be~~ forfeited.


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e. Within 30 days after the receipt of a complete application, the department shall approve or deny the application.

2. A medical marijuana treatment center, and any individual or entity who directly or indirectly owns, controls, or holds with power to vote 5 percent or more of the voting shares of a medical marijuana treatment center, may not acquire direct or indirect ownership or control of any voting shares or other form of ownership of any other medical marijuana treatment center.

3. A medical marijuana treatment center may not enter into any form of profit-sharing arrangement with the property owner or lessor of any of its facilities where cultivation, processing, storing, or dispensing of marijuana and marijuana delivery devices occurs.

4. All employees of a medical marijuana treatment center must be 21 years of age or older and have passed a background screening pursuant to subsection (9). As used in this subparagraph, the term "employee" means any person employed by a medical marijuana treatment center licensee in any capacity, including those whose duties involve any aspect of the cultivation, processing, transportation, or dispensing of marijuana. This requirement applies to all employees, regardless of the compensation received.

5. Each medical marijuana treatment center must adopt and enforce policies and procedures to ensure employees and volunteers receive training on the legal requirements to dispense marijuana to qualified patients.

6. When growing marijuana, a medical marijuana treatment center:

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a. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

b. Must grow marijuana within an enclosed structure and in a room separate from any other plant.

c. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state in accordance with chapter 581 and any rules adopted thereunder.

d. Must perform fumigation or treatment of plants, or remove and destroy infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

7. Each medical marijuana treatment center must produce and make available for purchase at least one low-THC cannabis product.

8. A medical marijuana treatment center that produces edibles must hold a permit to operate as a food establishment pursuant to chapter 500, the Florida Food Safety Act, and must comply with all the requirements for food establishments pursuant to chapter 500 and any rules adopted thereunder. Edibles may not contain more than 200 milligrams of tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may <u>not</u> have a potency variance ~~of no~~ greater than 15 percent. Marijuana products, including edibles, may not be attractive to children; be manufactured in the shape of humans, cartoons, or animals; be manufactured in a form that bears any reasonable

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resemblance to products available for consumption as commercially available candy; or contain any color additives. To discourage consumption of edibles by children, the department shall determine by rule any shapes, forms, and ingredients allowed and prohibited for edibles. Medical marijuana treatment centers may not begin processing or dispensing edibles until after the effective date of the rule. The department shall also adopt sanitation rules providing the standards and requirements for the storage, display, or dispensing of edibles.

9. Within 12 months after licensure, a medical marijuana treatment center must demonstrate to the department that all of its processing facilities have passed a Food Safety Good Manufacturing Practices, such as Global Food Safety Initiative or equivalent, inspection by a nationally accredited certifying body. A medical marijuana treatment center must immediately stop processing at any facility which fails to pass this inspection until it demonstrates to the department that such facility has met this requirement.

10. A medical marijuana treatment center that produces prerolled marijuana cigarettes may not use wrapping paper made with tobacco or hemp.

11. When processing marijuana, a medical marijuana treatment center must:

a. Process the marijuana within an enclosed structure and in a room separate from other plants or products.

b. Comply with department rules when processing marijuana with hydrocarbon solvents or other solvents or gases exhibiting potential toxicity to humans. The department shall determine by rule the requirements for medical marijuana treatment centers to


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use such solvents or gases exhibiting potential toxicity to humans.

c. Comply with federal and state laws and regulations and department rules for solid and liquid wastes. The department shall determine by rule procedures for the storage, handling, transportation, management, and disposal of solid and liquid waste generated during marijuana production and processing. The Department of Environmental Protection shall assist the department in developing such rules.

d. Test the processed marijuana using a medical marijuana testing laboratory before it is dispensed. Results must be verified and signed by two medical marijuana treatment center employees. Before dispensing, the medical marijuana treatment center must determine that the test results indicate that low-THC cannabis meets the definition of low-THC cannabis, the concentration of tetrahydrocannabinol meets the potency requirements of this section, the labeling of the concentration of tetrahydrocannabinol and cannabidiol is accurate, and all marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption. The department shall determine by rule which contaminants must be tested for and the maximum levels of each contaminant which are safe for human consumption. The Department of Agriculture and Consumer Services shall assist the department in developing the testing requirements for contaminants that are unsafe for human consumption in edibles. The department shall also determine by rule the procedures for the treatment of marijuana that fails to meet the testing requirements of this section, s. 381.988, or department rule. The department may select samples of marijuana

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from a medical marijuana treatment center facility which shall be tested by the department to determine whether the marijuana meets the potency requirements of this section, is safe for human consumption, and is accurately labeled with the tetrahydrocannabinol and cannabidiol concentration or to verify the result of marijuana testing conducted by a marijuana testing laboratory. The department may also select samples of marijuana delivery devices from a medical marijuana treatment center to determine whether the marijuana delivery device is safe for use by qualified patients. A medical marijuana treatment center may not require payment from the department for the sample. A medical marijuana treatment center must recall marijuana, including all marijuana and marijuana products made from the same batch of marijuana, that fails to meet the potency requirements of this section, that is unsafe for human consumption, or for which the labeling of the tetrahydrocannabinol and cannabidiol concentration is inaccurate. The department shall adopt rules to establish marijuana potency variations of no greater than 15 percent using negotiated rulemaking pursuant to s. 120.54(2)(d) which accounts for, but is not limited to, time lapses between testing, testing methods, testing instruments, and types of marijuana sampled for testing. The department may not issue any recalls for product potency as it relates to product labeling before issuing a rule relating to potency variation standards. A medical marijuana treatment center must also recall all marijuana delivery devices determined to be unsafe for use by qualified patients. The medical marijuana treatment center must retain records of all testing and samples of each homogeneous batch of marijuana for

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at least 9 months. The medical marijuana treatment center must contract with a marijuana testing laboratory to perform audits on the medical marijuana treatment center's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the marijuana or low-THC cannabis meets the requirements of this section and that the marijuana or low-THC cannabis is safe for human consumption. A medical marijuana treatment center shall reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of such audits. A medical marijuana treatment center may use a laboratory that has not been certified by the department under s. 381.988 until such time as at least one laboratory holds the required certification, but in no event later than July 1, 2018.

e. Package the marijuana in compliance with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq.

f. Package the marijuana in a receptacle that has a firmly affixed and legible label stating the following information:

(I) The marijuana or low-THC cannabis meets the requirements of sub-subparagraph d.

(II) The name of the medical marijuana treatment center from which the marijuana originates.

(III) The batch number and harvest number from which the marijuana originates and the date dispensed.

(IV) The name of the physician who issued the physician certification.

(V) The name of the patient.

(VI) The product name, if applicable, and dosage form,

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including concentration of tetrahydrocannabinol and cannabidiol. The product name may not contain wording commonly associated with products that are attractive to children or which promote the recreational use of marijuana.

(VII) The recommended dose.

(VIII) A warning that it is illegal to transfer medical marijuana to another person.

(IX) A marijuana universal symbol developed by the department.

12. The medical marijuana treatment center shall include in each package a patient package insert with information on the specific product dispensed related to:

a. Clinical pharmacology.

b. Indications and use.

c. Dosage and administration.

d. Dosage forms and strengths.

e. Contraindications.

f. Warnings and precautions.

g. Adverse reactions.

13. In addition to the packaging and labeling requirements specified in subparagraphs 11. and 12., marijuana in a form for smoking must be packaged in a sealed receptacle with a legible and prominent warning to keep away from children and a warning that states marijuana smoke contains carcinogens and may negatively affect health. Such receptacles for marijuana in a form for smoking must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center’s department-approved logo and the marijuana universal symbol.

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14. The department shall adopt rules to regulate the types, appearance, and labeling of marijuana delivery devices dispensed from a medical marijuana treatment center. The rules must require marijuana delivery devices to have an appearance consistent with medical use.

15. Each edible must be individually sealed in plain, opaque wrapping marked only with the marijuana universal symbol. Where practical, each edible must be marked with the marijuana universal symbol. In addition to the packaging and labeling requirements in subparagraphs 11. and 12., edible receptacles must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol. The receptacle must also include a list of all the edible's ingredients, storage instructions, an expiration date, a legible and prominent warning to keep away from children and pets, and a warning that the edible has not been produced or inspected pursuant to federal food safety laws.

16. When dispensing marijuana or a marijuana delivery device, a medical marijuana treatment center:

a. May dispense any active, valid order for low-THC cannabis, medical cannabis and cannabis delivery devices issued pursuant to former s. 381.986, Florida Statutes 2016, which was entered into the medical marijuana use registry before July 1, 2017.

b. May not dispense more than a 70-day supply of marijuana within any 70-day period to a qualified patient or caregiver. May not dispense more than one 35-day supply of marijuana in a form for smoking within any 35-day period to a qualified patient

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or caregiver. A 35-day supply of marijuana in a form for smoking may not exceed 2.5 ounces unless an exception to this amount is approved by the department pursuant to paragraph (4)(f).

c. Must have the medical marijuana treatment center's employee who dispenses the marijuana or a marijuana delivery device enter into the medical marijuana use registry his or her name or unique employee identifier.

d. Must verify that the qualified patient and the caregiver, if applicable, each have an active registration in the medical marijuana use registry and an active and valid medical marijuana use registry identification card, the amount and type of marijuana dispensed matches the physician certification in the medical marijuana use registry for that qualified patient, and the physician certification has not already been filled.

e. May not dispense marijuana to a qualified patient who is younger than 18 years of age. If the qualified patient is younger than 18 years of age, marijuana may only be dispensed to the qualified patient's caregiver.

f. May not dispense or sell any other type of cannabis, alcohol, or illicit drug-related product, including pipes or wrapping papers made with tobacco or hemp, other than a marijuana delivery device required for the medical use of marijuana and which is specified in a physician certification.

g. Must, upon dispensing the marijuana or marijuana delivery device, record in the registry the date, time, quantity, and form of marijuana dispensed; the type of marijuana delivery device dispensed; and the name and medical marijuana use registry identification number of the qualified patient or

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caregiver to whom the marijuana delivery device was dispensed.

h. Must ensure that patient records are not visible to anyone other than the qualified patient, his or her caregiver, and authorized medical marijuana treatment center employees.

(f) To ensure the safety and security of premises where the cultivation, processing, storing, or dispensing of marijuana occurs, and to maintain adequate controls against the diversion, theft, and loss of marijuana or marijuana delivery devices, a medical marijuana treatment center shall:

1.a. Maintain a fully operational security alarm system that secures all entry points and perimeter windows and is equipped with motion detectors; pressure switches; and duress, panic, and hold-up alarms; and

b. Maintain a video surveillance system that records continuously 24 hours a day and meets the following criteria:

(I) Cameras are fixed in a place that allows for the clear identification of persons and activities in controlled areas of the premises. Controlled areas include grow rooms, processing rooms, storage rooms, disposal rooms or areas, and point-of-sale rooms.

(II) Cameras are fixed in entrances and exits to the premises, which must ~~shall~~ record from both indoor and outdoor, or ingress and egress, vantage points.

(III) Recorded images must clearly and accurately display the time and date.

(IV) Retain video surveillance recordings for at least 45 days or longer upon the request of a law enforcement agency.

2. Ensure that the medical marijuana treatment center's outdoor premises have sufficient lighting from dusk until dawn.

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3. Ensure that the indoor premises where dispensing occurs includes a waiting area with sufficient space and seating to accommodate qualified patients and caregivers and at least one private consultation area that is isolated from the waiting area and area where dispensing occurs. A medical marijuana treatment center may not display products or dispense marijuana or marijuana delivery devices in the waiting area.

4. Not dispense from its premises marijuana or a marijuana delivery device between the hours of 9 p.m. and 7 a.m., but may perform all other operations and deliver marijuana to qualified patients 24 hours a day.

5. Store marijuana in a secured, locked room or a vault.

6. Require at least two of its employees, or two employees of a security agency with whom it contracts, to be on the premises at all times where cultivation, processing, or storing of marijuana occurs.

7. Require each employee or contractor to wear a photo identification badge at all times while on the premises.

8. Require each visitor to wear a visitor pass at all times while on the premises.

9. Implement an alcohol and drug-free workplace policy.

10. Report to local law enforcement and notify the department through e-mail within 24 hours after the medical marijuana treatment center is notified or becomes aware of any actual or attempted ~~the~~ theft, diversion, or loss of marijuana.

Section 6. Paragraph (d) of subsection (1) of section 381.988, Florida Statutes, is amended to read:

381.988 Medical marijuana testing laboratories; marijuana tests conducted by a certified laboratory.—

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(1) A person or entity seeking to be a certified marijuana testing laboratory must:

(d) Require all employees, owners, and managers to submit to and pass a level 2 background screening pursuant to chapter 435. The department shall deny certification if the person or entity seeking certification has a disqualifying offense as provided in s. 435.04 or has an arrest awaiting final disposition for, has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in chapter 837, chapter 895, or chapter 896 or similar law of another jurisdiction. Exemptions from disqualification as provided under s. 435.07 do not apply to this paragraph.

1. As used in this paragraph, the term:

a. "Employee" means any person whose duties or activities involve any aspect of regulatory compliance testing or research and development testing of marijuana for a certified marijuana testing laboratory, regardless of whether such person is compensated for his or her work.

b. "Manager" means any person with authority to exercise or contribute to the operational control, direction, or management of an applicant or certified marijuana testing laboratory or who has authority to supervise any employee of an applicant or a certified marijuana testing laboratory. The term includes an individual with the power or authority to direct or influence the direction or operation of an applicant or a certified marijuana testing laboratory through board membership, an agreement, or a contract.

c. "Owner" means any person who owns or controls a 5

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percent or greater share of interests of the applicant or a certified marijuana testing laboratory which include beneficial or voting rights to interests. In the event that one person owns a beneficial right to interests and another person holds the voting rights with respect to such interests, then in such case, both are considered the owner of such interests.

2. Such employees, owners, and managers must submit a full set of fingerprints to the department or to a vendor, entity, or agency authorized by s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing.

3.~~2.~~ Fees for state and federal fingerprint processing and retention must ~~shall~~ be borne by the certified marijuana testing laboratory. The state cost for fingerprint processing is ~~shall be~~ as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein.

4.~~3.~~ Fingerprints submitted to the Department of Law Enforcement pursuant to this paragraph must ~~shall~~ be retained by the Department of Law Enforcement as provided in s. 943.05(2)(g) and (h) and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's national retained print arrest notification program. Any arrest record identified must ~~shall~~ be reported to the department.

Section 7. Paragraphs (a) and (c) of subsection (2) of section 456.0145, Florida Statutes, are amended to read:

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456.0145 Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.—

(2) LICENSURE BY ENDORSEMENT.—

(a) An applicable board, or the department if there is no board, shall issue a license to practice in this state to an applicant who meets all of the following criteria:

1. Submits a complete application.

2. Holds an active, unencumbered license issued by another state, the District of Columbia, or a territory of the United States in a profession with a similar scope of practice, as determined by the board or department, as applicable. The term "scope of practice" means the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license issued in this state.

3.a. Has obtained a passing score on a national licensure examination or holds a national certification recognized by the board, or the department if there is no board, as applicable to the profession for which the applicant is seeking licensure in this state; or

b. Meets the requirements of paragraph (b).

4. Has actively practiced the profession for which the applicant is applying for at least 2 ~~3~~ years during the 4-year period immediately preceding the date of submission of the application.

5. Attests that he or she is not, at the time of submission of the application, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the United States Department of Defense for reasons related to the

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practice of the profession for which he or she is applying.

6. Has not had disciplinary action taken against him or her in the 5 years immediately preceding the date of submission of the application.

7. Meets the financial responsibility requirements of s. 456.048 or the applicable practice act, if required for the profession for which the applicant is seeking licensure.

8. Submits a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

The department shall verify information submitted by the applicant under this subsection using the National Practitioner Data Bank, as applicable.

(c) A person is ineligible for a license under this section if he or she:

1. Has a complaint, an allegation, or an investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;

2. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

3. Has had a health care provider license revoked or suspended by another state, the District of Columbia, or a territory of the United States, or has voluntarily surrendered any such license in lieu of having disciplinary action taken against the license; or

4. Has been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his

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or her name removed from the data bank. If the reported adverse action was a result of conduct that would not constitute a violation of any law or rule in this state, the board, or the department if there is no board, may:

a. Approve the application;

b. Approve the application with restrictions on the scope of practice of the licensee;

c. Approve the application with placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department if there is no board, may specify, including, but not limited to, requiring the applicant to submit to treatment, attend continuing education courses, or submit to reexamination; or

d. Deny the application.

Section 8. Paragraph (d) of subsection (1) and subsection (3) of section 456.44, Florida Statutes, are amended to read:

456.44 Controlled substance prescribing.—

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

(d) "Board-certified pain management physician" means a physician who possesses board certification in pain medicine by the American Board of Pain Medicine, board certification by the American Board of Interventional Pain Physicians, or board certification or subcertification in pain management or pain medicine by a specialty board recognized by the American Board of Physician Specialties ~~American Association of Physician Specialists~~ or the American Board of Medical Specialties or an osteopathic physician who holds a certificate in Pain Management by the American Osteopathic Association.

(3) STANDARDS OF PRACTICE FOR TREATMENT OF CHRONIC

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NONMALIGNANT PAIN.—The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient’s risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient’s risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant shall adjust drug therapy to the

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individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient is incompetent. The registrant shall use a written controlled substance agreement between the registrant and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant unless otherwise authorized by the treating registrant and documented in the medical record.

(d) The patient shall be seen by the registrant at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy

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shall depend on the registrant's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant shall reevaluate the appropriateness of continued treatment. The registrant shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or a psychiatrist.

(f) A registrant must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

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6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient’s government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant’s full name presented in a legible manner.

(g) A registrant shall immediately refer patients with signs or symptoms of substance abuse to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant’s report, a prescribing registrant shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant’s written report, the prescribing registrant shall incorporate the consultant’s recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient’s medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of

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controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Board of Physician Specialties ~~American Association of Physician Specialists~~, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

Section 9. Paragraph (i) of subsection (1) of section 458.3145, Florida Statutes, is amended to read:

458.3145 Medical faculty certificate.—

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

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

1. The University of Florida.
2. The University of Miami.
3. The University of South Florida.
4. The Florida State University.
5. The Florida International University.
6. The University of Central Florida.
7. The Mayo Clinic College of Medicine and Science in Jacksonville, Florida.
8. The Florida Atlantic University.
9. The Johns Hopkins All Children's Hospital in St. Petersburg, Florida.
10. Nova Southeastern University.
11. Lake Erie College of Osteopathic Medicine in Bradenton, Florida.
12. Burrell College of Osteopathic Medicine in Melbourne, Florida.
13. The Orlando College of Osteopathic Medicine.
14. Lincoln Memorial University-DeBusk College of Osteopathic Medicine in Orange Park, Florida.

Section 10. Subsection (1) of section 458.315, Florida Statutes, is amended to read:

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

(1) A physician ~~or physician assistant who is~~ licensed to practice in any jurisdiction of the United States ~~and~~ whose license is currently valid may be issued a temporary certificate

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for practice in areas of critical need. A physician seeking such certificate must pay an application fee of $300. A physician assistant licensed to practice in any state of the United States or the District of Columbia whose license is currently valid may be issued a temporary certificate for practice in areas of critical need.

Section 11. Subsection (1) of section 459.0076, Florida Statutes, is amended to read:

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

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

Section 12. Paragraph (a) of subsection (1) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

(1) REGISTRATION.—

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

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

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b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2).

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m) and must apply to the department for a certificate of exemption:

a. A clinic licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A clinic owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A clinic affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A clinic that does not prescribe controlled substances

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for the treatment of pain;

f. A clinic owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A clinic wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A clinic wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Board of Physician Specialties ~~American Association of Physician Specialists~~, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

Section 13. Paragraph (a) of subsection (1) of section 458.3475, Florida Statutes, is amended to read:

458.3475 Anesthesiologist assistants.—

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

(a) "Anesthesiologist" means an allopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education or its equivalent; and who is certified by the American Board of Anesthesiology, is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Board of Physician Specialties

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~~American Association of Physician Specialists~~.

Section 14. Paragraph (a) of subsection (1) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

(1) REGISTRATION.—

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

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2).

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m) and must apply to the department for a certificate of exemption:

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a. A clinic licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A clinic owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A clinic affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A clinic that does not prescribe controlled substances for the treatment of pain;

f. A clinic owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A clinic wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A clinic wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the <u>American Board of Physician Specialties</u> ~~American Association of Physician Specialists~~, or the American Osteopathic Association, perform interventional pain procedures of the type routinely

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billed using surgical codes.

Section 15. Paragraph (a) of subsection (1) of section 459.023, Florida Statutes, is amended to read:

459.023 Anesthesiologist assistants.—

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

(a) "Anesthesiologist" means an osteopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education, or its equivalent, or the American Osteopathic Association; and who is certified by the American Osteopathic Board of Anesthesiology or is eligible to take that board's examination, is certified by the American Board of Anesthesiology or is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Board of Physician Specialties ~~American Association of Physician Specialists~~.

Section 16. Subsection (4) of section 466.006, Florida Statutes, is amended to read:

466.006 Examination of dentists.—

(4) Notwithstanding any other provision of law in chapter 456 pertaining to the clinical dental licensure examination or national examinations, to be licensed as a dentist in this state, an applicant must successfully complete all ~~both~~ of the following:

(a) A written examination on the laws and rules of the state regulating the practice of dentistry.

(b) A practical or clinical examination, which must be the American Dental Licensing Examination produced by the American

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Board of Dental Examiners, Inc., or its successor entity, if any, which is administered in this state, provided that the board has attained, and continues to maintain thereafter, representation on the board of directors of the American Board of Dental Examiners, the examination development committee of the American Board of Dental Examiners, and such other committees of the American Board of Dental Examiners as the board deems appropriate by rule to assure that the standards established herein are maintained organizationally.

1. As an alternative to such practical or clinical examination, an applicant may submit scores from an American Dental Licensing Examination previously administered in a jurisdiction other than this state after October 1, 2011, and such examination results are recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensing Examination administered out of state is the same as the passing score for the American Dental Licensing Examination administered in this state. The applicant must have completed the examination after October 1, 2011. This subparagraph may not be given retroactive application.

2. If the date of an applicant’s passing American Dental Licensing Examination scores from an examination previously administered in a jurisdiction other than this state under subparagraph 1. is older than 365 days, such scores are nevertheless valid for the purpose of licensure in this state, but only if the applicant demonstrates that all of the following additional standards have been met:

a. The applicant completed the American Dental Licensing Examination after October 1, 2011. This sub-subparagraph may not



be given retroactive application.

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education. Provided, however, if the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. Such program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation. For purposes of this sub-subparagraph, a supplemental general dentistry program does not include an advanced education program in a dental specialty.

c. The applicant currently possesses a valid and active dental license in good standing, with no restriction, which has never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

d. The applicant must disclose to the board during the application process if he or she has been reported to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards Clearinghouse. This sub-subparagraph does not apply if the applicant successfully appealed to have his or her name

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removed from the data banks of these agencies.

e.(I)(A) The applicant submits proof of having been consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico in the 5 years immediately preceding the date of application for licensure in this state; or

(B) If the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant submits proof of having been engaged in the full-time practice of dentistry since the date of his or her initial licensure.

(II) As used in this section, "full-time practice" is defined as a minimum of 1,200 hours per year for each year in the consecutive 5-year period or, when applicable, the period since initial licensure, and must include any combination of the following:

(A) Active clinical practice of dentistry providing direct patient care.

(B) Full-time practice as a faculty member employed by a dental or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(C) Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(III) The board shall develop rules to determine what type of proof of full-time practice is required and to recoup the

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cost to the board of verifying full-time practice under this section. Such proof must, at a minimum, be:

(A) Admissible as evidence in an administrative proceeding;

(B) Submitted in writing;

(C) Further documented by an applicant's annual income tax return filed with the Internal Revenue Service for each year in the preceding 5-year period or, if the applicant has been practicing for less than 5 years, the period since initial licensure; and

(D) Specifically found by the board to be both credible and admissible.

(IV) The board may excuse applicants from the 1,200-hour requirement in the event of hardship, as defined by the board.

f. The applicant submits documentation that he or she has completed, or will complete before he or she is licensed in this state, continuing education equivalent to this state's requirements for the last full reporting biennium.

g. The applicant proves that he or she has never been convicted of, or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession in any jurisdiction.

h. The applicant has successfully passed a written examination on the laws and rules of this state regulating the practice of dentistry and the computer-based diagnostic skills examination.

i. The applicant submits documentation that he or she has successfully completed the applicable examination administered by the Joint Commission on National Dental Examinations or its successor organization.


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(c) The educational requirements provided under paragraph (2)(b) or subsection (3).

Section 17. Section 486.112, Florida Statutes, is amended to read:

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

ARTICLE I
PURPOSE AND OBJECTIVES

(1) The purpose of the compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The compact preserves the regulatory authority of member states to protect public health and safety through their current systems of state licensure. For purposes of state regulation under the compact, the practice of physical therapy is deemed to have occurred in the state where the patient is located at the time physical therapy is provided to the patient.

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

(a) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.

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

(c) Encourage the cooperation of member states in

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regulating multistate physical therapy practice.

(d) Support spouses of relocating military members.

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

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

ARTICLE II

DEFINITIONS

As used in the compact, and except as otherwise provided, the term:

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

(2) "Adverse action" means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a state's physical therapy licensing board. The term includes, but is not limited to, programs that address substance abuse issues.

(4) "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or physical therapist assistant in the remote state under its laws and rules.

(5) "Continuing competence" means a requirement, as a

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condition of license renewal, to provide evidence of participation in, and completion of, educational and professional activities relevant to the practice of physical therapy.

(6) "Data system" means the coordinated database and reporting system created by the Physical Therapy Compact Commission for the exchange of information between member states relating to licensees or applicants under the compact, including identifying information, licensure data, investigative information, adverse actions, nonconfidential information related to alternative program participation, any denials of applications for licensure, and other information as specified by commission rule.

(7) "Encumbered license" means a license that a physical therapy licensing board has limited in any way.

(8) "Executive board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(9) "Home state" means the member state that is the licensee's primary state of residence.

(10) "Investigative information" means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

(11) "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a specific state.

(12) "Licensee" means an individual who currently holds an authorization from a state to practice as a physical therapist or physical therapist assistant.

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(13) "Member state" means a state that has enacted the compact.

(14) "Party state" means any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege.

(15) "Physical therapist" means an individual licensed by a state to practice physical therapy.

(16)~~(15)~~ "Physical therapist assistant" means an individual licensed by a state to assist a physical therapist in specified areas of physical therapy.

(17)~~(16)~~ "Physical therapy" or "the practice of physical therapy" means the care and services provided by or under the direction and supervision of a licensed physical therapist.

(18)~~(17)~~ "Physical Therapy Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(19)~~(18)~~ "Physical therapy licensing board" means the agency of a state which is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

(20)~~(19)~~ "Remote state" means a member state other than the home state where a licensee is exercising or seeking to exercise the compact privilege.

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

(22)~~(21)~~ "State" means any state, commonwealth, district, or territory of the United States of America which regulates the practice of physical therapy.

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ARTICLE III

STATE PARTICIPATION IN THE COMPACT

(1) To participate in the compact, a state must do all of the following:

(a) Participate fully in the commission’s data system, including using the commission’s unique identifier, as defined by commission rule.

(b) Have a mechanism in place for receiving and investigating complaints about licensees.

(c) Notify the commission, in accordance with the terms of the compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

(d) Fully implement a criminal background check requirement, within a timeframe established by commission rule, which uses results from the Federal Bureau of Investigation record search on criminal background checks to make licensure decisions in accordance with subsection (2).

(e) Comply with the commission’s rules.

(f) Use a recognized national examination as a requirement for licensure pursuant to the commission’s rules.

(g) Have continuing competence requirements as a condition for license renewal.

(2) Upon adoption of the compact, a member state has the authority to obtain biometric-based information from each licensee applying for a compact privilege and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. s. 534 and 34 U.S.C. s. 40316.

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(3) A member state must grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules.

ARTICLE IV

COMPACT PRIVILEGE

(1) To exercise the compact privilege under the compact, a licensee must satisfy all of the following conditions:

(a) Hold a license in the home state.

(b) Not have an encumbrance on any state license.

(c) Be eligible for a compact privilege in all member states in accordance with subsections (4), (7), and (8).

(d) Not have had an adverse action against any license or compact privilege within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the compact privilege within a remote state.

(f) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a compact privilege.

(g) Report to the commission adverse action taken by any nonmember state within 30 days after the date the adverse action is taken.

(2) The compact privilege is valid until the expiration date of the home license. The licensee must continue to meet the requirements of subsection (1) to maintain the compact privilege in a remote state.

(3) A licensee providing physical therapy in a remote state under the compact privilege must comply with the laws and rules

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of the remote state.

(4) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any member state until the specific period of time for removal has ended and all fines are paid.

(5) If a home state license is encumbered, the licensee loses the compact privilege in any remote state until the following conditions are met:

(a) The home state license is no longer encumbered.

(b) Two years have elapsed from the date of the adverse action.

(6) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (1) to obtain a compact privilege in any remote state.

(7) If a licensee's compact privilege in any remote state is removed, the licensee loses the compact privilege in all remote states until all of the following conditions are met:

(a) The specific period of time for which the compact privilege was removed has ended.

(b) All fines have been paid.

(c) Two years have elapsed from the date of the adverse action.

(8) Once the requirements of subsection (7) have been met,

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the licensee must meet the requirements of subsection (1) to obtain a compact privilege in a remote state.

ARTICLE V
ACTIVE DUTY MILITARY PERSONNEL
AND THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may choose any of the following locations to designate his or her home state:

(1) Home of record.

(2) Permanent change of station location.

(3) State of current residence, if it is different from the home of record or permanent change of station location.

ARTICLE VI
ADVERSE ACTIONS

(1) A home state has exclusive power to impose adverse action against a license issued by the home state.

(2) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(3) The compact does not override a member state’s decision that participation in an alternative program may be used in lieu of adverse action and that such participation remain nonpublic if required by the member state’s laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state

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during the term of the alternative program without prior authorization from such other member state.

(4) A member state may investigate actual or alleged violations of the laws and rules for the practice of physical therapy committed in any other member state by a physical therapist or physical therapist assistant practicing under the compact who holds a license or compact privilege in such other member state.

(5) A remote state may do any of the following:

(a) Take adverse actions as set forth in subsection (4) of Article IV against a licensee’s compact privilege in the state.

(b) Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party ~~member~~ state for the attendance and testimony of witnesses or for the production of evidence from another party ~~member~~ state must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service laws of the state where the witnesses or evidence is located.

(c) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

(6)(a) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other

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member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

ARTICLE VII

ESTABLISHMENT OF THE

PHYSICAL THERAPY COMPACT COMMISSION

(1) COMMISSION CREATED.—The member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

(a) The commission is an instrumentality of the member states.

(b) Venue is proper, and judicial proceedings by or against the commission must be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) The compact may not be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP, VOTING, AND MEETINGS.—

(a) Each member state has and is limited to one delegate selected by that member state’s physical therapy licensing board to serve on the commission. The delegate must be a current member of the physical therapy licensing board who is a physical therapist, a physical therapist assistant, a public member, or the board administrator.


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(b) A delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring on the commission must be filled by the physical therapy licensing board of the member state for which the vacancy exists.

(c) Each delegate is entitled to one vote with regard to the adoption of rules and bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission.

(d) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(e) The commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws.

(f) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in Article IX.

(g) The commission or the executive board or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive board or other committees of the commission must discuss any of the following:

1. Noncompliance of a member state with its obligations under the compact.

2. The employment, compensation, or discipline of, or other matters, practices, or procedures related to, specific employees or other matters related to the commission's internal personnel practices and procedures.


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3. Current, threatened, or reasonably anticipated litigation against the commission, executive board, or other committees of the commission.

4. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.

5. An accusation of any person of a crime or a formal censure of any person.

6. Information disclosing trade secrets or commercial or financial information that is privileged or confidential.

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.

8. Investigatory records compiled for law enforcement purposes.

9. Information related to any investigative reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact.

10. Matters specifically exempted from disclosure by federal or member state statute.

(h) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission’s legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(i) The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action must be identified in the minutes. All minutes and documents of

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a closed meeting must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(3) DUTIES.—The commission shall do all of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take such actions as are consistent with the provisions of the compact and the bylaws.

(4) POWERS.—The commission may do any of the following:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of the compact. The rules have the force and effect of law and are binding in all member states.

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law is not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(e) Hire employees and elect or appoint officers; fix the compensation of, define the duties of, and grant appropriate authority to such individuals to carry out the purposes of the compact; and establish the commission’s personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(f) Accept any appropriate donations and grants of money,

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equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(i) Establish a budget and make expenditures.

(j) Borrow money.

(k) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in the compact and the bylaws.

(l) Provide information to, receive information from, and cooperate with law enforcement agencies.

(m) Establish and elect an executive board.

(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of physical therapy licensure and practice.

(5) THE EXECUTIVE BOARD.—

(a) The executive board may act on behalf of the commission according to the terms of the compact.

(b) The executive board shall be composed of the following

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nine members:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. One ex officio, nonvoting member from the recognized national physical therapy professional association.

3. One ex officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

(c) The ex officio members shall be selected by their respective organizations.

(d) The commission may remove any member of the executive board as provided in its bylaws.

(e) The executive board shall meet at least annually.

(f) The executive board shall do all of the following:

1. Recommend to the entire commission changes to the rules or bylaws, compact legislation, fees paid by compact member states, such as annual dues, and any commission compact fee charged to licensees for the compact privilege.

2. Ensure compact administration services are appropriately provided, contractually or otherwise.

3. Prepare and recommend the budget.

4. Maintain financial records on behalf of the commission.

5. Monitor compact compliance of member states and provide compliance reports to the commission.

6. Establish additional committees as necessary.

7. Perform other duties as provided in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization,


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and ongoing activities.

(b) The commission may accept any appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must total to an amount sufficient to cover the commission's annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based upon a formula to be determined by the commission, which shall adopt a rule binding upon all member states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet such obligations; nor may the commission pledge the credit of any of the member states, except by and with the authority of the member state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited yearly by a certified or licensed public accountant, and the report of the audit must be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.—

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and

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liability, whether personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. However, this paragraph may not be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities. However, this subsection may not be construed to prohibit any member, officer, executive director, employee, or representative of the commission from retaining his or her own counsel or to require the commission to defend such person if the actual or alleged act, error, or omission resulted from that person's intentional, willful, or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope


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of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, and use of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission, which data set must include all of the following:

(a) Identifying information.

(b) Licensure data.

(c) Investigative information.

(d) Adverse actions against a license or compact privilege.

(e) Nonconfidential information related to alternative program participation.

(f) Any denial of application for licensure, and the reason for such denial.

(g) Other information that may facilitate the administration of the compact, as determined by the rules of the

commission.

(3) Investigative information in the system pertaining to a licensee in any member state must be available only to other party ~~member~~ states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license in a member state. Adverse action information pertaining to a licensee in any member state must be available to all other member states.

(5) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(6) Any information submitted to the data system which is subsequently required to be expunged by the laws of the member state contributing the information must be removed from the data system.

ARTICLE IX

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.

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(3) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(4) Before adoption of a final rule by the commission, and at least 30 days before the meeting at which the rule will be considered and voted upon, the commission must file a notice of proposed rulemaking on all of the following:

(a) The website of the commission or another publicly accessible platform.

(b) The website of each member state physical therapy licensing board or another publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking must include all of the following:

(a) The proposed date, time, and location of the meeting in which the rule or amendment will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule or amendment from any interested person.

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before adoption of a proposed rule or amendment, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(7) The commission must grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is


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requested by any of the following:

(a) At least 25 persons.

(b) A state or federal governmental subdivision or agency.

(c) An association having at least 25 members.

(8) If a scheduled public hearing is held on the proposed rule or amendment, the commission must publish the date, time, and location of the hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must notify the executive director of the commission or another designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This article may not be construed to require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(10) If no written notice of intent to attend the public hearing by interested parties is received, the commission may proceed with adoption of the proposed rule without a public

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hearing.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this article are retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to do any of the following:

(a) Meet an imminent threat to public health, safety, or welfare.

(b) Prevent a loss of commission or member state funds.

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule.

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions must be posted on the website of the commission. The revision is subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing

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and delivered to the chair of the commission before the end of the notice period. If a challenge is not made, the revision takes effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE X
OVERSIGHT, DISPUTE RESOLUTION,
AND ENFORCEMENT

(1) OVERSIGHT.—

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and take all actions necessary and appropriate to carry out the compact's purposes and intent. The provisions of the compact and the rules adopted pursuant thereto shall have standing as statutory law.

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

(c) The commission is entitled to receive service of process in any such proceeding and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission renders a judgment or an order void as to the commission, the compact, or the adopted rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a member state has

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defaulted in the performance of its obligations or responsibilities under the compact or the adopted rules, the commission must do all of the following:

1. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and any other action to be taken by the commission.

2. Provide remedial training and specific technical assistance regarding the default.

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

(c) Termination of membership in the compact may be imposed only after all other means of securing compliance have been exhausted. The commission shall give notice of intent to suspend or terminate a defaulting member state to the governor and majority and minority leaders of the defaulting state’s legislature and to each of the member states.

(d) A state that has been terminated from the compact is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(e) The commission does not bear any costs related to a state that is found to be in default or that has been terminated

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from the compact, unless agreed upon in writing between the commission and the defaulting state.

(f) The defaulting state may appeal the action of the commission by petitioning the United States District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a member state, the commission must attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its discretion, shall enforce the compact and the commission's rules.

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

(c) The remedies under this article are not the exclusive

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remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XI
DATE OF IMPLEMENTATION OF THE
PHYSICAL THERAPY COMPACT
AND ASSOCIATED RULES;
WITHDRAWAL; AND AMENDMENTS

(1) The compact becomes effective on the date that the compact statute is enacted into law in the tenth member state. The provisions that become effective at that time are limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary for the implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is subject to the rules as they exist on the date that the compact becomes law in that state. Any rule that has been previously adopted by the commission has the full force and effect of law on the day the compact becomes law in that state.

(3) Any member state may withdraw from the compact by enacting a statute repealing the same.

(a) A member state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting

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requirements of this act before the effective date of withdrawal.

(4) The compact may not be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the provisions of the compact.

(5) The compact may be amended by the member states. An amendment to the compact does not become effective and binding upon any member state until it is enacted into the laws of all member states.

ARTICLE XII
CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to carry out the purposes thereof. The provisions of the compact are severable, and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any party ~~member~~ state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If the compact is held contrary to the constitution of any party ~~member~~ state, the compact remains in full force and effect as to the remaining party ~~member~~ states and in full force and effect as to the party ~~member~~ state affected as to all severable matters.

Section 18. Paragraph (d) of subsection (3) of section

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766.1115, Florida Statutes, is amended to read:

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

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

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician or physician assistant licensed under chapter 458.

5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced practice registered nurse licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association and its employees or a corporate medical group and its employees.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes

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an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.

15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9. and 13.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

Section 19. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, or, if this act fails to become a law until after June 1, 2025, it shall take effect upon becoming a law and shall operate retroactively to June 1, 2025, this act shall take effect July 1, 2025.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

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Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the Department of Health; amending chapter 2023-43, Laws of Florida; revising the repeal date of the definition of the term "messenger ribonucleic acid vaccine"; providing for contingent retroactive operation; reenacting ss. 381.00316(2)(g) and 381.00319(1)(e), F.S., relating to the prohibition on discrimination by governmental and business entities based on health care choices and the prohibition on mask mandates and vaccination and testing mandates for educational institutions, respectively, for purposes of preserving the definition of the term "messenger ribonucleic acid vaccine," notwithstanding its scheduled repeal; amending s. 381.026, F.S.; revising the rights of patients, which each health care provider and facility are required to observe, to include that such facilities and providers may not discriminate based on a patient's vaccination status; amending s. 381.986, F.S.; defining terms for purposes of background screening requirements for persons affiliated with medical marijuana treatment centers; requiring medical marijuana treatment centers to notify the Department of Health through e-mail within a specified timeframe after an actual or attempted theft, diversion, or loss of marijuana; requiring medical marijuana treatment centers to report attempted thefts, in addition to


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actual thefts, to law enforcement within a specified timeframe; amending s. 381.988, F.S.; defining terms for purposes of background screening requirements for persons affiliated with medical marijuana testing laboratories; amending s. 456.0145, F.S.; revising eligibility criteria for licensure by endorsement under the MOBILE Act; amending s. 456.44, F.S.; revising the definition of the term "board-certified pain management physician" to replace the term "American Association of Physician Specialists" with "American Board of Physician Specialties"; making a technical change; amending s. 458.3145, F.S.; revising the list of institutions at which the department is authorized to issue a medical faculty certificate to an individual who has been offered and has accepted a full-time faculty appointment; amending ss. 458.315 and 459.0076, F.S.; revising criteria authorizing physician assistants to be issued temporary certificates for practice in areas of critical need; amending ss. 458.3265, 458.3475, 459.0137, and 459.023, F.S.; revising definitions to replace the term "American Association of Physician Specialists" with "American Board of Physician Specialties"; amending s. 466.006, F.S.; revising the requirements for licensure as a dentist; amending s. 486.112, F.S.; defining the term "party state"; authorizing a remote state to issue subpoenas to individuals to testify or for the production of evidence from a party located in a party state; providing that such subpoenas are

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enforceable in the party state; requiring that investigative information pertaining to certain licensees in a certain system be available only to other party states; revising construction and severability of the compact to conform to changes made by the act; amending s. 766.1115, F.S.; revising the definition of the term “health care provider” or “provider”; providing effective dates.