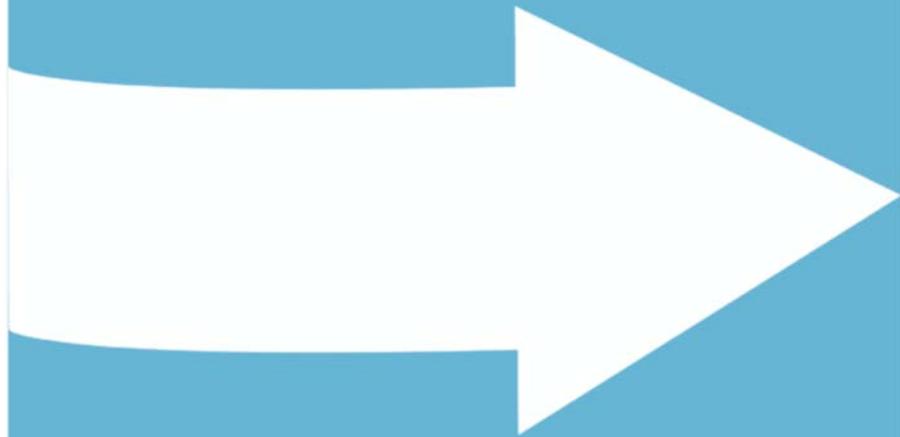


THE DOCTOR IS OUT: A PHYSICIAN'S GUIDE TO CLOSING A PRACTICE



NORTH CAROLINA
MEDICAL BOARD



**“Protecting the public,
strengthening the profession”**

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INTRODUCTION

Closing a medical practice temporarily or permanently, leaving one medical practice to go to another, or having a colleague leave practice suddenly - these are major changes in a licensee's professional life. The purpose of this document is to provide guidance to licensees¹ to help make these transitions as smooth as possible for both licensees and patients. The North Carolina Medical Board ("the Board") also offers this document to help licensees avoid pitfalls.

Most of the areas covered in this guide can be found on the Board's website, www.ncmedboard.org. A predecessor to this document was created by the North Carolina Medical Society Foundation's PractEssentials program, and the Board thanks the Foundation for allowing the use of "Closing a Medical Practice: What Physicians Should Know." The Board also thanks Medical Mutual Insurance Company, the North Carolina Academy of Physician Assistants and the physicians and attorneys who lent their knowledge and experience to this project.

The practice of medicine is a complex professional and business endeavor. Increasing numbers of physicians now work outside the traditional model of independent professionals, instead being employed by practices or hospitals. Employment contracts and covenants not to compete may determine a physician's contractual obligations upon leaving a practice (which could conflict with the physician's ethical obligations). There are numerous business and legal issues not addressed here; this guide is intended to help only with the professionalism aspects of the closure. This document is not intended to provide legal advice. You are strongly advised to seek independent business or legal advice as well.

PLAN AHEAD

All physicians or independently practicing mid-level providers should have a departure plan in place before they need it. This is especially true for solo practitioners, in case someone else must carry out that plan. Otherwise, a deceased physician's estate might not fulfill professional obligations in the way the physician would have wanted. Physicians joining or creating a practice arrangement should have employment agreements, partnership agreements, buy-sell agreements and other business arrangements in place at the beginning. These should be reviewed and updated over time. All of the items discussed in this guide should be considered, including ownership of medical records and the duty to provide advance notice to existing partners of the departure. Advance planning helps all parties meet professional obligations, maintain the solvency of the continuing practice, and minimize animosity about the departure.

Maybe you are thinking about retiring, selling your practice, or closing the doors. Perhaps you are moving to another medical practice – one that competes with your current one. Or you may be in a difficult situation where your practice must close: you need to get medical treatment, or you have lost the authority to practice by order or agreement with the Medical Board. Finally, this document may also be of use to individuals who have stepped in to help when another licensed medical professional must close shop. The resources referenced in this guide will help licensees grappling with all these scenarios.

¹ The majority of this document is directed at physicians: MDs and DOs, rather than other licensees of the North Carolina Medical Board. Special provisions relating to Physician Assistants and Nurse Practitioners are mentioned specifically.

Several of the Board's Position Statements concern the relationship between licensee and patient, and what to do when that relationship comes to an end. Position Statements may be found on the Board's website at: http://www.ncmedboard.org/position_statements. Position Statements are neither laws nor rules but are designed to provide guidance to licensees as to the Board's expectations on certain issues of practice and professionalism. (Attachment 1.)

The Board's Position Statement "*Departures from or closings of medical practices*" (Attachment 2) outlines the Board's expectations for licensees. The Board requires two things of individuals who are leaving or closing a practice: to assure continuity of care for patients, and to allow patients the freedom to choose their health care provider.

PROFESSIONAL OBLIGATIONS

BASIC FACT PATTERNS OF PHYSICIAN PRACTICE CLOSINGS OR DEPARTURES

Practically speaking, there are five scenarios that involve departures from practice:

1. A solo practitioner is retiring or closing a practice. The retiring physician should send a letter to patients with sufficient time to allow them to seek alternative care (thirty days, at a minimum), and an opportunity to pick up their medical records or request that they be transferred to another provider. Samples of these types of letters are Attachments 3 and 4.
2. A physician in a multi-physician practice is retiring or leaving the geographic practice area. In this instance, the departing physician and/or practice should send a letter notifying patients of the change, and offering to provide continuous care for the patients, or offering to transfer records to another provider upon request. Again, at least a thirty day notice should be provided. If a physician in a continuing practice dies, the practice may send a letter offering to provide continuing care or transfer records. Please see Attachment 5 for a sample.
3. A physician is leaving to join a competing practice. Often, these situations are acrimonious. The Position Statements do not specify whose duty it is to notify the patients, only that it must be done. The best approach is for the continuing practice and the departing physician to send a joint letter notifying patients of the departure, the departing physician's new practice location; and the willingness of the continuing practice to see the patients, transfer the patient's records to the departing physician or transfer the records to another physician. If it is not possible to send a joint letter, remember that the ultimate responsibility to inform the patients falls on the continuing practice. Bottom line: please do not allow a professional divorce to supersede one's professional duty. Please see Attachments 6 and 7 for sample letters. Attachment 8 is a sample Authorization for Transfer of Medical Records.
4. A physician in a solo practice must stop seeing patients at short notice. This may be due to the sudden onset of a health condition which makes it difficult for the physician to practice well. It may also arise from the physician's need to seek treatment for substance or alcohol abuse; the physician's execution of a non-practice agreement with the Medical Board; or because the Medical Board has suspended the physician's medical license.¹ (A variation of Attachment 3 may be used.)
5. A physician in a solo practice dies or abandons his practice. In this situation, members of the local medical community, professional society, specialty group or hospital may need to step in, as a service to the public, to provide notice to the patients and arrange storage and retrieval of medical records. In this situation, which fortunately is quite rare, it may be impracticable to provide notice by phone, email or U.S. mail. Instead, constructive notice may be made by placing a letter on the office door, and by placing an advertisement in the local newspaper. The duty to provide this notice and secure patient records is not imposed on anyone in particular. In the past, other local physicians, the county medical society, the physician's specialty group, or the Medical Board have stepped in to assist the patients. Please see Attachment 9 for a sample notice.

¹ A physician who has lost his license may still notify patients that the practice has been closed and may return patient records, or oversee that effort, since these acts, by themselves, do not constitute the practice of medicine.

PRECIPITOUS MEDICAL PRACTICE CLOSINGS

When a physician must close or leave his medical practice suddenly or without warning due to illness, injury, business failures, professional disputes, or Medical Board discipline it is important to recognize that the physician retains important responsibilities to make reasonable provisions for an orderly transition or transfer of patient care. Many of the same guidelines and principles discussed in other sections of this document are equally applicable to the precipitous practice closure and do not need to be repeated here, but there are additional considerations which the physician, office staff, or physicians remaining in the practice must consider under these circumstances. The best approach is anticipatory. No physician expects they will find themselves in a position to cease practice without warning, either temporarily or permanently. Developing written policies and procedures beforehand which address this issue will go a long way toward easing a very difficult transition.

While this may be somewhat less of a problem for larger group practices or the employed physician, and the unanticipated or precipitous practice closure burdens will fall most heavily on smaller or solo practitioners, all medical practices should anticipate that the unexpected may occur. Arrangements for orderly continuation or transfer of care depend to some degree on the duration the physician will be away from the practice.

- Practice office or business managers should be provided authority to efficiently allow patients access to their medical records and facilitate transfer of copies of patient medical records to other physicians.
- If possible, the physician should do anything he can to facilitate continuity of care and allow for patient choice on where to receive further care.
- Physicians should be familiar with the medical record retrieval and archiving policies for their particular electronic health records. For instance, if medical records are cloud-based, the physician should know what will happen to those medical records if the physician suddenly stops paying his monthly network fees and maintenance.
- Public notices to patients about the practice closure should provide full and forthright information about the expected duration of the practice closure and what patients can do to receive necessary or emergency interim medical care or transfer care to another physician.
- In the case of group practices, the remaining physicians should willingly accept responsibility for aspects of patient care such as medication refills; lab, x-ray, and consultant follow-up; completion of death certificates; and all of the other complex components of patient care that will result from this situation.
- If controlled substances are stored at the practice, the office staff should contact the DEA so that these drugs may be safely secured.
- Consider how ongoing, routine bills - such as rent, EHR monthly fees, and malpractice insurance – will be paid. Physicians may want to consider obtaining business continuity insurance to cover these ongoing aspects of a medical practice during such emergencies.

COMMUNICATION WITH PATIENTS

1. PROVIDE NOTICE TO PATIENTS

Because eventually all physicians will leave or close their practice, written policies and procedures regarding this matter should be developed in advance, and should be included in every practice's policy and procedure manual. New and current patients should be provided with a copy of those materials.

The Board's Position Statements are explicit on the duty to notify "patients" but are lacking on details about exactly who those patients are. Is a retiring physician required to reach out to every patient he has ever seen? Is it sufficient to provide notice only to those patients treated within the past year? Are there different standards for different treatment options – for example, patients at an urgent care center compared to those in a chronic care setting? Can a physician or practice notify more recent patients directly, and put others on constructive notice by placing an advertisement in a local newspaper or on the practice's website? Unfortunately, there are no black and white answers here. The Medical Board's expectation is that a departing physician will make a reasonable effort, given the current situation, to notify patients so that they are not put in a situation where their care is interrupted, or they have no opportunity to obtain their records.

The North Carolina Medical Society advises physicians to notify "current" patients about a physician leaving a practice. Obviously, this differs according to the type of practice; a surgical practice may see a patient for a limited span of time; an internist may see a patient over years.

Medical Mutual Insurance Company recommends that a departing physician or closing practice notify all patients seen within the past two years. However, they also have specific guidance for particular specialties.

- Place a notice at the door and/or in the waiting room about the change that is about to occur, including an effective date ("Dr. Smith will no longer be with this practice effective _____. He will no longer be taking new patients as of _____.") In surgical practices, a notice should be posted in the waiting room, and letters should be sent to current patients. The practice should establish a "cut off" date for surgical patients after which the departing physician will not be able to provide follow up care. If the departing physician generally performs procedures with a six to eight week post-op follow up, decide that he/she will not perform surgery within six to eight weeks of his departure.
- If the departing physician will continue to perform surgery until he/she departs, make sure that patients know that they may receive follow up care from another physician in the practice. The patient should have the choice of having the physician perform the surgery and receive follow up care from another physician in the same practice, or have the surgery performed by a different surgeon or practice altogether.
- For patients in emergent or high risk situations, like nephrology, notice that a physician is closing a practice or leaving a practice should be given both by telephone and mail. Medical Mutual recommends sending high risk patients notice by certified mail, return receipt requested. Again, sufficient time should be provided so that the patient may receive continuous treatment.
- If diagnostic tests are ordered but will not be completed before the departing physician leaves, that should also be addressed in advance. The patient should be informed that another provider will provide follow-up based on those tests. None of these changes should come as a surprise to the patients.

2. CONTINUITY OF CARE

In order to provide continuity of care, the physician must provide reasonable advance notice to patients. Through its Position Statement, the Board defines “reasonable” as at least thirty days. Continuity of care and the amount of advance notice may depend upon the type of medical care provided, as noted in the section below. Continuity of care, notice to patients and access to medical records also are discussed in the Board’s Position Statement, *“The physician-patient relationship”* (Attachment 10).

3. PERMIT PATIENT CHOICE OF HEALTHCARE PROVIDER

To effectuate patient choice, the departing physician must provide adequate communication to patients that they may choose their healthcare provider, and that they may obtain their medical records or have them transferred as they choose. They must also be told how to contact a departing practitioner, if that person will continue to practice elsewhere, at least upon the patient’s request.

Finally, *“Departures from or closings of medical practices”* recommends that practices develop written policies in advance of such situations to guide the practice in the event of a departure or closing.

The second Position Statement which is relevant to practice closure issues is *“The physician-patient relationship”* (Attachment 10). The final section of this Position Statement deals with terminations of patients from being treated by one or more particular physicians or an entire practice. While this is different from a practice closure situation, the guidelines set out there are on point: the patient must be given reasonable advance notice of the termination (at least thirty days) to allow the patient to seek other care, and the patient must be notified of his/her right to obtain medical records, and instructed on how to do so.¹

Another source of guidance on this is the American Medical Association. AMA Opinion 7.03 (Attachment 11) speaks to the requirements of notifying patients about the retirement or departure of a physician.

4. SPECIAL ISSUES CONCERNING MID-LEVEL PROVIDERS

As a general rule, the Board has felt that an on-site physician assistant or nurse practitioner who is part of a physician’s practice does not need to provide notice to patients and meet the other obligations discussed in this guide. However, the NC Academy of Physician Assistants advises that a “best practice” is to post a note at the practice site and the practice’s website (if any), advising patients that the PA or NP is departing. The patients’ expectations are important, and the relationships between PAs, NPs and their patients may be long term and very important to the patients.

However, the expectations are different for a physician assistant or nurse practitioner who practices independently with an offsite supervisor or has an ownership interest in a practice. For those PAs or NPs who are closing or leaving a practice, the obligations outlined in this document about notice to patients, continuity of care, provision of records, etc. also would apply. A midlevel professional in this situation is strongly advised to seek legal advice about this.

¹ Medical Mutual Insurance Company advises that if a practice believes that a current patient may endanger the safety of staff or other patients, the thirty day notice of termination may be waived. There should be strong documentation in the medical record to support such action.

PROFESSIONAL OBLIGATIONS

What if a Supervising or Back-up Supervising Physician is departing a practice? In many multi-physician practices, when a particular physician leaves, a PA is often reassigned to another MD/DO, likely one who served as a Back-up Physician previously. This doctor may not want the responsibility or liability of serving as a Supervising Physician. It is the duty of the PA or NP continuing with the practice to find an appropriate Supervising or Back-up Physician and update their practice information with the Medical Board.

MEDICAL RECORDS

1. RETENTION OF MEDICAL RECORDS

Records retention is a challenging issue. There is no “bright line” consistent with federal and state law which establishes how long medical records must be maintained in every case. Instead, a practice must try to harmonize a hodgepodge of statutes, regulations, case law and Board Position Statements. As electronic medical recordkeeping becomes more universal, the problem should be alleviated, as electronic data storage is relatively inexpensive and accessible. The current situation places physicians and practices in a confusing, expensive situation where cumbersome paper records must be stored indefinitely.

That being said, every medical practice should create a policy on record retention, based primarily on medical considerations and continuity of care. You should check with your medical liability insurance carrier and legal representative prior to finalizing it. You may wish to provide this policy to new patients as part of their “introduction to the practice” materials. When patients are informed in advance about how their medical records will be handled there is substantially less likelihood of a complaint to the Medical Board if and when a physician must close his practice. This is simply another aspect of “informed consent.”

The Board’s Position Statement, “*Retention of Medical Records*” (Attachment 12) provides guidelines for physicians on how long to keep medical records. Generally, a continuing practice should retain original medical records as long as possible. There are multiple reasons for retaining medical records: to provide patients with the information, should they wish to access it; to protect the physician in case a legal claim is made in the future; and to comply with federal regulations. If a physician is retiring or moving out of the area, it is more challenging to figure out what to do with the medical records. After providing patients with a sufficient time to pick up copies or have them transferred to another health care provider, the departing physician still will have reasons to retain the records. What are some options for storage of medical records? It may be possible to pay for storage at a neighboring medical office. Another option is to use a secure document storage facility. A departing solo physician may ask a fellow physician still practicing in the community to serve as custodian of the records. The Position Statement, “*Retention of Medical Records*” provides three definite time frames:

1. Medicare/Medicaid: up to seven years
2. HIPAA: up to six years
3. Immunization records: permanently

PROFESSIONAL OBLIGATIONS

The NCMS defines the “designated record set” as the medical record itself, plus records obtained by other providers (if used in the decision making), and financial records, including Explanation of Benefits. The NCMS and Medical Mutual provide these additional recommendations for records retention:

- Diagnostic images: five years from the date of procedure
- Adult patients: eleven years from last contact
- Fetal heart monitor: ten years after the infant reaches the age of majority (eighteen years old)
- Minor patient: when he/she reaches the age of majority (eighteen years old) plus seven years
- Operative notes, register of surgical procedures, chemotherapy records, immunization records, master patient indexes, birth and death records, and basic statistical data should be retained permanently. If this is not possible for indices and statistical data, the guideline should be compiled and maintained permanently.
- Deceased patients: five years after the patient’s death

There is no state statutory requirement for the retention of physician office medical records, but it is advisable to maintain these records at least according to the statute of limitations in North Carolina. The statute of limitations is the time frame in which a plaintiff may bring a legal action against someone for a civil wrong, such as alleged medical malpractice. The basic statute of limitations is three years following a wrongful injury, but there are several exceptions to this rule as outlined below.

- If an injury is not readily apparent, the patient may bring suit up to four years after the last act of treatment.
- If a foreign object with no therapeutic purpose is left in the patient’s body, the patient can file suit up to two years from the last act of the physician.
- A minor may wait until the age of nineteen to file an action.
- There is the “continued course of treatment” exception that states that if a patient is treated over an extended period of time, the statute of limitations does not start until the date of the last treatment.
- Overall, the longest possible time period for a malpractice action to be filed is ten years for adults and nineteen years for minors.

The North Carolina Health Information Management Association is another source of guidance on this issue (www.nchima.org/index.html). That organization recommends that whenever possible, medical records should be retained permanently either in their original form, microfilm, optical disk, or an electronic data storage medium. This recommendation is based on the increasing importance of the medical records to the health care provider, not only for continued care but for legal purposes. In the event you transfer original medical records to another physician, you should have a written agreement to ensure that the other physician will permit you to have access to the medical records for a reasonable period of time (and will maintain the records in accordance with all federal and state requirements).

2. PATIENT ACCESS TO MEDICAL RECORDS

The Board’s Position Statement, “*Access to Medical Records*” (Attachment 13) reiterates that the information in medical records belong to the patient; the practice is advised to retain the original records. That Position Statement references N.C. Gen. Stat. § 90-411 (Attachment 14), which allows health care practitioners to charge a fee for providing medical records

to a patient who requests them. Often a practice will only charge a fee when the patient chooses to switch health care providers, in the absence of a departure from or closing of a practice.

The Board's Position Statements do not make it explicit how patients can get their medical records, or how long they have to do so. Typically, practices send a letter to patients about a departure or closing and inform patients that they have a certain period of time (at least thirty days) in which to pick up their records or ask the practice to transfer them to another healthcare provider. If the practice is truly closing, it may be impracticable for an office to remain open very long. A practice which is closing permanently can provide its patients with the original medical records, upon receipt of the patient's signed authorization.

3. EMAIL AND ELECTRONIC MEDICAL RECORDS

The Board's Position Statements and policies generally pre-date the widespread adoption of email communication between physicians and patients and electronic medical recordkeeping. However, communication between patients and practices using electronic mail should suffice and should take the place of mailed communications.

The North Carolina General Assembly has equated the legal rights and responsibilities relating to electronic records to those created on paper or other media. N.C. Gen. Stat. § 90-412 (Attachment 15). If the medical records have been generated and maintained electronically, and can be transferred to another provider electronically, that will suffice. If EHRs cannot be transmitted (for example, the recipient provider uses a different EHR system) then the records may have to be printed onto paper, a CD, or zip drive.

4. BALANCE BETWEEN RECORD RETENTION, PATIENT ACCESS AND PRIVACY

There must be a balance between providing medical records to the patient and preserving patient privacy. If you have tried to contact the patient by email or by sending a letter to the patient's last known address, then you might place a notice on the practice's website and in the local newspaper notifying patients of how and where to pick up their records. If continued, secure storage is not reasonably possible and if you have allowed a reasonable time for patients to get their records, you should destroy the records to protect confidential patient information. Incineration or shredding by a bonded company is the preferred method to destroy medical records, so that confidential patient information is not disclosed. As stated in Attachment 13, "Licensees should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records."

There have been some situations where no one has come forward to responsibly secure, distribute and retain medical records, and by default, the North Carolina Medical Board has appointed a custodian of them. The Board is permitted to do this by statute, N.C. Gen. Stat. § 90-5.1, (Attachment 16) but is reluctant to do so except where there are extenuating circumstances, such as a physician abandoning a practice. In challenging circumstances, such as the death of a solo practitioner, the Board often seeks assistance from the local medical community, medical society, or hospital in handling patient records.

APPROPRIATE UPDATES AND NOTICES

1. LICENSEE INFORMATION PAGE

The North Carolina Medical Board's Licensee Information Pages provide a service to the public and are mandated by statute, N.C. Gen. Stat. § 90-5.2 (Attachment 17). A physician who is departing a practice for whatever reason can go to the Board's website to update his or her information, such as address and phone number of the primary practice setting. For more information, go to: http://www.ncmedboard.org/professional_resources/infopages.

2. CORPORATE RECORDS WITH THE NCMB AND THE SECRETARY OF STATE

A physician who is a shareholder in a corporate medical practice, who is departing that practice, must inform the North Carolina Medical Board of the changes. The Board's website includes a guide to Professional Corporations and Professional Limited Liability Companies, including what must be done upon dissolution or the death of a shareholder.

http://www.ncmedboard.org/images/uploads/other_pdfs/PC_PLLC_Guide_12_12_12.pdf. For more information on this subject, contact the Board's Corporations Coordinator at (919) 326-1109 ext. 231.

3. THE CENTER FOR MEDICARE AND MEDICAID SERVICES

Physicians leaving practice for whatever reason who have treated patients on Medicare or Medicaid should advise CMS of the change in their practice.

4. THE DRUG ENFORCEMENT ADMINISTRATION

If you are retiring or terminating your prescription of controlled substances, you must notify the Drug Enforcement Administration (DEA) in writing to request that your DEA number be deleted from the DEA system. In addition, you must return your original DEA certificate of registration for cancellation and any unused "222 forms." It is advisable to send this notice and certificate by certified mail, return receipt requested. If you are moving to a new practice within North Carolina, you must update your address with the DEA before beginning to dispense or prescribe controlled substances. For more information, contact the DEA at 1801 Stanley Road, Suite 201, Greensboro, NC 27407 or by phone: (336) 547-4219. Visit their website at <http://www.justice.gov/dea/index.shtml>.

5. THE NC CONTROLLED SUBSTANCE REPORTING SYSTEM

If you have been registered with the NC Controlled Substance Reporting System and are leaving practice, you should notify them. For more information, contact the NC Controlled Substance Reporting System by mail: 3008 Mail Service Center, Raleigh, NC 27699-3008 or by phone: (919) 733-1765. Visit their website at <http://www.ncdhhs.gov/MHDDSAS/controlledsubstance/>.

6. THE NC BOARD OF PHARMACY

If you are a dispensing physician, and will no longer be dispensing medications, you must provide notice to the NC Board of Pharmacy to cancel your state drug dispensing license. In addition, you will need to dispose of any unwanted drugs. Non-controlled substance pharmaceuticals may be returned to their manufacturer, incinerated at a proper facility, or disposed of by other means which will preclude unauthorized use or possession.

PROFESSIONAL OBLIGATIONS

The disposition of controlled substances is more rigorously regulated.

- The permit holder must file a request with the NC Board of Pharmacy for authority to do so and to receive instructions;
- If the destruction occurs on the permit holder's premises, it must be jointly witnessed by two licensed pharmacists;
- The destruction must be documented;
- The documentation must be retained by the permit holder for at least three years;
- A copy of the documentation shall be sent to the DEA.

Please see Attachment 18, 21 NCAC 46.3001, "Procedure for disposing of drugs." The Board of Pharmacy also provides the form, "Drug disposal procedures" that must be submitted when disposing of drugs. The form can be found here: <http://www.ncbop.org/Forms/DrugDisposalForm.pdf>. The federal government has proposed new rules about disposal of controlled substances. For more information, please go to: http://www.deadiversion.usdoj.gov/fed_regs/rules/2012/fr1221_8.htm.

A significant problem frequently encountered when a physician closes (or is forced to close) his practice is ongoing prescription refills for his patients. The Board of Pharmacy has a rule which can temporarily mitigate the adverse health consequences of this situation. See Attachment 18. The Board of Pharmacy takes the position that a prescriber's death, retirement or loss of license does not void an existing prescription. For more information, contact the Board at 6015 Far-rington Road, Suite 201, Chapel Hill, North Carolina 27517. They may also be reached by phone: (919) 246-1050 or fax: (919) 246-1056. Visit their website at <http://www.ncbop.org/>.

RETIREMENT

In most instances, there are parallel requirements for physicians and PAs in regard to the issues covered in this section. Because there are fewer PAs in our state who are nearing retirement age, the numbers of PAs retiring is currently very low. To see the rules, license applications and other documents pertaining to PAs and volunteer licenses, reactivation, reinstatement and reentry, please contact the NC Medical Board's Licensing department at (919) 326-1109 or visit the Board's website at www.ncmedboard.org.

RETIRED AND INACTIVE

If you are retiring from practicing medicine or practicing as a PA, you should consider the status of your medical license or PA license. It is your choice as to whether to inactivate your license ("go inactive") or retain your active physician or PA licensure status, and there are positives and negatives to both.

"Going inactive" requires notifying the NC Medical Board that you are no longer going to practice medicine or surgery. As noted in the Board's Position Statement, "*The retired physician/licensee*" (Attachment 19), once your license is inactive, you may not practice medicine, which means you may not:

- Provide patient services;
- Order tests or therapies;
- Prescribe, dispense, or administer drugs;
- Perform any other medical and/or surgical acts; or
- Receive income from the provision of medical and/or surgical services performed following retirement.

However, neither do you have to renew your license annually, pay the Board's renewal fee, or stay current with your Continuing Medical Education. Although you lose your mailed subscription to the *The Forum*, anyone can access that free via the Board's website (<http://www.ncmedboard.org/newsletter>).

RETIRED WITH ACTIVE LICENSE

If you simply stop working but retain your full, active license, you must renew that license annually, pay the Board's renewal fee, maintain your CME, and abide by the Board's Position Statements, rules, and statutes. Some physicians and PAs misguidedly consider maintaining their active license status after retirement so that they may treat themselves and their family members. In general, this is not an acceptable practice and such treatment may violate the Board's Position Statement, "*Self Treatment and Treatment of Family Members.*"

LICENSE FOR VOLUNTEER WORK

Another alternative for the retired physician or PA is to work at clinics serving indigent patients. You may not receive any type of compensation whatsoever for your services in this capacity. A physician holding a limited volunteer licensee may not work more than thirty days in a calendar year. However, the retired volunteer licensee is not so limited. More information can be found on the Board's website at: http://www.ncmedboard.org/licensing/volunteer_application.

If you are a licensed NC physician who wishes to convert your "full" active license to a retired limited license, you must simply inform the Board of this by going the Board's website, completing the form listed, and submitting it to the Board's Licensing Department. A copy of this form is Attachment 20.

RETIREMENT

If you have converted your license status from “active” to “inactive,” but then wish to do volunteer work, you must reapply for a license. The Board has two special license categories for such physicians, and allows them to volunteer their services in clinics serving the indigent. How a physician applies for a volunteer license depends upon whether the physician ever held a North Carolina license, how long the physician has been out of practice, and how many days in a calendar year the physician plans to volunteer. Physicians holding these licenses do not have to pay annual renewal fees, but do have to maintain their CME. Please see administrative rules 21 NCAC 32B .1701, .1702, .1703 and .1704, which follow as Attachments 21, 22, 23 and 24. If you have questions about which application process applies to you, please contact the Board’s Licensing Department at Licensing@ncmedboard.org.

RETURNING TO PRACTICE

If you retire from practice, ask the NC Medical Board to make your license “inactive,” and then change your mind, what are your options? You may seek to regain a full physician license; you may wish to obtain a retired limited license; or you may seek a limited volunteer license. The requirements for the Board’s retired physician limited license and limited volunteer physician license may be found at: http://www.ncmedboard.org/licensing/volunteer_application. The administrative rules covering those two licensees are Attachments 21, 22, 23 and 24.

REACTIVATION

The first approach for regaining your full, active medical license is called *Reactivation*. This process is available to a physician whose license status has been inactive for less than one year, without any disciplinary Board action (or threat thereof) being involved. This is a simple and short application; the physician must still show current CME. Please see administrative rule 21 NCAC 32B .1360, which follows as Attachment 25.

REINSTATEMENT

The second avenue for applying for a full, active physician license is called *Reinstatement*. Guidelines surrounding this process can be found in Attachment 26. This is the process you should take if you have held a medical license in this state, but have been:

- Inactive for more than one year, or
- Your license became inactive because of disciplinary action by the Board, or
- You surrendered your license prior to having charges filed against you by the Board.

REENTRY

A more difficult path lies ahead for the physician or PA who has been out of practice with an inactive license for more than two years. At that point, in order to obtain a physician or PA license of any kind (active, retired, or limited volunteer), the applicant must complete a *Reentry Program*.

A frequent area of misunderstanding concerns the physician or PA who has been out of practice for more than two years, who has maintained an active license, and then decides to return to clinical work. As long as the physician’s license has remained “active,” the Board cannot compel the licensee to participate in a Board-approved or supervised reentry program. However, the best approach is for anyone, regardless of license status, who has been out of practice for over two years, to participate in a reentry program. This ensures that the physician’s fund of knowledge and clinical skills are current and up to par.

Reentry is a structured system that takes steps to ensure that physicians and physician assistants who return to medical practice after a significant period of inactivity can practice safely. Licensees who have been out of clinical practice for two or more years are required to complete an approved program of reentry before returning to unrestricted practice in North Carolina. The Board views its reentry program as a cost-effective alternative to other ways of demonstrating clinical competence before reentering active clinical practice, such as completing a mini-residency program or a formal personalized education program. To view more information about the reentry requirements for physicians and PAs, please visit: http://www.ncmedboard.org/professional_resources/special_topics_detail/reentry_to_the_practice_of_medicine.

RETURNING TO PRACTICE

Materials found both online and in this document include:

- The Board’s reentry position statement and rule (Attachments 27 - 28)
- Reentry plan content guidelines (Attachment 29)
- Sample letter notifying licensee of reentry requirement (Attachment 30)
- Sample reentry plan (document submitted by the licensee seeking reentry/licensure that describes his/her proposed reentry program) (Attachment 31)
- Sample reentry program (binding legal document executed by the Board that describes requirements and terms of licensee’s reentry program) (Attachment 32)

CONCLUSION

Physicians and other licensees may leave practice for any number of reasons: to relax; to concentrate on their health; to move to a different practice group, state, or area of specialty; or in response to a disciplinary action. Complexities about what else a departing physician may need to do include: whether or not to purchase ongoing professional liability, or “tail” coverage; whether or not to stay involved in organized medical societies; whether or not to maintain one’s status in specialty boards, and more. Physicians are encouraged to seek advice from their state medical society, their professional liability insurance carrier, their attorney, or their business advisor about these and other issues. Please also keep in mind that this document is based on laws, regulations, Position Statements and policies which change frequently. The Board will update this document as frequently as possible, but be aware that you should check the Board’s website for the most current versions of the authorities cited herein.

We hope this document has been helpful to you. For more information, feel free to contact the NC Medical Board with your questions.

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ATTACHMENT 1

"What are the position statements of the Board and to whom do they apply?"

(NCMB Position Statement)

The North Carolina Medical Board's Position Statements are interpretive statements that attempt to define or explain the meaning of laws or rules that govern the practice of physicians,* physician assistants, and nurse practitioners in North Carolina, usually those relating to discipline. They also set forth criteria or guidelines used by the Board's staff in investigations and in the prosecution or settlement of cases.

When considering the Board's Position Statements, the following four points should be kept in mind.

In its Position Statements, the Board attempts to articulate some of the standards it believes applicable to the medical profession and to the other health care professions it regulates. However, a Position Statement should not be seen as the promulgation of a new standard as of the date of issuance or amendment. Some Position Statements are reminders of traditional, even millennia old, professional standards, or show how the Board might apply such standards today.

The Position Statements are not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. Therefore, the absence of a Position Statement or a Position Statement's silence on certain matters should not be construed as the lack of an enforceable standard.

The existence of a Position Statement should not necessarily be taken as an indication of the Board's enforcement priorities.

A lack of disciplinary actions to enforce a particular standard mentioned in a Position Statement should not be taken as an abandonment of the principles set forth therein.

The Board will continue to decide each case before it on all the facts and circumstances presented in the hearing, whether or not the issues have been the subject of a Position Statement. The Board intends that the Position Statements will reflect its philosophy on certain subjects and give licensees some guidance for avoiding Board scrutiny. The principles of professionalism and performance expressed in the Position Statements apply to all persons licensed and/or approved by the Board to render medical care at any level.

*The words "physician" and "doctor" as used in the Position Statements refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina.

Created: Nov 1, 1999

Modified: Reviewed May 2010

ATTACHMENT 2

"Departures from or closings of medical practices" (NCMB Position Statement)

Departures from or closings of medical practices are trying times. If mishandled, they can significantly disrupt continuity of care and endanger patients.

Provide Continuity of Care

Practitioners continue to have obligations toward their patients during and after the departure from or closing of a medical practice. Practitioners may not abandon a patient or abruptly withdraw from the care of a patient. Patients should therefore be given reasonable advance notice (at least 30 days) to allow other medical care to be secured. Good continuity of care includes preserving and providing appropriate access to medical records.* Also, good continuity of care may often include making appropriate referrals. The practitioner(s) and other parties that may be involved should ensure that the requirements for continuity of care are effectively addressed.

It is the position of the North Carolina Medical Board that during such times practitioners and other parties that may be involved in such processes must consider how their actions affect patients. In particular, practitioners and other parties that may be involved have the following obligations.

Permit Patient Choice

It is the patient's decision from whom to receive care. Therefore, it is the responsibility of all practitioners and other parties that may be involved to ensure that:

- Patients are notified in a timely fashion of changes in the practice and given the opportunity to seek other medical care, sufficiently far in advance (at least 30 days) to allow other medical care to be secured, which is often done by newspaper advertisement and by letters to patients currently under care;
- Patients clearly understand that they have a choice of health care providers;
- Patients are told how to reach any practitioner(s) remaining in practice, and when specifically requested, are told how to contact departing practitioners; and
- Patients are told how to obtain copies of or transfer their medical records.

No practitioner, group of practitioners, or other parties involved should interfere with the fulfillment of these obligations, nor should practitioners put themselves in a position where they cannot be assured these obligations can be met.

Written Policies

The Board recommends that practitioners and practices prepare written policies regarding the secure storage, transfer and retrieval of patient medical records. Practitioners and practices should notify patients of these policies.

*NOTE: The Board's Position Statement on the Retention of Medical Records applies, even when practices close permanently due to the retirement or death of the practitioner.

ATTACHMENT 2

At a minimum, the Board recommends that such written policies specify:

- A procedure and timeline that describes how the practitioner or practice will notify each patient when appropriate about (1) a pending practice closure or practitioner departure, (2) how medical records are to be accessed, and (3) how future notices of the location of the practice's medical records will be provided;
- How long medical records will be retained;
- The procedure by which the practitioner or practice will dispose of unclaimed medical records after a specified period of time;
- How the practitioner or practice shall timely respond to requests from patients for copies of their medical records or to access to their medical records; In the event of the practitioner's death or incapacity, how the deceased practitioner's executor, administrator, personal representative or survivor will notify patients of the location of their medical records and how patients can access those records; and
- The procedure by which the deceased or incapacitated practitioner's executor, administrator, personal representative or survivor will dispose of unclaimed medical records after a specified period of time.

The Board further expects that its licensees comply with any applicable state and/or federal law or regulation pertaining to a patient's protected healthcare information.

Created: Jan 1, 2000

Modified: August 2003, July 2009

ATTACHMENT 3

Sample patient letter 1: Letter for physician retiring or discontinuing practice

Date

Patient Name

Address

Dear Patient:

Please be advised that because of _____ (retirement, illness, etc), I am discontinuing the practice of medicine on _____ (date). I will not be able to provide you with medical care after that date.

I recommend that you find another physician to take care of you. If you do not know another physician, you may visit the North Carolina Medical Board website at www.ncmedboard.org and search for one using the "Look up a doctor or PA" tool.

You may wish to obtain copies of your medical records, and you have a few options. If you like, you may come to the office and pick them up between now and _____ (date). Or, I will transfer my records of your care to a physician you designate. Since these records are confidential, I need your written authorization to make them available to another physician. For this reason, I am enclosing an authorization form. Please complete the form and return it to me by _____ (date).

I am sorry that I cannot continue as your physician. I extend to you my best wishes for your future health and happiness.

Sincerely,

Physician's Signature

ATTACHMENT 4

Sample patient letter 2: Letter for physician retiring or discontinuing practice, multiple provider practice

Place practice letterhead here

Date

Patient Name

Address

Dear Patient:

The purpose of this letter is to let you know of my plans for retirement. On _____ (date) I will be retiring from the practice of medicine.

I enjoyed my years of service to my patients and my community as a practicing _____ (name of specialty: physician or surgeon) in _____ (city). Thank you for entrusting me with your medical care.

My last day to see patients will be _____ (date). Therefore, you will need to make arrangements to find another physician to provide your medical care. You may find another physician from the community by searching the yellow pages under _____ (name of speciality), or use the "Look up a doctor or PA" search tool on the North Carolina Medical Board's website at www.ncmedboard.org. You may also remain with _____ (name of practice) and continue your medical care with any one of the practice's physicians.

Until my retirement, your medical records will be available _____ (location of records). Upon proper authorization, you may have a copy of your medical record or have a copy sent to the physician of your choice. For your convenience a Medical Record Release form is enclosed. Complete the form and send it to _____ (person/company responsible for release of patient's medical record and provide contact information). (If applicable advise patient of fees for record copies.)

After my retirement, you may contact _____ (contact information of person/company responsible for release of patient's medical record and provide contact information) to obtain your records.

It has been my pleasure and privilege to treat you during the course of my practice. I wish you and your family well.

Sincerely,

Physician's Signature

Enclosure: Medical Record Release Form

ATTACHMENT 5

Sample patient letter 1: From continuing practice which physician is leaving

Date (at least 30 days in advance)

Patient Name

Address

Dear Patient:

Please be advised that on _____ (date) _____ (name of physician) is retiring after a long and distinguished career in medicine, and we wish him the best.

The physicians, nurses, allied health professionals and staff at our practice will continue to provide the same quality health care you received from _____ (name of physician). If you wish to remain a patient of this practice, you do not have to do anything.

If, however, you would prefer to seek medical care elsewhere, you are free to do so. You may pick up a copy of your medical records at our office or you may ask us to transfer them directly to another office. For either of these options, we will need a signed authorization to transfer records. You may find this on our website at: _____ (website address). You may return that to our office in person, electronically, or by mail.

Please call us if you have any questions about your current or future treatment.

Sincerely,

Continuing Physician or Practice Manager Signature

ATTACHMENT 6

Sample patient letter 2: From continuing practice which physician is leaving to go to a competitor

Date (at least 30 days in advance)

Patient Name

Address

Dear Patient:

Please be advised that _____ (name of physician) has accepted a position with a practice in a nearby city, and will be leaving us soon. We wish him the very best in his new venture.

Patients who wish to be treated by _____ (name of physician) at his new practice may have a copy of their records transferred at no charge. Your original records will be retained at our practice. You have the right to choose your health-care provider, and we are committed to fully supporting your decision.

_____ (name of founding physician) , founder of the practice, along with our entire nursing and allied healthcare team, will continue to provide the latest in a wide range of medical services. Care you have received from _____ (name of physician) in the past will remain available at our practice.

If you wish to have a copy of your medical records sent to _____'s (name of physician) new practice, or have any questions about current or future treatment, please contact our office.

Sincerely,

Continuing Physician or Practice Manager Signature

ATTACHMENT 7

Sample patient letter: From physician entering new practice to former patients

Date

Patient Name

Address

Dear Patient:

I am excited to announce that I am now a part of _____ (name of new medical practice).

I enjoyed caring for you at _____, (name of former medical practice) and my primary goal during my transition is to maintain the health and wellness of all my patients.

Being a part of _____ (name of new medical practice) will allow me to continue offering you primary care and wellness services. I am also excited to offer you additional benefits and resources, including the latest medical records technology and access to _____ specialists.

If you need primary care or wellness services, I would be happy to continue caring for you at my new location at _____ (name and address of new medical practice). If you wish to have your medical records transferred from my former practice location, please contact that office directly and ask them to do so.

If you would like to make an appointment with me, please call _____ (phone number). I will begin seeing patients on _____ (date).

Thank you for your patience and understanding during this transition. I hope to re-establish care with you at my new practice location.

Sincerely,

Physician's Signature

ATTACHMENT 8

Authorization to transfer records

Authorization to Release Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), federal law pertaining to Early Childhood Intervention (34 C.F.R. part 300), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (N.C.G.S. 122C).

Patient Name

Date of Birth

Persons/organizations providing the Information

Persons/organizations receiving the information

Specify description of information (including dates):

All records of or other information regarding my treatment for all dates.

Purpose of the disclosure:

I understand that this authorization will expire on _____ (date) or one year from the date it is signed, whichever is earlier. Initials: _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any affect on any actions taken before the revocation was received. Initials: _____

I understand that I am authorizing the release of substance abuse, AIDS, HIV, or other communicable diseases, if such information is present in my record. Initials: _____

Signature of Patient or Patient’s Representative (Form MUST be completed before signing).

Date

Printed Name of Patient’s Representative

Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

ATTACHMENT 9

Notice for door of practice, advertisement in newspaper, or posting on practice's website

Re: Solo Physician who died or abandoned his practice

IF YOU ARE OR WERE A PATIENT OF _____ (name of physician):

We regret to inform you that _____ (name of physician) died/closed his practice/terminated his practice on _____ (date).

If you would like to pick up copies of your medical records, please contact _____ (name of contact) at _____ (contact information) by _____ (date) to make arrangements to do so. The records will be available free of charge. After _____ (date), the records will be destroyed to protect your confidential information.

If you have questions, please contact _____ (name of contact) at _____ (contact information).

ATTACHMENT 10

"The physician-patient relationship" (NCMB Position Statement)

The duty of the physician is to provide competent, compassionate, and economically prudent care to all his or her patients. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual relationship with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that:

- There be adequate communication between the physician and the patient;
- The physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
- There be no conflict of interest between the patient and the physician or third parties;
- Personal details of the patient's life shared with the physician be held in confidence;
- The physician maintain professional knowledge and skills;
- There be respect for the patient's autonomy;
- The physician be compassionate;
- The physician respect the patient's right to request further restrictions on medical information disclosure and to request alternative communications;
- The physician be an advocate for needed medical care, even at the expense of the physician's personal interests; and
- The physician provide neither more nor less than the medical problem requires.

ATTACHMENT 10

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust—communication, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, appropriate care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

This same fundamental physician-patient relationship also applies to all licensees.

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient.

The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. A copy of such notification is to be included in the medical record. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves only the individual physician or includes other members of the group. In the latter case, those members of the group joining in the termination must be designated. It is advisable that the notice of termination also include instructions for transfer of or access to the patient's medical records.

Created: July 1, 1995

Modified: July 1998, January 2000, March 2002, August 2003, September 2006, July 2012

ATTACHMENT 11

AMA Opinion 7.03 - Records of physician upon retirement or departure from a group

A patient's records may be necessary to the patient in the future not only for medical care but also for employment, insurance, litigation, or other reasons. When a physician retires or dies, patients should be notified and urged to find a new physician and should be informed that upon authorization, records will be sent to the new physician. Records which may be of value to a patient and which are not forwarded to a new physician should be retained, either by the treating physician, another physician, or such other person lawfully permitted to act as a custodian of the records.

The patients of a physician who leaves a group practice should be notified that the physician is leaving the group. Patients of the physician should also be informed of the physician's new address and offered the opportunity to have their medical records forwarded to the departing physician at his or her new practice location. It is unethical to withhold such information upon request of a patient. If the responsibility for notifying patients falls to the departing physician rather than to the group, the group should not interfere with the discharge of these duties by withholding patient lists or other necessary information. (IV)

Issued prior to April 1977

Updated: June 1994, June 1996 and February 2002

ATTACHMENT 12

"Retention of medical records" (NCMB Position Statement)

Licensees have both a legal and ethical obligation to retain patient records. The Board, therefore, recognizes the necessity and importance of a licensee's proper maintenance, retention, and disposition of medical records. The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

- State and federal laws require that records be kept for a minimum length of time including but not limited to:
 - The physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
 - Medicare and Medicaid Investigations (up to 7 years);
 - HIPAA (up to 6 years);
 - Medical Malpractice (varies depending on the case but should be measured from the date of the last professional contact with the patient)—licensees should check with their medical malpractice insurer); North Carolina has no statute relating specifically to the retention of medical records;
 - Immunization records always must be kept.
- In addition to existing state and federal laws, medical considerations may also provide the basis for deciding how long to retain medical records. Patients should be notified regarding how long the licensee will retain medical records.
- In deciding whether to keep certain parts of the record, an appropriate criterion is whether a licensee would want the information if he or she were seeing the patient for the first time. The Board, therefore, recognizes that the retention policies of licensees giving one-time, brief episodic care may differ from those of licensees providing continuing care for patients.
- In order to preserve confidentiality when discarding old records, all records should be destroyed, including both paper and electronic medical records.
- Those licensees providing episodic care should attempt to provide a copy of the patient's record to the patient, the patient's primary care provider, or, if applicable, the referring licensee.
- If it is feasible, patients should be given an opportunity to claim the records or have them sent to another licensee before old records are discarded.
- The licensee should respond in a timely manner to requests from patients for copies of their medical records or to access to their medical records.
- Licensees should notify patients of the amount, and under what circumstances, the licensee will charge for copies of a patient's medical record, keeping in mind that N.C. Gen. Stat. 90-411 provides limits on the fee a licensee can charge for copying of medical records.

ATTACHMENT 12

1 Licensees should retain medical records as long as needed not only to serve and protect patients, but also to protect themselves against adverse actions. The times stated may fall below the community standard for retention in their communities and practice settings and for the specific needs. Licensees are encouraged (may want to) seek advice from private counsel and/or their malpractice insurance carrier.

Created: May 1, 1998

Modified: May 2009; Reviewed July 2013

ATTACHMENT 13

"Access to medical records" (NCMB Position Statement)

A licensee's policies and practices relating to medical records under his or her control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. Such policies and practices should conform to applicable federal and state laws governing health information.

It is the position of the North Carolina Medical Board that notes made by a licensee in the course of diagnosing and treating patients are primarily for the licensee's use and to promote continuity of care. Patients, however, have a substantial right of access to their medical records and a qualified right to amend their records pursuant to the HIPAA privacy regulations.

Medical records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient. Licensees are responsible for safeguarding and protecting the medical record and for providing adequate security measures.

Each licensee has a duty on the request of a patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the licensee believes that such release would endanger the patient's life or cause harm to another person. This includes medical records received from other licensee offices or health care facilities. A summary may be provided in lieu of providing access to or copies of medical records only if the patient agrees in advance to such a summary and to any fees imposed for its production.

Licensees may charge a reasonable fee for the preparation and/or the photocopying of medical and other records. To assist in avoiding misunderstandings, and for a reasonable fee, the licensee should be willing to review the medical records with the patient at the patient's request. Medical records should not be withheld because an account is overdue or a bill is owed (including charges for copies or summaries of medical records).

Should it be the licensee's policy to complete insurance or other forms for established patients, it is the position of the Board that the licensee should complete those forms in a timely manner. If a form is simple, the licensee should perform this task for no fee. If a form is complex, the licensee may charge a reasonable fee.

To prevent misunderstandings, the licensee's policies about providing copies or summaries of medical records and about completing forms should be made available in writing to patients when the licensee-patient relationship begins.

Licensees should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records.*

[*] See also Position Statement on Departures from or Closings of Medical Practices.

ATTACHMENT 13

When responding to subpoenas for medical records, unless there is a court or administrative order, licensees should follow the applicable federal regulations.

Created: Nov 1, 1993

Modified: May 1996, September 1997, March 2002, August 2003, September 2010

ATTACHMENT 14

N.C. Gen. Stat. § 90-411. Record copy fee.

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars (\$10.00), inclusive of copying costs. If requested by the patient or the patient's designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record. This section shall only apply with respect to liability claims for personal injury, and claims for social security disability, except that charges for medical records and reports related to claims under Article 1 of Chapter 97 of the General Statutes shall be governed by the fees established by the North Carolina Industrial Commission pursuant to G.S. 97-26.1. This section shall not apply to Department of Health and Human Services Disability Determination Services requests for copies of medical records made on behalf of an applicant for Social Security or Supplemental Security Income disability. (1993, c. 529, s. 4.3; 1993 (Reg. Sess., 1994), c. 679, s. 5.5; 1995 (Reg. Sess., 1996), c. 742, s. 36; 1997-443, ss. 11.3, 11A.118(b).)

ATTACHMENT 15

N.C. Gen. Stat. § 90-412. Electronic medical records.

- (a) Notwithstanding any other provision of law, any health care provider or facility licensed, certified, or registered under the laws of this State or any unit of State or local government may create and maintain medical records in an electronic format. The health care provider, facility, or governmental unit shall not be required to maintain a separate paper copy of the electronic medical record. A health care provider, facility, or governmental unit shall maintain electronic medical records in a legible and retrievable form, including adequate data backup.
- (b) Notwithstanding any other provision of law, any health care provider or facility licensed, certified, or registered under the laws of this State or any unit of State or local government may permit authorized individuals to authenticate orders and other medical record entries by written signature, or by electronic or digital signature in lieu of a signature in ink. Medical record entries shall be authenticated by the individual who made or authorized the entry. For purposes of this section, “authentication” means identification of the author of an entry by that author and confirmation that the contents of the entry are what the author intended.
- (c) The legal rights and responsibilities of patients, health care providers, facilities, and governmental units shall apply to records created or maintained in electronic form to the same extent as those rights and responsibilities apply to medical records embodied in paper or other media. This subsection applies with respect to the security, confidentiality, accuracy, integrity, access to, and disclosure of medical records. (1999-247, s. 2; 2007-248, s. 3.)

ATTACHMENT 16

N.C. Gen. Stat. § 90-5.1. Powers and duties of the Board.

- (a) The Board shall:
- (1) Administer this Article.
 - (2) Issue interpretations of this Article.
 - (3) Adopt, amend, or repeal rules as may be necessary to carry out and enforce the provisions of this Article.
 - (4) Require an applicant or licensee to submit to the Board evidence of the applicant's or licensee's continuing competence in the practice of medicine.
 - (5) Regulate the retention and disposition of medical records, whether in the possession of a licensee or nonlicensee. In the case of the death of a licensee, the rules may provide for the disposition of the medical records by the estate of the licensee. This subsection shall not apply to records created or maintained by persons licensed under other Articles of this Chapter or to medical records maintained in the normal course of business by licensed health care institutions.
 - (6) Appoint a temporary or permanent custodian for medical records abandoned by a licensee.

ATTACHMENT 17

N.C. Gen. Stat. § 90-5.2. Board to collect and publish certain data.

- (a) The Board shall require all physicians and physician assistants to report to the Board certain information, including, but not limited to, the following:
- (1) The names of any schools of medicine or osteopathy attended and the year of graduation.
 - (2) Any graduate medical or osteopathic education at any institution approved by the Accreditation Council of Graduate Medical Education, the Committee for the Accreditation of Canadian Medical Schools, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.
 - (3) Any specialty board of certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.
 - (4) Specialty area of practice.
 - (5) Hospital affiliations.
 - (6) Address and telephone number of the primary practice setting.
 - (7) An e-mail address or facsimile number which shall not be made available to the public and shall be used for the purpose of expediting the dissemination of information about a public health emergency.
 - (8) Any final disciplinary order or other action required to be reported to the Board pursuant to G.S. 90-14.13 that results in a suspension or revocation of privileges.
 - (9) Any final disciplinary order or action of any regulatory board or agency including other state medical boards, the United States Food and Drug Administration, the United States Drug Enforcement Administration, Medicare, or the North Carolina Medicaid program.
 - (10) Conviction of a felony.
 - (11) Conviction of certain misdemeanors, occurring within the last 10 years, in accordance with rules adopted by the Board.
 - (12) Any medical license, active or inactive, granted by another state or country.
 - (13) Certain malpractice information received pursuant to G.S. 90-5.3, G.S. 90-14.13, or from other sources in accordance with rules adopted by the Board.
- (b) Except as provided, the Board shall make information collected under G.S. 90-5.2(a) available to the public.
- (c) The Board may adopt rules to implement this section.
- (d) Failure to provide information as required by this section and in accordance with Board rules or knowingly providing false information may be considered unprofessional conduct as defined in G.S. 90-14(a)(6).
- (2007-346, s. 6; 2009-217, s. 2.)

ATTACHMENT 18

21 NCAC 46.3001 Procedure for disposing of drugs

- (a) All registrants under G.S. 90-85.21 shall develop and implement policies and procedures to insure that all outdated, improperly labeled, adulterated, damaged or unwanted drugs or drug containers with worn, illegible or missing labels are destroyed or disposed of so as to render them unusable.
- (b) Any permit holder in possession of outdated, adulterated or unwanted drugs other than controlled substances may dispose or destroy such drugs by returning them to the manufacturer, by incineration at a properly permitted facility, or by any other means approved by the Board which will assure protection against unauthorized possession or use. Destructions under this Paragraph taking place at the permit holder's premises shall be witnessed by a licensed pharmacist and documented.
- (c) Any permit holder in possession of any controlled substance and desiring or required to dispose of such substance may file a written request on a form provided by the Board for authority and instructions to dispose of such substance. If destruction under this Paragraph takes place at the permit holder's premises such destruction shall be jointly witnessed by at least two licensed pharmacists approved by the Board. All destructions of controlled substances shall be documented and the document shall be retained by the permit holder for a period of at least three years. Copies of the document shall be sent to the Drug Enforcement Administration.

History Note: Authority G.S. 90-85.6; 90-85.21;

Eff. October 1, 1993.

ATTACHMENT 19

"The retired physician/licensee" (NCMB Position Statement)

The retirement of a licensee is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the licensee in any form or setting. According to the Board's definition, the retired licensee is not required to maintain a currently registered license and SHALL NOT:

- Provide patient services;
- Order tests or therapies;
- Prescribe, dispense, or administer drugs;
- Perform any other medical and/or surgical acts; or
- Receive income from the provision of medical and/or surgical services performed following retirement.

The North Carolina Medical Board is aware that a number of licensees consider themselves "retired," but still hold a currently registered medical license (full, volunteer, or limited) and provide professional medical and/or surgical services to patients on a regular or occasional basis. Such licensees customarily serve the needs of previous patients, friends, nursing home residents, free clinics, emergency rooms, community health programs, etc. The Board commends those licensees for their willingness to continue service following "retirement," but it recognizes such service is not the "complete cessation of the practice of medicine" and therefore must be joined with an undiminished awareness of professional responsibility.

That responsibility means that such licensees SHOULD:

- Practice within their areas of professional competence;
- Prepare and keep medical records in accord with good professional practice; and
- Meet the Board's continuing medical education requirement.

The Board also reminds "retired" licensees with currently registered licenses that all federal and state laws and rules relating to the practice of medicine and/or surgery apply to them, that the position statements of the Board are as relevant to them as to licensees in full and regular practice, and that they continue to be subject to the risks of liability for any medical and/or surgical acts they perform.

Created: Jan 1, 1997

Modified: September 2006, July 2012

ATTACHMENT 20

Conversation of full license to retired volunteer license form

NC Medical Board

PO Box 20007

Raleigh, NC 27619

Conversion of Full License to Retired Volunteer License

To: North Carolina Medical Board

By submission of this form I wish to convert my full North Carolina medical license to a Retired Volunteer License. By my signature below, I certify that I have no expectation of payment or compensation for any medical services I render pursuant to the Limited Volunteer License, if granted by the Board. I certify that I shall not receive or accept any compensation or payment, direct, monetary, in-kind, or otherwise, for the provision of medical services pursuant to the Limited Volunteer License. I understand I will be required to comply with Continuing Medical Education requirements as required by NC General Statute 90-14 (a)(15). I understand the Limited Volunteer License allows me to practice medicine and surgery only at clinics that specialize in the treatment of indigent patients.

I propose to practice in the following location(s): _____

Full Name (Printed)

Social Security Number

Signature

Date

Revised: 8/12

ATTACHMENT 21

21 NCAC 32B .1701 Scope of practice under limited volunteer license and retired limited volunteer license

The holder of a Limited Volunteer License or a Retired Volunteer Limited License may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients, and may not receive any compensation for services rendered, either direct or indirect, monetary, in-kind, or otherwise for the provision of medical services.

History Note: Authority G.S. 90-8.1; 90-12.1A;

Eff. August 1, 2010;

Amended Eff. November 1, 2013.

ATTACHMENT 22

21 NCAC 32B .1702 Application for limited volunteer license

- (a) The Limited Volunteer License is available to physicians who hold an active license in a state or jurisdiction other than North Carolina, and who wish to volunteer at civilian indigent clinics.
- (b) In order to obtain a Limited Volunteer License, an applicant shall:
- (1) Submit a completed application, attesting under oath or affirmation that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
 - (2) Submit a photograph, two inches by two inches, affixed to the oath or affirmation attested to by a notary public;
 - (3) Submit documentation of a legal name change, if applicable;
 - (4) Submit proof of active licensure from another state or jurisdiction indicating the status of the license and whether or not any action has been taken against the license;
 - (5) Submit a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
 - (6) Submit a NPDB report, dated within 60 days of submission of the application;
 - (7) Submit a FSMB Board Action Data Bank report;
 - (8) Submit two completed fingerprint record cards supplied by the Board;
 - (9) Submit a signed consent form allowing a search of local, state, and national files for any criminal record;
 - (10) Pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a) to cover the cost of a criminal background check;
 - (11) Upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.
- (c) All materials must be submitted directly to the Board from the primary source, when possible.
- (d) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.
- (e) An application must be completed within one year of the date of submission.

History Note: Authority G.S. 90-8.1; 90-12.1A;

Eff. August 1, 2010;

Amended Eff. November 1, 2013.

ATTACHMENT 23

21 NCAC 32B .1703 Scope of practice under retired volunteer license

The holder of a Retired Limited Volunteer License may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients, and may not receive any compensation for services rendered, either direct or indirect, monetary, in-kind, or otherwise for the provision of medical services.

History Note: Authority G.S. 90-8.1; 90-12.1A;

Eff. August 1, 2010.

ATTACHMENT 24

21 NCAC 32B .1704 Application for retired limited volunteer license

- (a) The Retired Limited Volunteer License is available to physicians who have been licensed in North Carolina or an other state or jurisdiction, have an inactive license, and who wish to volunteer at indigent clinics.
- (b) An applicant who has never held a North Carolina license but held an active license in another state or jurisdiction, which is currently inactive, shall:
 - (1) Submit a completed application, attesting under oath or affirmation that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
 - (2) Submit a photograph, two inches by two inches, affixed to the oath or affirmation which has been attested to by a notary public;
 - (3) Submit documentation of a legal name change, if applicable;
 - (4) Supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
 - (5) Submit proof of licensure from another state or jurisdiction indicating the status of the license and whether or not any action has been taken against the license;
 - (6) Submit two completed fingerprint record cards supplied by the Board;
 - (7) Submit a signed consent form allowing a search of local, state and national files for any criminal record;
 - (8) Pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a) to cover the cost of a criminal background check;
 - (9) Submit a FSMB Board Action Data Bank report;
 - (10) Submit a NPDB report, dated within 60 days of submission of the application;
 - (11) Upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.
 - (12) All materials must be submitted to the Board from the primary source, when possible.
- (c) An applicant who holds an active North Carolina physician license may convert that to a Retired Limited Volunteer License by completing the Application for Retired Volunteer License.
- (d) An applicant who held a North Carolina license which has been inactive less than six months may convert to a Retired Limited Volunteer License by completing the Application for Retired Volunteer License.
- (e) An applicant who held a North Carolina license which has been inactive for more than six months but less than two years shall meet the requirements set forth in 21 NCAC 32B .1360.
- (f) An applicant who held a North Carolina license which has been inactive for more than two years shall meet the requirements set forth at 21 NCAC 32B .1350.

ATTACHMENT 24

- (g) A physician who has been out of practice for more than two years will be required to complete a reentry program as set forth in 21 NCAC 32B .1370.
- (h) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.
- (i) An application must be completed within one year of the date of submission.

History Note: Authority G.S. 90-8.1; 90-12.1A;

Eff. August 1, 2010;

Amended Eff. November 1, 2013.

ATTACHMENT 25

21 NCAC 32B .1360 Reactivation of physician license

- (a) Reactivation applies to a physician who has held a physician license in North Carolina, and whose license has been inactive for up to one year except as set out in Rule .1704(e) of this Subchapter. Reactivation is not available to a physician whose license became inactive either while under investigation by the Board or because of disciplinary action by the Board.
- (b) In order to reactivate a Physician License, an applicant shall:
- (1) Submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
 - (2) Supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States; (Note: there may be some applicants who are not present in the US and who do not plan to practice physically in the US. Those applicants shall submit a statement to that effect);
 - (3) Submit a FSMB Board Action Data Bank report;
 - (4) Submit documentation of CME obtained in the last three years;
 - (5) Submit two completed fingerprint record cards supplied by the Board;
 - (6) Submit a signed consent form allowing search of local, state, and national files for any criminal record;
 - (7) Pay to the Board the relevant, non-refundable fee, plus the cost of a criminal background check; and
 - (8) Upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.
- (c) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

History Note: Authority G.S. 90-8.1; 90-9.1; 90-12.1A; 90-13.1; 90-14(a)(11a);

Eff. August 1, 2010.

ATTACHMENT 26

21 NCAC 32B .1350 Reinstatement of physician license

- (a) Reinstatement is for a physician who has held a North Carolina License, but whose license either has been inactive for more than one year, or whose license became inactive as a result of disciplinary action (revocation or suspension) taken by the Board. It also applies to a physician who has surrendered a license prior to charges being filed by the Board.
- (b) All applicants for reinstatement shall:
- (1) Submit a completed application, attesting under oath or affirmation that information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
 - (2) Submit documentation of a legal name change, if applicable;
 - (3) Supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
 - (4) If a graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, shall furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:
 - (A) The applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or
 - (B) The applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;
 - (5) Submit the AMA Physician Profile; and, if applicant is an osteopathic physician, also submit the AOA Physician Profile;
 - (6) Submit a NPDB/HIPDB report dated within 60 days of the application's submission;
 - (7) Submit a FSMB Board Action Data Bank report;
 - (8) Submit documentation of CME obtained in the last three years, upon request;
 - (9) Submit two completed fingerprint cards supplied by the Board;
 - (10) Submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;
 - (11) Provide two original references from persons with no family or material relationship to the applicant. These references must be:
 - (A) From physicians who have observed the applicant's work in a clinical environment within the past three years;
 - (B) On forms supplied by the Board;
 - (C) Dated within six months of submission of the application; and
 - (D) Bearing the original signature of the author;

ATTACHMENT 26

- (12) Pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check; and
 - (13) Upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.
- (c) In addition to the requirements of Paragraph (b) of this Rule, the applicant shall submit proof that the applicant has:
- (1) Within the past 10 years taken and passed either:
 - (A) An exam listed in G.S. 90-10.1 (a state board licensing examination; NBME; NBOME; USMLE; FLEX; COMLEX; or MCCQE or their successors);
 - (B) SPEX (with a score of 75 or higher); or
 - (C) COMVEX (with a score of 75 or higher);
 - (2) Within the past ten years:
 - (A) Obtained certification or recertification of CAQ by a specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA; or
 - (B) Met requirements for ABMS MOC (maintenance or certification) or AOA OCC (Osteopathic Continuous Certification);
 - (3) Within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or
 - (4) Within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.
- (d) All reports must be submitted directly to the Board from the primary source, when possible.
- (e) An applicant shall be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character if the Board needs more information to complete the application.
- (f) An application must be complete within one year of submission. If not, the applicant shall be charged another application fee plus the cost of another criminal background check.

History Note: Authority G.S. 90-8.1; 90-9.1; 90-10.1; 90-13.1;

Eff. August 1, 2010;

Amended Eff. November 1, 2013; November 1, 2011.

ATTACHMENT 27

"Competence and reentry to the active practice of medicine" (NCMB Position Statement)

The ability to practice medicine results from a complex interaction of knowledge, physical skills, judgment, and character tempered by experience leading to competence. Maintenance of competence requires a commitment to lifelong learning and the continuous practice of medicine, in whatever field one has chosen. Absence from the active practice of medicine leads to the attenuation of the ability to practice competently.

It is the position of the North Carolina Medical Board, in accord with GS 90-14 (11a), that practitioners seeking licensure, or reactivation of a North Carolina medical license, who have had an interruption, for whatever reason, in the continuous practice of medicine greater than two (2) years must reestablish, to the Board's satisfaction, their competence to practice medicine safely.

Any such applicant must meet all the requirements for and completion of a regular license application. In addition, full-scale assessments, engagement in formal training programs, supervised practice arrangements, formal testing, or other proofs of competence may be required.

The Board will cooperate with appropriate entities in the development of programs and resources that can be used to fulfill the above requirements, including the issuance, when necessary and appropriate, of a time or location limited and/or restricted license (e.g., residency training license).

It shall be the responsibility of the applicant to develop a reentry program subject to the approval of the Board.

Created: Jul 1, 2006

ATTACHMENT 28

21 NCAC 32B .1370 Reentry to active practice

- (a) A physician or physician assistant applicant (“applicant” or “licensee”) who has not actively practiced or who has not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for a license from the Board shall complete a reentry agreement as a condition of licensure.
- (b) The applicant shall identify a mentoring physician.
- (c) The applicant shall propose a reentry plan containing the components outlined in Paragraphs (g) and (h) of this Rule to the Board. The Board shall review the proposed reenter plan and interview the applicant.
- (d) Factors that may affect the length and scope of the reentry plan include:
 - (1) The applicant’s amount of time out of practice;
 - (2) The applicant’s prior intensity of practice;
 - (3) The reason for the interruption in practice;
 - (4) The applicant’s activities during the interruption in practice, including the amount of practice relevant continuing medical education;
 - (5) The applicant’s previous and intended area(s) of practice;
 - (6) The skills required of the intended area(s) of practice;
 - (7) The amount of change in the intended area(s) of practice over the time the applicant has been out of continuous practice;
 - (8) The applicant’s number of years of graduate medical education;
 - (9) The number of years since completion of graduate medical education; and
 - (10) As applicable, the date of the most recent ABMS, AOA or equivalent specialty board, or National Commission on Certification of Physician Assistant certification or recertification.
- (e) If the Board approves an applicant’s reentry plan, it shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board and the mentoring physician.
- (f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a restricted License. The licensee may not practice outside of the scope of the reentry agreement and its referenced reentry plan during the reentry period.
- (g) The first component of a reentry plan is an assessment of the applicant’s current strengths and weaknesses in his or her intended area of practice. The process used to perform the assessment shall be described by the applicant and confirmed by the mentoring physician. The process may include self-reflection, self-assessment, and testing and evaluation by colleagues, educators or others. The applicant and mentoring physician shall evaluate and describe applicant’s strengths and areas of needed improvement in regard to the core competencies. The assessment shall continue throughout the reentry period as the licensee and the mentoring physician practice together.

- (h) The second component of the reentry plan is education. Education shall address the licensee's areas of needed improvement. Education shall consist of:
- (1) A reentry period of retraining and education under the guidance of a mentoring physician, upon terms as the Board may decide, or
 - (2) A reentry period of retraining and education under the guidance of a mentoring physician consisting of the following:
 - (A) Phase I – The observation phase. During the observation phase, the licensee will not practice, but will observe the mentoring physician in practice.
 - (B) Phase II – Direct supervision phase. During the direct supervision phase, the licensee shall practice under the direct supervision of the mentoring physician. Guided by the core competencies, the mentoring physician shall reassess the licensee's progress in addressing identified areas of needed improvement.
 - (C) Phase III – Indirect supervision phase. During the indirect supervision phase, the licensee shall continue to practice with supervision of the mentoring physician. Guided by the core competencies, and using review of patient charts and regular meetings, the mentoring physician shall reassess the licensee's progress in addressing the areas of needed improvement.
 - (D) No later than 30 days after the end of phase I and II, the mentoring physician shall send a report to the Board regarding the licensee's level of achievement in each of the core competencies. At the completion of phase III the mentoring physician shall submit a summary report to the Board regarding the licensee's level of achievement in each of the core competencies and affirm the licensee's suitability to resume practice as a physician or to resume practice as a physician assistant.
 - (E) If the mentoring physician reassesses the licensee and concludes that the licensee requires an extended reentry period or if additional areas of needed improvement are identified during Phases II or III, the Board, the licensee and the mentoring physician shall amend the reentry agreement.
- (i) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the mentoring physician may terminate his role as the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The licensee's approval is not required for the mentoring physician to terminate his role as mentoring physician. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.

ATTACHMENT 28

- (j) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the licensee may terminate the relationship with the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The mentoring physician's approval is not required for the licensee to terminate this relationship. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.
- (k) The licensee shall meet with members of the Board at such dates, times and places as directed by the Board to discuss the licensee's transition back into practice and any other practice-related matters.
- (l) Unsatisfactory completion of the reentry plan or practicing outside the scope of the reentry agreement, as determined by the Board, shall result in the automatic inactivation of the licensee's license, unless the licensee requests a hearing within 30 days of receiving notice from the Board.
- (m) If the Board determines the licensee has successfully completed the reentry plan, the Board shall terminate the reentry agreement and notify the licensee that the license is no longer restricted.

History Note: Authority G.S. 90- 8.1; 90-14(a)(11a);

Eff. March 1, 2011.

ATTACHMENT 29

Reentry plan content guidelines

The following information is meant to assist North Carolina Medical Board Physician License Applicants who are requested to provide a reentry plan as a condition of licensure. Your reentry plan will become part of your license application. After your license application and reentry plan have been approved by the Board, the Board will create a formal Reentry Agreement that reflects information contained in your reentry plan. The Reentry Agreement is a non-disciplinary consent order between the applicant and the Board, an example is included in this packet of information for your review. (The Reentry Agreement is for your information only. Please do not submit a Reentry Agreement with your reentry plan.) Please be aware that after your reentry plan and license application are approved, you will receive a full and unrestricted license. That license will be conditional upon the terms of the Reentry Agreement but will allow you to apply for malpractice insurance and hospital privileges, and charge for your services.

You will need to identify a suitable mentor prior to developing and submitting a reentry plan. Your mentor should not have a North Carolina Medical Board public disciplinary record, and preferably should be ABMS or AOA certified in the area of practice that you are reentering. You are expected to develop a reentry plan, with your mentor's help and guidance that best addresses your circumstances. When you have completed your plan, it should be submitted for Board staff review. Board staff may make suggestions that will help your plan receive Board approval. It is your decision whether or not to accept staff suggestions for improvement. Both the Medical Director and the Associate Medical Director on the Board staff are available to discuss your plan and any questions you may have about the reentry process.

Reentry Plan Content:

You should provide a brief but detailed description of your previous clinical experience with emphasis on the 2 – 5 years directly preceding your period of clinical inactivity. You should describe how many hours you worked, your patient volume and acuity, on-call responsibilities, whether you provided inpatient care, and other details of your practice that gives the Board a good perspective of your clinical experience. You should describe your future scope of practice plans. If you are able, you should describe your future practice setting, referencing the number of hours you plan to work, expected patient volume and acuity, on-call responsibilities and inpatient work, along with other details that give the Board a good understanding of what you plan to do. This is important information that helps guide the Board with regard to its review of your reentry plan.

You should provide a detailed statement in the language of the core competencies that describes your current strengths and weaknesses. You may wish to access the Good Medical Practice USA document for a general review of the core competencies at gmpusa.org. The basis for your assessment should be described, e.g., self-reflection, testing, mentor/previous colleague/educator evaluation, CPEP, or other pertinent sources.

You should provide a detailed statement describing your education program (please see the enclosed example). The education program should address weaknesses identified by the assessments from item 2, above. The program should include a detailed timeline and detailed content description. It is strongly suggested that you use a three phase timeline for the Patient Care competency. This three phase timeline may also be used to guide education for the remaining

competencies. With a three phase timeline, phase one should be a period of your observation of your mentor in clinical practice. The goals of this phase of observation should be described. Your time commitment, the observed patient volume and acuity, and the mentor's means of monitoring and assessing progress toward your goals during this phase should be specified. Your mentor will submit a written report to the Board at the end of this phase and you should reference this in your description.

Phase two will be a period of directly supervised practice. Your description of phase two should specify your goals and how your mentor will assess whether you meet them. You should specify that your mentor will directly witness fundamental aspects of your practice (including procedures) in order to confirm that you possess the knowledge and skills to perform these aspects of practice competently. Once confirmed, you and your mentor may decrease the degree of directly witnessed practice as appropriate. However, it is strongly suggested that all your clinical work during this phase be reviewed by your mentor prior to the implementation of any significant clinical management recommendations that affect a patient's care. For applicants who will be providing face-to-face patient care, it is strongly suggested that you and your mentor discuss each patient you care for prior to the patient's discharge from an outpatient or inpatient setting. You should provide a detailed description of your planned hours of work, your patient volume and acuity, and any procedures you will perform. You may wish to begin this phase with an appropriately diminished patient volume and acuity level, and work towards a stated higher goal. You should specify a regularly recurring time for you and your mentor to discuss your progress. You should reference your mentor's phase two reports to the Board. That report should include a statement of your goals for phase two and whether they have been met.

During phase three you may practice independently but with appropriate supervision. Your stated goals for this phase should include preparing you for independent practice. Your mentor's means of monitoring and assessing your patient care competency during this phase should be specified. You should specify your hours of work, your patient volume and acuity, and any planned changes in these parameters as phase three progresses. For applicants that are providing face-to-face patient care, it is suggested that all patients of high acuity and/or complexity, and all patients with problems that are new to the applicant be discussed with the mentor prior to each patient's discharge from an outpatient or inpatient setting. At the completion of phase three, you should specify that the mentor will provide a summary approval letter to the Board.

The three phase timeline established for the Patient Care competency may be used to guide focused retraining and education, and mentor reporting for the remaining competencies. For the topic of Medical Knowledge, the applicant should describe the content of focused category 1 and 2 CME including maintenance of competency activities pertinent to the applicant's specialty. If applicable, plans for obtaining ABMS certification or recertification in the applicant's area of specialty should be included. The focus of continued education plans should address weaknesses identified by previous assessments and/or the mentor. A plan describing how the applicant's mentor is to assess and approve the applicant's competency in this area should be specified. For the topic Communication, the applicant may choose focused CME or other activities pertinent to this competency. A plan describing how the applicant's mentor is to assess and approve the applicant's communication skills should be specified. For the topic Systems based practice, the applicant may choose to outline specific plans of selected readings, hospital QIM work or other focused CME. There should be a description of

how the applicant's mentor is to assess and approve the applicant's competency in this area. For the topic Practice-based Learning, the applicant may choose to describe how the experience gained early during the reentry period will be applied to further augment re-entry period learning and/or help guide future practice-based learning. There should be a description of how the applicant's mentor is to assess and approve the applicant's competency in this area. For the topic Professionalism, the applicant should specify a plan to remediate weaknesses identified during assessment, and a description of how the applicant's mentor is to assess and approve the applicant's competency in this area should be included. Other information and activities that the applicant feels are pertinent to reentry should be included.

Information obtained from the Mentor by the applicant and to be submitted to the Board:

The applicant should obtain from the mentor:

- A copy of the mentor's Curriculum Vitae
- A statement from the mentor of his/her previous experience as an educator, mentor, and teacher. This may include experience gained from previous residency training, current experience in practice based learning, participation in practice/hospital quality improvement activities or other pertinent information.
- A statement of financial arrangements between the mentor and the applicant that describe how the mentor is to be compensated by the applicant during the reentry period. If the mentor is serving on a voluntary basis, this should be specified.
- A statement of the mentor's current and expected future personal and professional relationships with the licensee.
- A statement that the mentor has reviewed and approved the licensee's scope of practice, assessment, and reentry program. The statement should include an estimate of the mentor's expected time commitment to each phase of the reentry program.
- Other information that the mentor feels are pertinent to the applicant's re-entry plan should be included.

ATTACHMENT 30

Sample letter notifying licensee of reentry requirement

Date

Physician Name

Physician Address

Dear Physician:

Due to the time you have been away from active clinical practice you will be required to meet with a member of the Board as part of the application process for NC medical license. You should contact one of the Board members on the enclosed list to schedule the interview. Once you have made an appointment you must notify this office with the name of the Board member and the date of the interview in order that your file can be forwarded to them. The interview must be conducted no later than _____ (date) or portions of the application may have to be updated.

You will be required to develop a reentry plan as part of your license application. It is your responsibility to be prepared to present a plan of re-training and supervision that will establish proof of competency in your chosen area of medicine. It will facilitate the license process to present a written plan for reentry at your interview. Although the Board does not take responsibility for developing reentry plans it has developed guidelines to assist the re-entry applicant in developing such a plan. I have enclosed a copy of those guidelines and a copy of a sample plan. I am also enclosing an example of a reentry agreement. This is a non-disciplinary consent order between you and the Board. As you will see by reviewing this document, it is not detailed and does not include a detailed description of a re-entry plan. If you have questions as you develop your re-entry plan, both the Medical Director and the Associate Medical Director on the Board staff are available to help and can be reached by telephone at the Board.

The details from your re-entry plan will be reviewed with you during your Board member interview. It is not a public document but will be kept in your file. The public, non-punitive re-entry agreement between you and the Board will be available to the public on the Board's website.

Once an applicant's re-entry plan is approved, a re-entry agreement will be completed that will allow you to begin your re-entry plan. When you have completed your re-entry plan and fulfilled the terms of your re-entry agreement, a full and unrestricted license may follow. If you choose to not pursue a reentry plan a request for withdrawal of your application may be granted.

Sincerely,

Director of Licensing

ATTACHMENT 31

Sample reentry plan

Re-entry Plan of _____ (name of physician) submitted to the North Carolina Medical Board**1. Introduction**

I initially obtained my license to practice medicine from the North Carolina Medical Board on July 24, 1999. I worked as an ABMS certified, Emergency Medicine physician at _____ (location) from July 1999 to July 2006 on a full-time basis. I left the practice of Medicine in December of 2006 to care for my children. I wish to regain my license and reenter medical practice as an urgent care physician.

During my seven years of active practice, there were no patients, peers or others familiar with my practice who indicated that there were any deficiencies in my abilities as a practitioner, either generally or in any of the domains of competency delineated in the National Alliance for Physician Competence's "Guide to Good Medical Practice – USA."

2. Scope of Future Practice Plans

Upon re-entering into the clinical practice of medicine I plan to enter into an Urgent Care office with Dr. _____ (name of physician) in _____ (location). I ultimately plan to work full-time at approximately thirty to forty hours each week. I will be seeing patients of all ages. I will provide immediate, walk-in medical service (no appointment needed) offering outpatient care for minor acute illnesses and injuries. The office currently has one physician and two physician assistants. The acuity level is typically low with the exception of the occasional patient presenting with more serious complaints that require a higher level of care. Those patients are immediately transferred to the local hospital emergency department for further evaluation using the practice's existing policies and procedures for such patients. If needed, EMS is called for transport. No direct admissions are done from this office, the practitioners in this office do not provide in-patient hospital service. Most patients present with complaints of minor musculoskeletal complaints, upper respiratory infections, ear infections, and other problems typical for an urgent care walk-in practice.

The volume is approximately eighty to ninety patients per day. This aspect of Urgent Care Medicine requires a broad, comprehensive fund of knowledge. Having trained in Emergency Medicine, I am well qualified to provide such care.

To ensure the best patient care I plan on limiting my practice to no more than two patients per hour. This will allow complete history taking, physical examination, and appropriate treatment decisions relating to each patient. If, during a brief period of time where there is increased demand for medical care, I will add a third patient per hour as necessary.

Upon completing my re-entry plan, I would like to return to the practice of medicine in an urgent care setting or the urgent-care side of an Emergency Department. I intend on working no more than forty hours a week and will not be taking any call. I intend on seeing patients in an Urgent Care or urgent-care side of an Emergency Department. There will be no in-patient care of patients. I would only request privileges, if working in a hospital, to see patients in an Emergency Department setting, and only in an urgent care side of an Emergency Department.

I plan on implementing my reentry plan and remediation at _____ (name of practice) in _____ (location) as soon as it is approved by the Board. _____ (name of physician) has agreed to serve as my mentor, he is an Urgent Care Provider, with an extensive practice teaching experience.

3. Strengths and weaknesses

Strengths:

A. Patient care

The patient care I have provided has been excellent. My strengths in this core competency include performing and obtaining adequate physical examinations, including social and psychological factors. I encourage patients to be involved in their medical care including lifestyle choices that can directly impact their health, wellness, and treatment outcomes. I encourage patients to make healthy choices to improve and maintain their health. I prioritize care based on clinical need and am an excellent physician with invasive and non-invasive procedures. I also have had very positive feedback from patients and other clinicians regarding the care that I have provided.

B. Medical knowledge and skills

It is very important for a physician to have sound medical knowledge. During the past three years I have completed over one-hundred and fifty hours of Category I evidence based CME. My CME has primarily been in Emergency Medicine and Urgent Care Medicine. I will continue to keep current with my CME and make certain that it is varied and inclusive of the areas addressed by Urgent Care and Emergency Medicine Care.

I will review my CME with _____ (name of physician) and ask for additional appropriate CME to further my education and prepare me for working in an Emergency Department. We will review evidence based guidelines relevant to the practice of Urgent Care Medicine.

C. Practice-based learning and improvement

As I re-enter the practice of medicine in Urgent Care Medicine, I will need to review pertinent medical literature relevant to Urgent Care Medicine. I will have an in depth and focused review/discussion of an individual medical disease entity each day which relates to a patient that I/we have seen during the day. I will read and review the literature that is relevant to the patients I have seen that day.

I will incorporate performance and practice improvements from feedback from my mentor, patients, and colleagues. _____ (name of physician) will assess my individual patient care abilities and evaluate my progress.

D. Interpersonal and communication skills

I have always had excellent interpersonal and communication skills. I will continue to listen to patients, staff and colleagues and will continue to improve these skills. I will continue to speak honestly and with compassion, especially when relaying unfortunate medical information to patients. I will be courteous with staff and colleagues and continue to work on improving my communication skills.

E. Professional behavior

I feel that I behave in a professional manner. I will continue to do so and try to always be honest. I will be accountable for mistakes I make and will correct my mistakes and promptly admit it when I am wrong. I believe that medical professionals need to earn respect from patients, colleagues, staff and the general public by exhibiting professional behavior. By demonstrating respect and compassion to the patient this respect is earned.

F. Systems-based practice

Re-entering into the practice of medicine in Urgent Care Medicine will quickly expose me to various types of medical practice, delivery systems and payment methods as these are quite different from those encountered in the Emergency Department.

I believe it is important to utilize the medical delivery system to properly allocate resources to provide cost-effective, accessible, and high quality patient care. As a medical provider, one of my goals is to educate the patient of their role, as well as the other medical personnel, to effectively utilize the system's resources to provide optimal medical care.

Weaknesses:

A. New medications

I will need to ensure that I have current knowledge of new medications that have become available during the time I have been away from practice. Although I have kept my CME current, I will need to do further review of these new medications and/or dosing changes of previously available medications.

B. Current practice guidelines

I will need to further review practice guidelines relevant to Urgent Care Practice, as some of these will vary from those in Emergency Medicine.

C. Clinical Skills

I will ensure that my skills are appropriate, particularly in the areas of performing histories, physical exams, generating differential diagnoses, and formulating treatment plans.

4. Remediation Program**Phase I - Clinical observation:**

Prior to beginning my re-entry, I will attend a thirty hour category 1 CME conference providing and intensive review of Urgent/Emergency Medicine. Phase I will consist of a two-week period of shadowing _____ (name of physician) in his Urgent Care practice. He is an excellent physician who has a wonderful rapport with his patients, family, staff and colleagues. The goal of this phase is to refresh my recognition of what is involved in obtaining a history, performing the physical exam, ordering the appropriate ancillary studies, establishing a differential diagnoses and developing a treatment plan. This time period will allow me to become familiar with _____ (name of physician's) office, his practice's system processes with regard to the delivery of care and for me to become refreshed through observation with outpatient medicine. I will be working approximately thirty to forty hours per week during which time I will be seeing patients with _____ (name of physician). He sees approximately two patients per hour. There will be no on call during the

re-entry plan. At the end of each day, _____ (name of physician) and I will discuss the various medical conditions that have been presented during the day, the treatments of those conditions, the practice processes involved in the evaluation and the management of those patients with those conditions.

Phase I will consist of a two week time period of direct observation by _____ (name of physician). He will address discussions on refreshing my recognition of the components of the history and physical examinations, the appropriate use of ancillary tests, establishment of a differential diagnosis and the formulation of a treatment plan.

Phase II - Patient care with supervision

Phase II will be a four week time period in which I will provide Urgent Care patient care under the direct clinical supervision of _____ (name of physician) in his _____ (location) Urgent Care office. This four week period will be structured in phases of increasing patient acuity and volume. Initially I will be seeing patients with simple complaints not complicated by other existing medical conditions. If there is a patient complaint not familiar to me, _____ (name of physician) will provide one-on-one mentor review of history, physical examination and medical treatment. If there is a simple procedure that needs done such as suturing, foreign body removal, etc., _____ (name of physician) will directly supervise such procedures. _____ (name of physician) will provide direct supervision of all patient history and physical examinations performed until he confirms my ability to take an adequate history and do an appropriate physical examination. _____ (name of physician) will provide one-on-one supervision of all medical decision making. During this phase, I will present every patient I see to _____ (name of physician) before the patient's discharge and he will be review the chart on every patient I see prior to the patient's discharge. I will be seeing 1 patient per hour. After two weeks into Phase II, I will begin seeing patients with simple complaints, but with other existing medical problems such as diabetes, hypertension and cardiac disease. I will gradually increase patient volume and at the end of Phase II I will be seeing approximately two patients per hour. I will continue to present every patient I see to _____ (name of physician) prior to the patient's discharge from the clinic and the patient's chart will be reviewed by _____ (name of physician) no later than the end of the day of the patient's visit. I will be working thirty to forty hours per week and will be seeing approximately sixty to eighty patients per week.

I will be doing CME at home relative to Urgent Care Medicine to add to my knowledge base. At the end of every day, _____ (name of physician) and I will discuss areas of improvement, disease models in patients that we have seen during the day, and medical treatment rendered. No on call will be done during the entire re-entry plan. _____ (name of physician) and I will meet once a week for an hour to discuss my progress during this phase and review cases of interest, focused CME, my records and other items as appropriate. The goal of this phase is to re-introduce me to direct patient contact and to establish my competency in doing a history and physical exam, generating a differential diagnosis, and establishing a treatment plan.

Phase II will consist of a four week time period of direct observation by _____ (name of physician). At the end of this time period, a second written evaluation of his assessment of my skills and competency in performing a history and physical examination, deciding on appropriate ancillary testing, differential diagnosis formulations and appropriate treatment planning will be forwarded to the Board. _____ (name of physician's) written evaluation will incorporate reference to the core competencies in his discussion of my performance.

Phase III - Independent supervised care

Phase III will be a four and a half month time period in which I will provide independent supervised patient care. The goal will be to re-introduce me to more independent and unsupervised patient care. I will be working thirty to forty hours per week and seeing approximately two patients per hour. I will be responsible for seeing the patient, performing the history and physical examination, medically treating the patient, and completing chart documentation. _____ (name of physician) will monitor this phase by focused chart reviews of all new practice patients, higher acuity patients, patients with problems not seen in Phases I or II, and random chart audits with a minimum of fifty percent charts reviewed. Patients new to the practice, high acuity patients, and patients with problems not seen in Phases I or II will be discussed with _____ (name of physician) prior to patient discharge. Record review as described above will occur at the end of every practice day. At the end of every other week, _____ (name of physician) and I will meet for one hour and discuss patients of interest, my focused CME, my medical record documentation, and other items as appropriate.

I will keep a log of all procedures I do during phases II and III and _____ (name of physician) will supervise all procedures that I do until he confirms that I performed the procedure competently. He will sign the procedure log when he confirms my competency for the procedure.

Upon completion of Phase III, _____ (name of physician) will provide the Board with a summary approval letter stating my completion of the re-entry plan and on my ability and competence to practice independent unsupervised patient care. His letter will provide the Board a detailed summary and final report of my clinical skills and progress, including an assessment of my remediation activities, clinical skills, procedural skills, and medical record documentation in the context of core competencies.

ATTACHMENT 32

Sample reentry agreement

BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:)
) REENTRY AGREEMENT
Dr. _____)
)
Applicant.)

This Reentry Agreement is agreed to between the North Carolina Medical Board (“Board”), _____, M.D. (referred to as “Dr. _____” or “Mentee”) and _____, M.D. solely in his/her capacity as an agent of the Board (referred to as “Dr. _____” or “Mentor”).

Whereas, this matter is before the Board on the application of Dr. (Mentee) for a license to practice medicine and surgery; and

Whereas, Dr. (Mentee) has not actively practiced medicine since (date) and acknowledges the need to complete a program of reentry into the practice of medicine in order for the Board to issue him/her a license to practice medicine; and

Whereas, Dr. (Mentee) met with (a subcommittee of the Board/single Board member) to discuss his/her application, including the need for a program of reentry to ensure his/her safe transition back into the practice of medicine; and Now, therefore, it is ORDERED that:

1. The Board shall issue Dr. (Mentee) a license to practice medicine and surgery.
2. Dr. (Mentee) shall undertake a program of reentry into the practice of medicine pursuant to a reentry plan that shall consist of a period of mentoring from (date) to (date) (“Reentry Period”) by Dr. (Mentor). Dr. (Mentor) shall serve as Dr. (Mentee)’s mentor and provide the Board with a series of letters that describe his/her mentoring and make an assessment of Dr. (Mentee)’s competency.
3. Dr. (Mentee) may not practice medicine and surgery outside of the scope of this Reentry Agreement.
4. Dr. (Mentee) shall arrange to have Dr. (Mentor) perform mentoring of him/her in his/her practice of medicine during the Reentry Period. The Reentry Period shall consist of the following three phases:
 - a. Phase I – Observation of Mentor: The first phase of the Reentry Period shall last from (date) to (date) (“Observation Phase”). The Observation Phase shall consist of observation-only practice during which time Mentee will not be directly involved in the evaluation and management of any patients, but will observe the Mentor in these activities. Mentee and Mentor shall discuss aspects of the Mentor’s practice that shall include:
 - (1) Patient care;

- (2) Medical knowledge;
- (3) Communication
- (4) Practice based learning
- (5) Systems based care; and
- (6) Professionalism.

For the remainder of this Reentry Agreement, the above (1) – (6) shall be referred to collectively as the “Core Mentor Practice Areas.”

- b. Phase II – Direct Mentoring of Patient Care: The second phase of the Reentry Period shall last from (date) to (date) (“Direct Mentoring Phase”). The Direct Mentoring Phase shall consist of directly supervised practice during which time Mentee will be involved in the evaluation and management of patients under the direct supervision of the Mentor. Mentee and Mentor shall discuss aspects of Mentee’s practice that shall include the Core Mentor Practice Areas.
- c. Phase III – Independent Mentored Patient Care:
The third phase of the Reentry Period shall last from (date) to (date) (“Independent Mentored Phase”). The Independent Mentored Phase shall consist of Mentee’s independent, mentored practice during which time Mentee shall be involved in the evaluation and management of patients. Mentee and Mentor shall discuss aspects of Mentee’s practice that shall include the Core Mentor Practice Areas.

5. Dr. (Mentee) shall ensure that the Mentor delivers letters to the Board’s Director of Compliance no later than 30 days after the end of each phase which describe with detail the nature of the mentoring and state an opinion as to the level of competency with which Dr. (Mentee) practiced during each of the three mentoring phases. The detailed description of the nature of the mentoring will include comments about Dr. (Mentee)’s competency in each of the Core Mentor Practice Areas.

6. If the Board requests, then Dr. (Mentee) shall meet with members of the Board at such dates, times and places as directed by the Board to discuss his/her transition back into the practice of medicine, his/her clinical skills and any other subject the Board may deem necessary to discuss.

7. Any failure to comply completely and specifically with all terms, conditions and provisions of this Reentry Agreement shall constitute unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and shall be grounds, after any required notice and hearing, for the Board to annul, suspend, revoke, condition, limit and/or otherwise take action against Dr. (Mentee)’s license to practice medicine or to deny any application he/she might make in the future or then have pending for a license to practice medicine. Dr. (Mentee) acknowledges that this Reentry Agreement including, and not limited to, the admissions contained herein shall be admissible in any hearing before the Board that relates in any way to Dr. (Mentee).

8. This Reentry Agreement shall be treated as a public record within the meaning of Chapter 132 of the North Carolina General Statutes and shall be subject to public inspection and dissemination pursuant to the provisions thereof.

9. Dr. (Mentee) shall notify the Board in writing of any change in his/her practice address within ten (10) days of the change.

ATTACHMENT 32

10. This Reentry Agreement shall take effect upon full execution by Mentee, the Board and the Mentor and shall continue in effect until Mentee receives written confirmation from the Board that he/she has satisfactorily completed all requirements herein.

11. Mentor shall have the right, upon written notice to the Board, to withdraw as the Mentor. Such written notice shall state with particularity the reasons for withdrawal. Mentee's approval is not required for the Mentor to withdraw as Mentor.

12. It is specifically understood and agreed upon by all parties to this Reentry Agreement that the Mentor is acting solely as an agent of the Board pursuant to its powers contained in N.C. Gen. Stat. § 90-5.1. As an agent of the Board, the Mentor shall be immune from civil liability pursuant to N.C. Gen. Stat. § 90-14(e) and § 90-14(f).

13. Indemnification: Dr. (Mentee) agrees to and does hereby indemnify, save and hold harmless the Mentor in his/her reentry mentoring capacity and the Board from any and all loss and damage (including court costs and reasonable attorneys' fees) arising out of a complaint, suit and/or any type of legal action against the Board and/or the Mentor, the subject of which concerns care rendered during the Reentry Period to a patient by Dr. (Mentee). The intent of this paragraph is for Dr. (Mentee) to indemnify and hold harmless the Board and Mentor in his/her reentry mentoring capacity in the event that Dr. (Mentee) is sued along with the Board and Mentor arising out of patient care that Dr. (Mentee) rendered during the Reentry Period.

14. Dr. (Mentee) agrees not to seek any remedy or commence any action or legal proceeding of any nature or kind against the Mentor arising out of the performance of the Mentor's good faith duties as a Mentor.

15. The time frames, terms, provisions and conditions of the Reentry Period may be changed in Mentor's discretion, except that written approval from the Board's Medical Director is required if the timeframes provided in the Reentry Period are to be reduced in any way. Such Medical Director approval shall not be unreasonably withheld and shall be confirmed in writing or by electronic mail.

By consent and agreement of all parties and by Order of the North Carolina Medical Board this the ____ day of _____, 2009.

NORTH CAROLINA MEDICAL BOARD

By: _____
President

Dr. _____

I, a Notary Public within and for said County and State, do hereby certify that _____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

SWORN TO AND SUBSCRIBED

before me this _____ day of _____, 2009

Notary Public

My commission expires:

STATE OF NORTH CAROLINA

COUNTY OF _____

Dr. _____,

As Agent of The North Carolina Medical Board

I, a Notary Public within and for said County and State, do hereby certify that _____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

SWORN TO AND SUBSCRIBED

before me this _____ day of _____, 2009

Notary Public

My commission expires:

STATE OF NORTH CAROLINA

COUNTY OF _____